



PAIN COMPLAINT QUESTIONNAIRE

Please complete this questionnaire as accurately as possible. Your answers help us understand your pain and prior treatment.

PATIENT & VISIT INFORMATION

Date of Appointment: _____

Patient Name: _____ Height: _____ Weight: _____

Date of Birth: _____ Body Part/Location of Pain: _____

How did this problem begin? ☐ Fall/Direct Blow ☐ Motor Vehicle Accident ☐ Work Injury ☐ Sports Injury ☐ Gradual/Other

When did the pain begin? _____ Please describe how the pain or injury began, including important details:

Is today's visit related to an accident, injury, or personal injury claim. ☐ No ☐ Yes — Complete Sections A and B if applicable.

A. INJURY / CASE INFORMATION

Exact Date of Injury: _____ ☐ AM ☐ PM File/Case #: _____

Were you working or on the clock at the time of injury? ☐ No ☐ Yes Adjuster Name: _____

Attorney / Law Firm: _____ Phone: _____

B. MOTOR VEHICLE ACCIDENT DETAILS Complete only if injury resulted from a motor vehicle accident.

Total vehicles involved: _____ Your vehicle make/model: _____

Your position: ☐ Driver ☐ Front Passenger ☐ Rear Behind Driver ☐ Rear Behind Passenger ☐ Rear Center ☐ Other

Seat belt? ☐ No ☐ Yes Airbags deploy? ☐ No ☐ Yes Loss of consciousness? ☐ No ☐ Yes – For how long? _____

Vehicle moving during impact? ☐ No ☐ Yes Impact location: ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side ☐ Multiple

Did you anticipate the crash: ☐ No ☐ Yes Was your vehicle towed or is it undrivable? ☐ No ☐ Yes

Did another vehicle hit yours? ☐ No ☐ Yes Other occupants in your vehicle: _____

AT THE SCENE Police came to scene? ☐ No ☐ Yes Ambulance came to scene? ☐ No ☐ Yes

How did you leave the scene? ☐ Drove ☐ Ride from another person ☐ Transported by Ambulance ☐ Other

Where did you go immediately after? ☐ Home ☐ Relative/Friend ☐ Urgent Care ☐ Hospital ☐ Other

CURRENT SYMPTOMS

☐ Recent fever ☐ Chills ☐ Night sweats ☐ Unintentional weight change ☐ Cough ☐ Shortness of breath ☐ Nausea/vomiting

☐ Constipation ☐ Diarrhea ☐ GI bleeding/ulcer symptoms ☐ Pain with urination ☐ Urinary retention ☐ Bladder incontinence

☐ Bowel incontinence ☐ Trouble sleeping ☐ Memory problems ☐ Seizures ☐ Skin breakdown ☐ Groin/saddle numbness

☐ New/progressive weakness ☐ Other current symptoms: _____ ☐ None

Current infection, open wound, fever, or antibiotics? ☐ No ☐ Yes Details: _____

Implanted device? ☐ None ☐ Pacemaker/ICD ☐ Spinal cord stimulator ☐ Peripheral nerve stimulator ☐ Pump ☐ Other

Before this problem, had you ever had pain, treatment, imaging, a car accident, fall, sports injury, or other significant injury involving the same body area(s)? ☐ No ☐ Yes – Describe what happened, the body area involved, and approximate date(s):



PAIN LOCATION & SEVERITY

Use the diagram to show where you have pain:

Pain Levels

WORST PAIN: _____(0-10)

ON AVERAGE: _____(0-10)

