NAME: _____ DATE: _____

DALLAS BACK PAIN QUESTIONNAIRE

PLEASE MAKE AN "X" ALONG THE LINE TO SHOW HOW FAR FROM NORMAL TOWARD THE WORST POSSIBLE SITUATION YOUR PAIN PROBLEM HAS TAKEN YOU.

1. How bad is your pain?

|_____|_____|_____|_____|_____|

no pain worst possible

2. How bad is the pain at night?

|_____|_____|_____|_____|_____|

no pain worst possible

3. Does the pain interfere with your lifestyle?

|_____|_____|_____|_____|_____|

no problem total change in lifestyle

4. How good are the pain killers for your pain?

|_____|_____|_____|_____|_____|

complete relief no relief

5. How stiff is your back?

|_____|_____|_____|_____|_____|

no stiffness worst possible stiffness

6. Does your pain interfere with walking?

|_____|_____|_____|_____|_____|

no problem cannot walk

7. Do you hurt when walking?

|_____|_____|_____|_____|_____|

no pain worst possible pain

8. Does your pain keep you from standing still?

|_____|_____|_____|_____|_____|

can stand as long as I want cannot stand at all

9. Does your pain keep you from twisting?

|_____|_____|_____|_____|_____|

no problem cannot twist

DALLAS BACK PAIN QUESTIONNAIRE

10. Does your pain allow you to sit in an upright hard chair?

sit as long as I like — cannot us a hard chair at all

11. Does your pain allow you to sit in a soft arm chair?

sit as long as I like — cannot use a soft chair at all

12. Do you have back pain when lying in a bed?

no pain — no relief at all

13. How much does your pain limit your normal lifestyle?

no limit — cannot do anything

14. Does your pain interfere with your work?

no problem — totally cannot work

15. How much have you had to change your work place because of back pain?

no change — so much that I cannot keep a job

MCGILL PAIN QUESTIONNAIRE - SHORT FORM*

Directions: Please read each word below, and decide whether it describes what your pain has felt like over the PAST 4 WEEKS. If a word does not describe your pain, circle *NO* (DOES NOT APPLY), and go on to the next item. If a word does describe your pain, then rate how strongly you have felt that sensation (1 = Mild, 2 = Moderate, 3 = Severe). Remember, make these ratings as to how your pain has felt over the PAST 4 WEEKS.

My pain felt like it was . .	***DOES NOT APPLY***	***MILD***	***MODERATE***	***SEVERE***
1. THROBBING	NO	1	2	3
2 SHOOTING	NO	1	2	3
3. STABBING	NO	1	2	3
4. SHARP	NO	1	2	3
5. CRAMPING	NO	1	2	3
6. GNAWING	NO	1	2	3
7. HOT - BURNING	NO	1	2	3
8. ACHING	NO	1	2	3
9. HEAVY	NO	1	2	3
10. TENDER	NO	1	2	3
11. SPLITTING	NO	1	2	3
12. TIRING - EXHAUSTING	NO	1	2	3
13. SICKENING	NO	1	2	3
14. FEARFUL	NO	1	2	3
15. PUNISHING - CRUEL	NO	1	2	3

Please circle the number which describes your level of pain right now:

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Worst Pain Possible

Please circle the number which describes your typical level of pain:

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Worst Pain Possible

Please check the word that best describes your pain this week:

- ☐ NO PAIN
- ☐ MILD
- ☐ DISCOMFORTING
- ☐ DISTRESSING
- ☐ HORRIBLE
- ☐ EXCRUCIATING

COMPREHENSIVE
PAIN QUESTIONNAIRE

Please complete this form before your first appointment with the The Lakewood Group. Your careful answers will help us to understand your pain problem and design the best treatment program for you.

You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission.

BACKGROUND INFORMATION

1. Today's date: _____

2. Patient's full name: _____

3. Address: _____

4. Home phone: Area code _____ Number _____

5. Cell phone: Area code _____ Number _____

6. Work phone: Area code _____ Number _____

7. Person to contact in an emergency:

   Name: _____, Phone number: _____

   Address: _____

8. Gender: _____

9. Age: _____ Date of birth: _____

10. Height: _____ Weight: _____

11. Referring physician's name: _____

12. Education (please check all that apply and write number of years completed):

    Years of formal education: _____

    ☐ High school graduate

    ☐ College graduate

    ☐ Advanced degree . . . What degree?

13. Marital status (please check current status):

- □ Single (never married)
- □ Married . . . . How long?_____
- □ Remarried . . . How long?_____
- □ Separated . . . How long?_____
- □ Divorced . . . How long?_____
- □ Widowed . . . How long?_____

If married, please give your spouse's occupation: _____

14. Number of children: _____ Number of grandchildren: _____

15. With whom are you currently living (please check all that apply)?

- □ Alone
- □ Parent
- □ Spouse
- □ Other(s) . . . Who?_____
- □ Children . . . How many live with you?_____

16. Current occupation or last job: _____

17. Current employment status (please check all that apply):

- □ Employed full-time
- □ Employed part-time
- □ Unemployed
- □ Homemaker
- □ Retired
- □ Student
- □ Unemployed because of pain

18 . Are you currently working?

