ADVANCE SPINE CARE AND PAIN MANAGEMENT
PAIN FREE, LIVE FREE
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New Patient Pain History Questionnaires

PATIENT INFORMATION **患者信息**

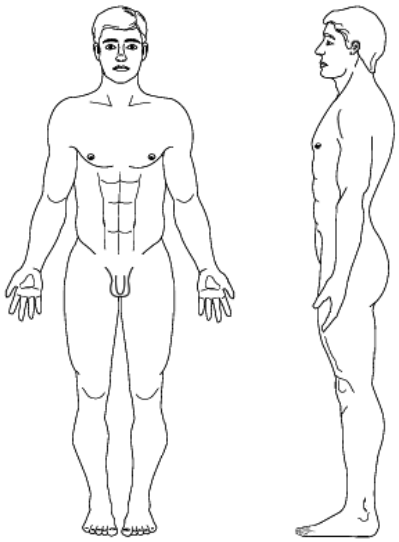
Patient Name 患者姓名_____ Date of Birth 出生日期_____

THE REASON(S) FOR THIS CONSULTATION **咨询原因**

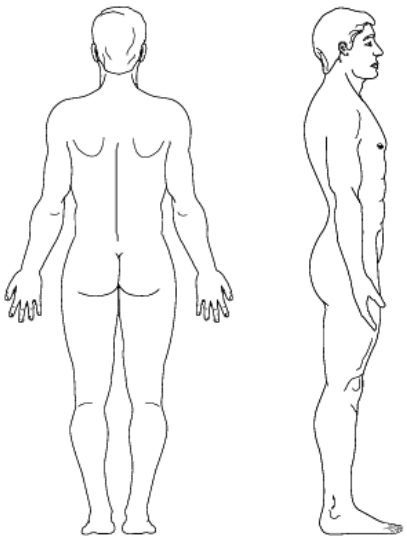
_____

DESCRIPTION OF YOUR SYMPTOMS
症状描述

Location: **How many area(s) do you currently have pain?** _____
位置：您目前有多少个区域疼痛？
If you have more than one pain area, Please mark them with different **symbols (X, O, or △).**
如果您有多个疼痛区域，请用不同的符号(X, O, or △)标记它们



(Front and Left) (正面和左边)



(Back and Right) (背面和右边)

1. Quality of Pain (please write down the corresponding number for the description of pain for each pain area**)**
疼痛质量（请为每个疼痛区域写下相应的编号以描述疼痛）

Painful Area 疼痛区域	X	O	△
Quality of Pain 疼痛质量 (Please choose numbers below for different pain area) (请为不同的疼痛区域选择以下数字)			

⑴ Burning 烧灼痛	⑸ Cramping 痉挛	⑼ Constant 持续地痛	⒀ Tender 敏感	⒄ Shooting 放射性
⑵ Dull 钝痛/隐痛	⑹ Fullness 脹	⑽ Crushing 壓迫痛	⒁ Throbbing 抽痛、悸痛	⒅ Vague 模糊
⑶ Pulsating 跳痛	⑺ Radiating 放射痛	⑾ Pressure 压痛	⒂ Deep aching pain 深部的痛	⒆ Other 其他
⑷ Stabbing 刀刺痛	⑻ Stiffness 僵硬	⑿ Sharp 刺痛	⒃ Pressure sensation 壓力	

2. Intensity of Pain (Please write the number that correlate to your pain. 0 = no pain, 10 = worst pain imaginable)
疼痛强度（请输入与您的疼痛相关的数字。0=无疼痛，10 =可以想象的最严重疼痛）

Painful Area 疼痛区域		X	O	△
Intensity of Pain 疼痛强度	Current 当前 Worst 最严重 Least 最轻	_____out of 10 _____out of 10 _____out of 10	_____out of 10 _____out of 10 _____out of 10	_____out of 10 _____out of 10 _____out of 10

3. How long have you had this pain?
您的这种疼痛多久了？

Painful Area 疼痛区域	X	O	△
Duration of Pain 疼痛持续时间	_____ Days _____ Weeks _____ Months _____ Years	_____ Days _____ Weeks _____ Months _____ Years	_____ Days _____ Weeks ___ Months _____ Years

