

Clearwater Pain Management Associates
New Patient Questionnaire

Name _____ Age _____ Date _____
Referring Physician _____ Primary Care Physician _____
Occupation _____

I. Chief Complaint:

1) Where is your pain located? _____

2) When and how did it begin? _____

3) Does your pain radiate anywhere? _____

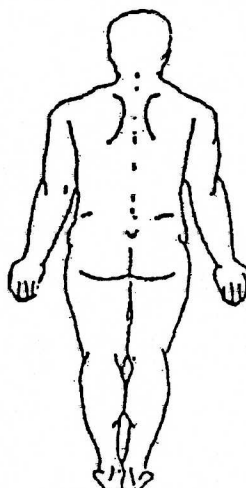
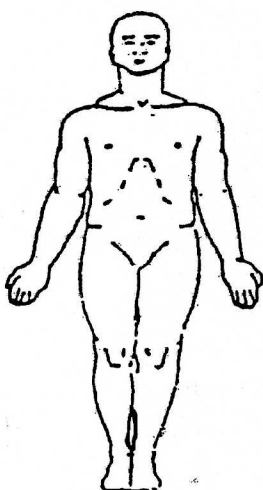
4) Please mark the area(s) in the diagrams below where you are having pain:

FRONT

RIGHT SIDE

BACK

LEFT SIDE



5) On a scale from 0-10, with 0 being no pain and 10 being the worst pain imaginable, what number describes your pain:

At it's best: _____ At it's worst _____ Right at this moment: _____

6) How often does the pain occur: Continuously Several times a day Intermittent
 Occasionally Less than daily

7) When is your pain worse?

Morning Afternoon Evening No Usual Pattern All the time

8) How has the pain intensity changed since it began?

Better Worse No change