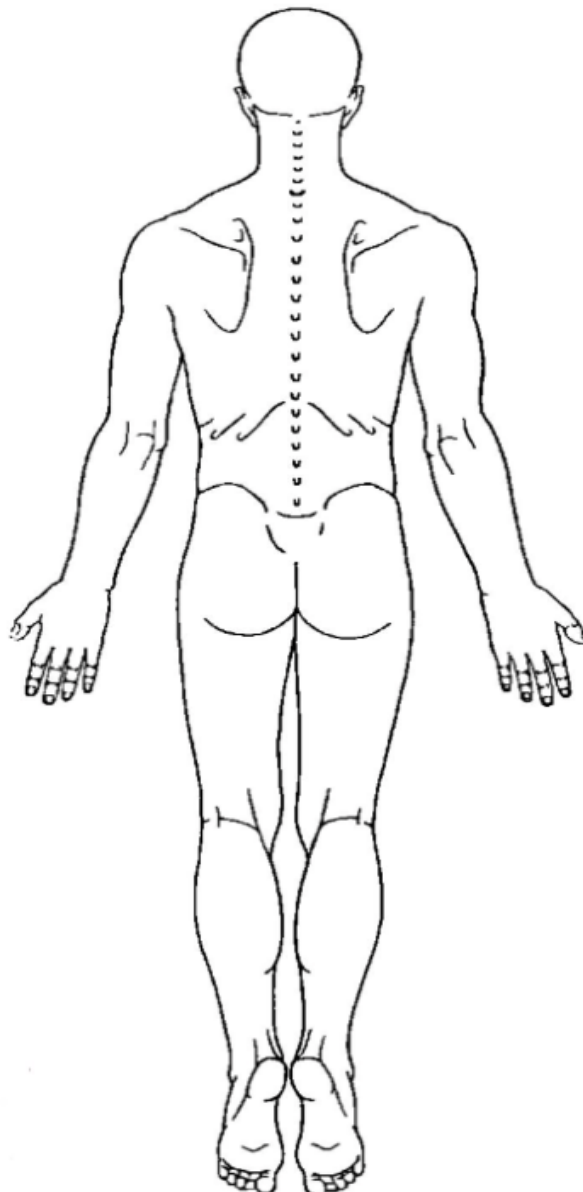
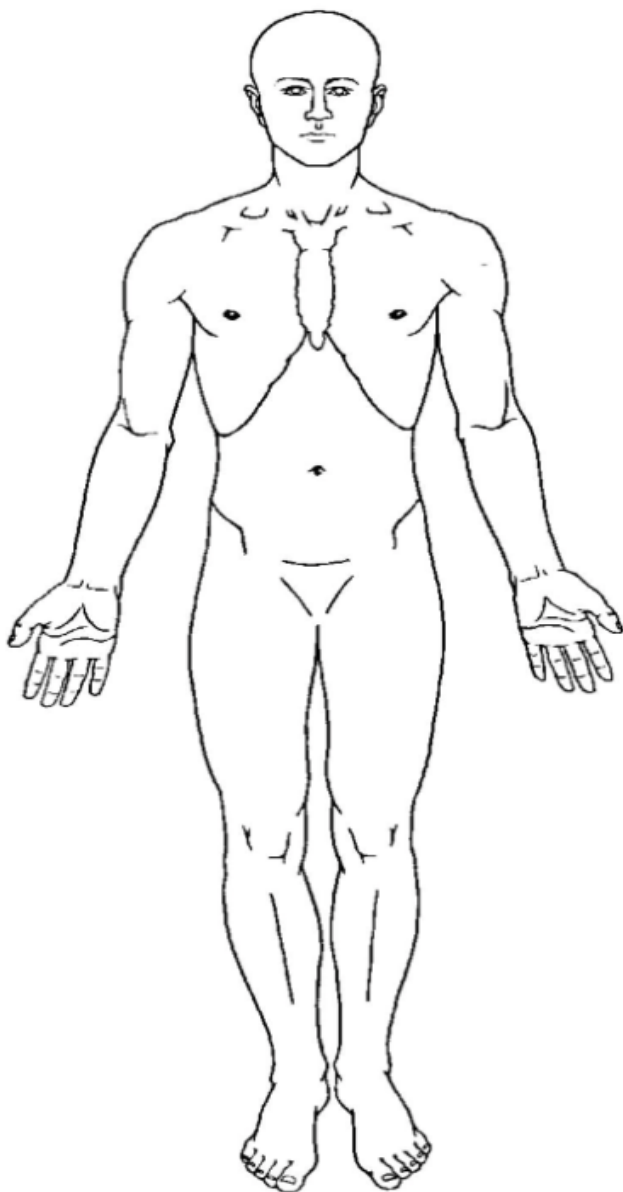
LEAST PAIN: _____(0-10)

N = pain that is present now

W = pain that existed before but is now worse

R = pain that had improved or resolved and has returned

Shade areas of numbness or tingling.



