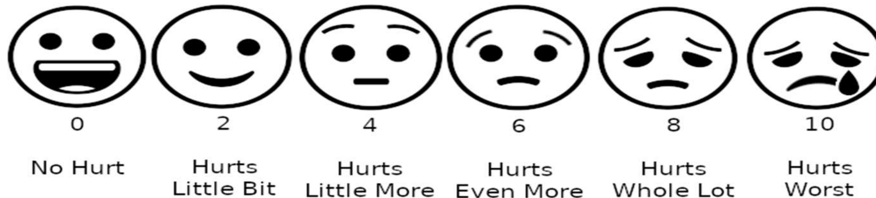
Patient Name: ___________________________________ Date of Birth: ______________________

WEST WICHITA FAMILY PHYSICIANS, P.A.
8200 West Central, Suite One
Wichita, Kansas 67212-9501
316-721-4544

PAIN QUESTIONNAIRE

Date Symptoms Started: _______________________

Current Pain Level (0- no pain and 10- the worst pain): _____________



Location of Pain (Circle **all** that apply)

Neck pain	**Arm pain** Right / Left / Both
Back pain	**Leg pain** Right / Left / Both

Additional Symptoms: (Circle **all** that apply)

Tingling	Numbness
Weakness	Balance problems
Difficulty walking	

Treatments tried	Place (x) if utilized	Start Date - End Date	Facility Where Completed
Ice or Heat		-	
Home stretching		-	
Physical therapy		-	
Chiropractic		-	
Massage/Acupuncture		-	
TENS therapy		-	
Bracing/Orthotics		-	

Medications	Place (x) if utilized	Name of medication tried
Anti-inflammatory (NSAIDS) Aspirin, Ibuprofen, Aleve, Meloxicam, Celebrex, Diclofenac		
Oral steroids Methylprednisolone, Prednisone		
Muscle Relaxers Cyclobenzaprine, Methocarbamol, Baclofen, Carisoprodol, Tizanidine		
Pain Medication Tylenol, Hydrocodone, Oxycodone		

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What medical tests have been completed to evaluate your pain? (Fill in chart)

	Date Performed	Facility Where Completed
X-ray		
CT Scan		
Myelogram		
MRI		

Have you received previous Epidural steroid injections for this source of pain? (Circle) **Yes / No**

If yes, Date: ______________

If you answered yes, what percentage of pain relief did you receive? (Circle)

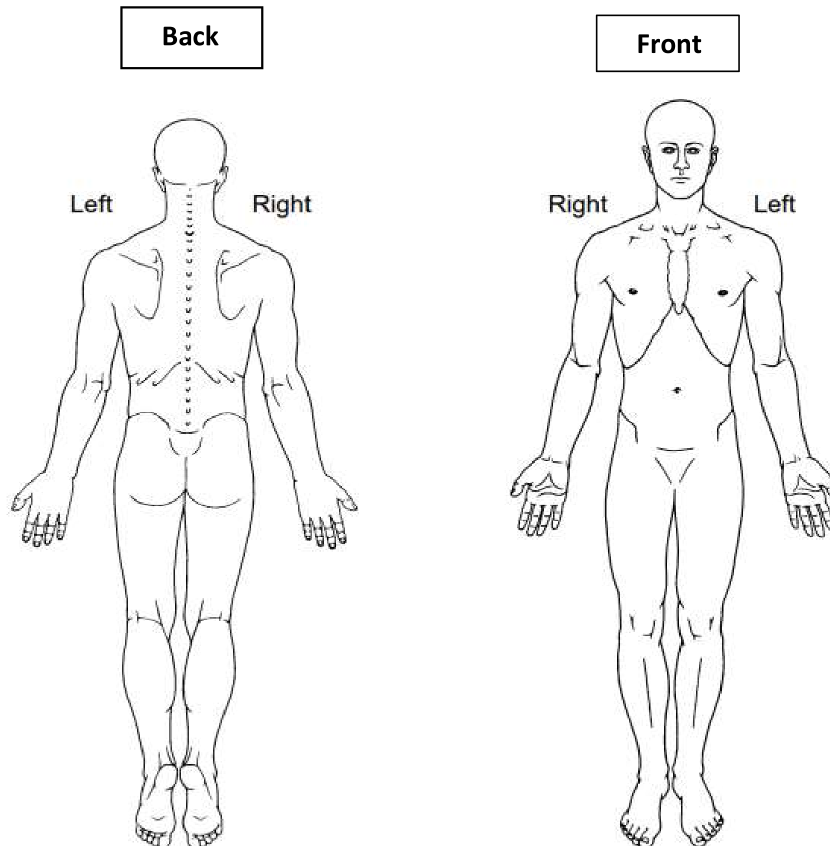
No pain relief 50 % pain relief Greater than 50 % pain relief

Has your pain interfered with?

Work	Yes / No
House Responsibilities	Yes / No
Hobbies/ Recreation	Yes / No
Sleep	Yes / No

Pain Location

Mark a **solid** dot where your pain is located. If your pain radiates elsewhere, draw a **line** from the solid black dot to where the pain travels and ends.



Patient Signature: ____ Date:__________________________