SPECTRUM PAIN CLINICS
~A Division of Encore Health Group~

ESTABLISHED PATIENT PAIN QUESTIONNAIRE

(PLEASE FILL OUT THIS QUESTIONNAIRE AND BRING IT WITH YOU TO YOUR FIRST APPOINTMENT)

Date: _____ Patient Name: _____ DOB: _____

Where is the location of your pain: _____

If you are a FEMALE patient do you believe you could be pregnant? ☐ Yes ☐ No Date of last menstrual cycle? _____

Have you been diagnosed with a new disease/disorder? ☐ Yes ☐ No If yes, please list? _____

Have you had any medication changes? ☐ Yes ☐ No If yes, please list? _____

Have you had any new surgeries? ☐ Yes ☐ No If yes, please list? _____

Are you currently taking pain medications? ☐ Yes ☐ No

*Please note that ALL pain medication must be present at every visit to be counted. This includes any empty bottles.

Does your pain medication cause any adverse reactions? ☐ Yes ☐ No

If yes, please mark which of the following reactions you are experiencing: ☐ Vision Changes ☐ Dizziness ☐ Fogginess ☐ Appetite Changes ☐ Weight Changes ☐ Forgetfulness ☐ Itching ☐ Nausea ☐ Sleepiness ☐ Constipation

Please mark any of the following symptoms/problems that you currently have:

General: ☐ Weight Loss ☐ Weight Gain ☐ Fever ☐ Night Sweats ☐ Fatigue

HEENT: ☐ Headaches ☐ Sinusitis ☐ Hearing Loss

Respiratory: ☐ Shortness of breath ☐ Sleep Apnea ☐ C-Pap

Cardiology: ☐ Chest Pain ☐ Irregular Heartbeat ☐ High Blood Pressure

Gastroenterology: ☐ Appetite Loss ☐ Chronic Nausea ☐ Heartburn ☐ Constipation

Genitourinary: ☐ Painful Urination ☐ Blood in Urine ☐ Enlarged Prostate

Endocrine: ☐ Abnormal Blood Sugars ☐ Easy Bruising/Bleeding

Vascular: ☐ Swelling in Legs

Musculoskeletal: ☐ Joint Pain ☐ Muscle Spasm ☐ Neck Pain ☐ Back Pain

Neurology: ☐ Drowsiness ☐ Dizziness ☐ Seizures ☐ Weakness/Numbness

Psychiatric: ☐ Depression ☐ Anxiety

Skin: ☐ Rash