□ Yes . . . please skip to question 24. □ No . . . Go to question 19.

19. Would you return to work if you had no pain problem? □ Yes □ No

20. Have you tried to return to work? □ Yes □ No

21. Is your present or previous job still open to you? □ Yes □ No

22. What was your last day of work? Month_____ Day_____ Year_____

23. Has your employer been helpful and understanding about your pain problem?

□ Yes □ No □ Not applicable

24. Are you receiving compensation or disability payments now? □ Yes □ No

If yes, are payments adequate? □ Yes □ No

25. Do you have an application for compensation or disability payments pending?

□ Yes □ No

26. Is your pain the result of an accident? □ Yes □ No

If yes, where did it occur? Circle one: home, work, vacation, car, other (describe):

27. Are you suing anyone because of your pain or injury? □ Yes □ No

28. Have you brought suit in the past? □ Yes □ No

If yes, what was the outcome?_____

CHARACTERISTICS OF PAIN

29. What is the main problem for which you are seeking treatment at The Lakewood Group?

_____

_____

30. Please describe the location(s) of your pain:

_____

31. How long have you had your current pain problem (in years and/or months)?

_____

32. How did your current pain start? Was there a precipitating event?

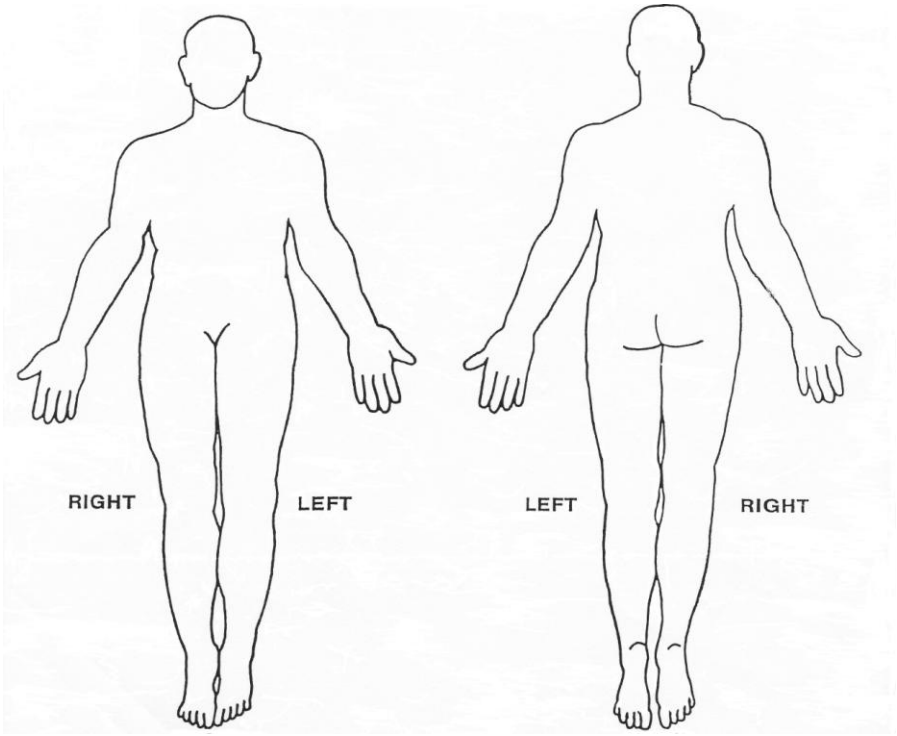
_____

_____

33. How often do you have your pain (please check one)?

□ Constantly (100% of the time)
□ Nearly constantly (60% to 95% of the time)
□ Intermittently (30% to 60% of the time)
□ Occasionally (less than 30% of the time)

34. Please mark the location(s) of your pain on the diagrams below with an "X." If whole areas are painful. please shade in the painful area.



Front *Back*

35. In general, during the past month when has your pain been the worst (please check one)? □ Morning □ Afternoon □ Evening □ Night □ No typical pattern

36. How do the following affect your pain (please check one for each item)?

	Decrease	*No Effect*	*Increase*
Lying down			
Standing			
Sitting			
Walking			
Exercise (if applicable)			
Medication			
Relaxation			
Thinking about something else			
Coughing/Sneezing			
Urination			
Bowel movements			

Are there other factors that make your pain . . .

better (please list)? _____

worse (please list)?_____

37. During the past month, how much did pain interfere with the following activities (circle the number for each item that best describes your situation)?

