



Danya Godoy, M.D
 601 Seventh Street South
 St. Petersburg, Florida 33701
 (727) 824-8383 • Fax: (727) 824-8388
 www.suncoastmedicalclinic.com

COMPREHENSIVE PAIN QUESTIONNAIRE

NAME: _____ AGE: _____ SEX: _____

Who referred you? _____ Family physician: _____

CHARACTERISTICS OF PAIN:

What is the main problem for which you are seeking treatment? _____

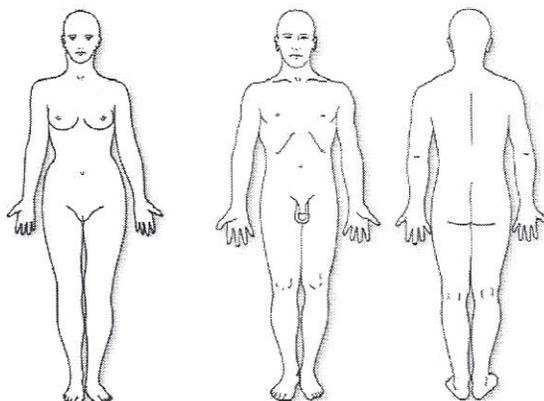
How long have you had your current pain? _____ years _____ months

What was the precipitating event, illness, or injury? (Explain)

Injury at work? _____ Injury not at work? _____ Motor vehicle accident? _____

PAIN LOCATION/ PAIN RADIATION:

Please **mark the location(s) of your pain on with an "X"**. If whole areas are painful, **circle the areas**. If pain travels, **draw an arrow** indicating where pain starts and ends.



PAIN/SYMPATOM QUALITY: (please circle) Burning Cramping Sharp Dull/aching Throbbing

SEVERITY OF PAIN: (please circle) Mild Moderate Severe

PAIN SCALE: (0 being no pain and 10 severe pain) 0 1 2 3 4 5 6 7 8 9 10

ASOCIATED SYMPTOMS: (please circle)

Stiffness
 Muscle spasm
 Swelling

Urinary incontinence
 Sexual dysfunction
 Bowel incontinence

Redness/Warmth
 Weakness
 Numbness/Tingling

PAIN FREQUENCY: (please circle) Constant pain (all the time) Intermittent pain (comes & goes)

PAIN BETTER WITH: (please circle)

Rest	Elevation	Walking
Heat	Stretching	Medications
Ice	Sitting	Lying down
Massage	Standing	

PAIN WORSE WITH: (please circle)

Bending forward	Walking	Lifting
Bending backward	Standing	Twisting
Weight bearing	Sitting	Other _____

PREVIOUS TREATMENTS: Please place "X" next to items that apply.

Previous Treatments	When?	Good Results?	Poor results?
Physical Therapy			
Acupuncture			
Chiropractic Therapy			
Nerve Blocks			

PAST MEDICAL HISTORY: (please circle all that apply)

Acid Reflux /GERD	Heart Attack	Kidney disease
Alcoholism	Hepatitis B or C	Obesity
Anxiety	Bleeding problems	Osteoporosis
Irregular heart beat	Depression	Oxygen dependent
Osteoarthritis	Diabetes	Stroke
Rheumatoid arthritis	Emphysema /COPD	Seizure disorder
Asthma	Fibromyalgia	Ulcer
Cancer: _____	High blood pressure	Other: _____
Cirrhosis	Hyperthyroidism	
Coronary Artery Disease	Hypothyroidism	

PAST SURGICAL HISTORY:

Date /Type of Operation	% relief if applicable	Duration of relief

ALLERGIES:

_____ No Known Drug Allergies

Allergy _____	Reaction _____

MEDICATIONS:

Medication Name	Dose (mg, mcg)	Directions (how many/day)	Prescribing Doctor

FAMILY HISTORY: Please specify any medical or psychiatric conditions in your family:

History of addiction in your family? Yes ___ No ___

Family Member	Living?	Deceased?	Age (current or at time of death)	Health Conditions or Illnesses
Father				
Mother				
Sibling				
Sibling				
Sibling				

TOBACCO/ALCOHOL/SUPPLEMENTS: Please place "X" in applicable column

Substance	No-Never	Yes-In past	Yes-Currently	Amount
Tobacco				
Alcohol				

SUBSTANCE ABUSE: Please place "X" in applicable column

Substance	No-Never	Yes-In past	Yes-Currently
Alcoholism			
Marijuana			
Cocaine			
Prescription drug abuse			
IV drug use			

How many years has it been since you last abused alcohol or drugs? _____

If you have a history of substance abuse, have you ever been in a detoxification program?
 ___ No ___ Yes When? _____

MARITAL STATUS: (please circle one) Single Married Divorced Widowed Domestic Partner

NUMBER OF CHILDREN: (please circle one) 0 1 2 3 4 5 6 7 8 9

EMPLOYMENT: (please circle) Full-time Part-time Retired Unemployed Disabled

Occupation: _____

If you are unemployed or employed part-time, is it due to your present pain condition? ___ No ___ Yes

If you are currently unemployed, indicate how long you have been off work: _____

PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem, including your current pain? ___Yes ___No

For what diagnosis were you treated? When? _____

Please list you current or last therapists:

REVIEW OF SYSTEMS (ROS): (please circle all symptoms that apply)

- | | | |
|---------------------------|-------------------------|-----------------------|
| Fatigue | Chest Pain | Joint pain/stiffness |
| Unintentional weight loss | Fluttering of the heart | Seizures |
| Unintentional weight gain | Swelling in the feet | Fainting/ dizziness |
| Fever | Easy bruising | Headaches |
| Chills | Excessive bleeding | Tremor |
| Glasses or contacts | Abdominal pain | Weakness |
| Blurred or double Vision | Heartburn | Balance problems |
| Ringing of the ears | Diarrhea | Depression |
| Ear pain | Constipation | Anxiety |
| Hearing problems | Nausea | Suicidal thoughts |
| Difficulty swallowing | Vomiting | Sleeping problems |
| Tooth pain | Frequent urination | Memory loss |
| Shortness of breath | Poor bladder control | Heat/cold intolerance |
| Wheezing | Bladder Infections | Excessive sweating |
| Chronic cough | Painful urination | Anemia |
| TB (Tuberculosis) | Back pain | Itchiness |
| Coughing up blood | Limb pain | Hives/ rashes |

2/9/2010