Pattern: ☐ Brief ☐ Intermittent ☐ Continuous

Does pain radiate? ☐ No ☐ Yes – Where? _____

Describe (check all that apply): ☐ Aching ☐ Burning ☐ Cramping

Weakness? ☐ No ☐ Yes

☐ Dull ☐ Numb ☐ Sharp ☐ Shooting ☐ Spasm ☐ Stabbing

Numbness/tingling? ☐ No ☐ Yes

☐ Tender ☐ Throbbing ☐ Tingling ☐ Other _____



What actions or positions make your pain worse?

What makes your pain better?

Pain at rest, while lying in bed or relaxing? ☐ No ☐ Yes

Does pain interfere with sleep? ☐ No ☐ Yes

Activities that are difficult because of pain: ☐ Sleep ☐ Sitting ☐ Standing ☐ Walking ☐ Working ☐ Exercise ☐ Self-care
☐ Household tasks ☐ Driving ☐ Social activities

How does pain limit daily activities, function, or work?

What are the most important activities that you want to do?

Overall pain interference: _____ (0 = none - 10 = completely)

EMPLOYMENT & FUNCTIONAL STATUS

Currently employed? ☐ No ☐ Yes – ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed Years with employer: _____

Job Title: _____ Employer: _____

Approx. hours/week: _____ Has your ability to work changed because of this condition/injury? ☐ No ☐ Yes

Current work status / restrictions: _____

Dates missed due to injury: _____

MEDICAL EVALUATION, TESTING & TREATMENT

Have you previously seen a physician for this problem? ☐ No ☐ Yes – Date first sought care: _____

Evaluation: ☐ Hospital / ER ☐ Urgent Care ☐ Primary Care ☐ Chiropractor ☐ Physical Therapy ☐ Pain Specialist ☐ Other

Provider / Facility	Specialty / Type of Care	Approx. Dates Seen

- Imaging of the same body area(s)? ☐ X-ray ☐ MRI ☐ CT ☐ EMG/Nerve Conduction Study ☐ Other ☐ None

Facility / Approximate Date: _____

- Previous treatments tried and/or failed: ☐ Advil/Motrin/ibuprofen ☐ Tylenol/acetaminophen ☐ Topicals ☐ Ice / Heat
☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture ☐ Massage ☐ Other _____

Injections for this problem/injury? ☐ No ☐ Yes – Type/Provider/Date: _____

Surgery for this problem/injury? ☐ No ☐ Yes – Type/Surgeon/Date: _____

Before this problem, had you ever had another significant injury involving the same body area(s)? ☐ No ☐ Yes

Prior Accident / Injury	Approx. Year	Treatment	Improvement or relief?

Have you ever made an injury claim before this incident? ☐ No ☐ Yes – Briefly describe and provide approximate dates: _____



ALLERGIES ☐ No Known Allergies

Betadine: ☐ No ☐ Yes Steroids: ☐ No ☐ Yes List any medication, food, latex, adhesive, or other allergies and the reaction:

Allergy	Reaction

CURRENT MEDICATIONS

Medication / Strength	How Often	Prescriber / Reason

*If additional space is needed, please provide your complete medication list at check-in for your appointment.

ANYTHING ELSE WE SHOULD KNOW?

Please include any other history, concern, treatment goal, or information you think may be important to your care:

PATIENT CERTIFICATION

I understand that this information becomes part of my medical record. I certify that the information provided is accurate to the best of my knowledge and that I have not intentionally omitted prior symptoms, treatment, injuries, imaging, or claims relevant to the current condition.

Patient/Legal Representative Signature _____ Date _____ Printed Name _____

ACCIDENT / PERSONAL INJURY BILLING ELECTION - Complete only if applicable

Our standard policy requires us to bill your health insurance unless you, the patient, specifically request by signature below not to do so.

I DO NOT want my health insurance billed.

Please be advised that if you later decide to bill health insurance, it will be billed from that time and date only.

Patient/Legal Representative Signature _____ Date _____