Independence-Monmouth Family Medicine

1430 Monmouth St., P.O. Box 309 Independence, Or 97351

CHRONIC PAIN QUESTIONNAIRE

Fill out completely and hand to receptionist before we take you back to exam room.

How were you functioning before or without your current pain management program?

	Very Well	Well Enough	Almost Well	Poorly	Not at all
At home house/yard tasks…….					
Hobbies.....					
Job.....					
Family functions.....					
Sexual and marital…….					
Exercise……..					

How well are you functioning now?

At home house/yard tasks…….					
Hobbies.....					
Job.....					
Family functions.....					
Sexual and marital…….					
Exercise……..					

What is helping you to function better? Exercise Spinal injections Pain medication
Heat/Ice Massage Other_____

What is/are the major impairments to your function?
What are your painful areas?
Are these any better or any worse since your last visit?
What side effects are you having from your medications?
Please list your medications that we use to deal with your pain and how many of each do you take per 24 hours?

_____ #/24 hours_____
_____ #/24 hours_____
_____ #/24 hours_____
_____ #/24 hours_____

Do you need refills of medications? Yes/No Of what?

_____

Name: _____ Date:_____