	Not at all	*A little bit*	*Moder-ately*	*Quite a bit*	*Extremely*
Going to work	1	2	3	4	5
Performing household chores	1	2	3	4	5
Doing yard work or	1	2	3	4	5
Socializing with friends	1	2	3	4	5
Participating in recreation	1	2	3	4	5
Having sexual relations	1	2	3	4	5
Physically exercising	1	2	3	4	5
Sleeping	1	2	3	4	5
Eating	1	2	3	4	5

38. How often during the day do you lie down because of pain?

□ Never □ Seldom □ Sometimes □ Often □ Constantly

39. Which of the following best describes your usual level of pain?

□ Mild □ Uncomfortable □ Distressing □ Very Severe □ Unbearable

40. Please rate your pain intensity on a scale from 0 = no pain to 10 = excruciating, incapacitating, worst pain possible.

Write the *number* in the spaces below:

Describes your pain at its worst _____

Describes your pain at its least _____

Describes your pain on the average _____

41. When you are in pain, how often is your husband/wife/other family member supportive and encouraging?

□ Never □ Seldom □ Sometimes □ Frequently □ Always

42. When you are in pain, how often does your husband/wife/other family member ignore you or become angry?

□ Never □ Seldom □ Sometimes □ Frequently □ Always

43. How often has there been disharmony/conflict between you and your spouse, parent or children since the start of your pain?

□ Never □ Seldom □ Sometimes □ Frequently □ Always

44. During the past month, how often have you been tense or anxious?

□ Never □ Seldom □ Sometimes □ Frequently □ Always

45. During the past month, how often have you been depressed or discouraged?

□ Never □ Seldom □ Sometimes □ Frequently □ Always

46. During the past month, how often have you been irritable and upset?

□ Never □ Seldom □ Sometimes □ Frequently □ Always

47. Have any of your family members ever had a chronic pain problem?
□ Yes □ No

If yes, who?_____

What kind of pain?_____

PAIN TREATMENT

48. Please check all of the treatments you have tried for your pain, and complete the appropriate columns at the right.

	Treatment	*Dates*	*Results*
□	Hospital bed rest		
□	Traction		
□	Surgery		
□	Hypnosis		
□	Acupuncture		
□	Nerve block or injection		
□	TENS (electrical stimulator)		
□	Physical Therapy		
□	Exercise		
□	Heat Treatment		
□	Cold Treatment		
□	Biofeedback		
□	Psychotherapy		
□	Chiropractic		
□	Other		

49. Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? □ Yes □ No

If yes, when?_____

50. In the past year, has your weight (check one)

□ Remained the same?

□ Increased? By how many pounds?_____

□ Decreased? By how many pounds?_____

If your weight decreased were you dieting? □ Yes □ No

51. Do you smoke cigarettes? □ Yes □ No

If yes, how many packs a day?_____For how many years?_____

52. Do you drink alcoholic beverages? □ Yes □ No

If yes, what/how much?_____How often?_____

53. Please check all of the medications you have tried for your current pain problem, and complete the appropriate columns at right. **Or provide a list of all your medications.**

	Medication type	**Drug Name**	**Start/stop dates**	**Daily Dose**
□	Aspirin			
□	Acetominophen			
□	Nonsteroidal anti-inflammatories (Motrin, Naprosyn, Indocin, Feldine)			
□	Antidepressants (Elavil, Desyrel, Nardil, Tofranil, Sinequan, Trazodone, Prozac, Zoloft, Paxil, Cymbalta, ...)			
□	Codeine or products with codeine			
□	Oral narcotics (Percocet, Darvocet, Dilaudid, Talwin, Oxycontin)			
□	Injectable narcotics (Morphine, Demerol)			
□	Barbiturates (Nembutal, Seconal)			
□	Tranquilizers (Valium, Librium, Xanax, Ativan)			
□	Muscle relaxants (Robaxin, Flexeril, Baclofen...)			
□	Major tranquilizers (Thorazine, Stellazine, Haldol)			
□	Sleeping medications (Restoril, Ambien, Lunesta, Trazondone			

54. Aside from your pain problem, how is your general health (please check one)?

□ Excellent □ Minor health problems only □ Major health problems

55. Have you had any of the following health problems (please check all that apply)?

	High blood pressure		Diabetes or high blood sugar
	Angina or chest pain		Kidney disease
	Heart attack		Liver disease
	Asthma or wheezing		Tumor-induced angiogenesis (TIA) or stroke
	Chronic cough		Seizure or epilepsy
	Bleeding problem		Cancer
	Arthritis		Other; specify _____

56. Are there things causing stress in your life other than your current pain problem?
□ Yes □ No
If yes, please describe: _____

_____

57. What medications are you taking (other than those you have listed for your pain problem)?

_____

58. Do you have any allergies?_____

59. Surgeries:

Date	Hospital	Type of Operation	Type of Anesthesia

60. What are you expecting from treatment. Is there any additional information you think we should have?

_____

_____

_____