Name_________________________________ DOB________________________

Pain Questionnaire

Did you have an injury in a car accident?◯Yes ◯No Accident Date_______

◯T-bone ◯Rear-end ◯Side collision ___________

Where you the: ◯Driver ◯Passenger Did you have seat belt on: ◯ Yes ◯No

Did you have a work injury?◯Yes ◯No Injury date_______Occupation at the time: ____________________

Is your pain in the

Neck ◯Left ◯Right ◯Both

Mid back ◯Left ◯Right ◯Both

Low back ◯Left ◯Right ◯Both

Hip ◯Left ◯Right ◯Both

Does your pain radiate to

Head ◯

Upper shoulder ◯Left ◯Right ◯Both

Arm and hand ◯Left ◯Right ◯Both

Between shoulders ◯Left ◯Right ◯Both

Buttock ◯Left ◯Right ◯Both

Groin ◯Left ◯Right ◯Both

Front of thighs ◯Left ◯Right ◯Both

Outer thighs ◯Left ◯Right ◯Both

Inner thighs ◯Left ◯Right ◯Both

Back of thighs ◯Left ◯Right ◯Both

Lower legs and feet ◯Left ◯Right ◯Both

Is your pain

◯Sharp ◯Dull ◯Aching ◯Throbbing ◯Burning ◯Shooting ◯Stabbing ◯ Electric shock-like

Do you have

◯Numbness ◯ Tingling

Rate your average pain level (1 is the least amount of pain and 10 is the highest amount of pain)

1 2 3 4 5 6 7 8 9 10

What makes your pain better?

◯Sitting ◯Laying down ◯Physical therapy ◯Chiropractor ◯Massage ◯Medications ◯Other: _______

What makes your pain worse?

◯Standing ◯Walking ◯Reaching ◯Bending ◯Lifting ◯Other:___________________________________

What type of treatment have you tried so far?

◯Muscle relaxants ◯Anti-inflammatory medication ◯Pain medication ◯PT ◯Massage ◯Chiropractor

◯ TENS unit ◯Trigger point injections ◯Other injections________________ ◯Other_______________

Did you have Xray, CT or MRI of your spine / joint? Date______________

You must bring CD of your MRI or CT to you appointment in order to schedule an injection. *Report of your imaging sent to us from your referring physician is not enough. We must be able to view your images to plan an appropriate injection for you.*