4. In what time period is your pain WORST?
在什么时候疼痛**最严重**？

Painful Area 疼痛区域	X	O	△
When is the pain worst? 什么时候疼痛最严重？			
Is the pain constant or come-and-go? 疼痛是持续发生还是持续发作？			

5. What makes your pain WORST?
是什么让您的疼痛**最严重**？

Painful Area 疼痛区域	X	O	△
What positions make pain worst? 什么姿势会使疼痛加重？			
What activities make the pain worst? 哪些活动会使疼痛加剧？			
Anything else makes the pain worst? 还有什么使疼痛加剧？			

6. What RELIEVES your pain?
什么**减轻**了您的疼痛？

Painful Area 疼痛区域	X	O	△
What positions relieve the pain? 什么姿势可以减轻疼痛？			
What activities relieve the pain? 哪些活动可以减轻疼痛？			
Anything else relieves the pain? 还有什么使疼痛减轻？			

Please check of the following treatments you have had including the dates and results if possible
如果可能，请检查以下治疗方法，包括日期和结果

Treatment 治疗方法	When 日期	By Whom	Did this help you with your pain? 这对您的疼痛有帮助吗？	
			Yes 有	No 没有
Nerve Blocks				
Physical Therapy 物理疗法				
Acupuncture 針灸				
Chiropractic 推拿				
Surgery 手术				

Does the pain travel to other parts of your body? □ Yes □ No
疼痛会传播到身体的其他部位吗？ 有 没有

If yes, where _____
如果有，哪里

How did the pain start?
疼痛是如何开始的？

How has the pain symptoms progress?
疼痛症状如何进展？

Is your pain caused by injury? ☐ Yes ☐ No Work-related? ☐ Yes ☐ No
您的疼痛是受伤造成的吗？ 有 没有 与工作有关？ 有 没有

If yes, please explain. (Include the date of injury)
如果是，请解释。（包括受伤日期）

Is your case in litigation? ☐ Yes ☐ No Are you ☐ **Right or** ☐ **Left** hand-dominated? (Please choose one)
您的案件正在诉讼中吗？ 有 没有 您是 ☐右撇子还是 ☐左撇子？ （请选择一个）

Do you have the following symptoms <u>RECENTLY?</u> (Please check all that apply)
您**<u>最近</u>**有以下症状吗？（请选中所有适用项）

Weight loss 体重减轻	Weight loss despite no appetite 体重减轻没胃口	Frequent fatigue 经常疲劳	Fever 发烧	Bowel dysfunction 肠功能障碍	Bladder dysfunction 膀胱功能障碍
Change appetite 食欲改变	Weight gain despite no appetite 体重增加没胃口	Gait difficulty	Sleep disturbance 睡眠障碍	Night sweat 盗汗	Muscle weakness 肌肉无力

<u>MEDICAL HISTORY</u> <u>医疗纪录</u>

Past Medical History (Please check all that apply**)**
既往病史（请选中所有适用项）

Heart attack 心脏病发作	Stroke 中风	Asthma 哮喘	Arthritis 关节炎	Seizure 癫痫发作
Bronchitis 支气管炎	Ulcer 溃疡	Emphysema 气肿	Diabetes 糖尿病	Fainting/Dizziness 晕眩/头晕
Cancer 癌症	Urinary 泌尿	Prostate problem 前列腺问题	Headaches 头疼	Hepatitis 肝炎
Kidney problems 肾脏问题	High blood pressure 高血压	Gastrointestinal problem 肠胃问题		

Others 其他			
Any of these conditions? 这些条件中的任何一个？	Hepatitis B 乙型肝炎	Hepatitis C 丙型肝炎	HIV/AIDS HIV 爱滋病
Please answer **yes** or **no** 请回答是或否			

Are you currently under treatment by other health care practitioners? ☐ Yes ☐ No | Please explain if **Yes**_____
您目前正在接受其他保健医生的治疗吗？ 有 没有 |如果是，请说明

Psychological History 心理病史

Do you have any history of depression, anxiety, bipolar? ☐ Yes ☐ No | Please explain if **Yes** _____
您是否有抑郁，焦虑，躁郁症的病史？ 有 没有 |如果是，请说明

Have you ever had suicidal thoughts or suicidal attempts? ☐ Yes ☐ No | Please explain if **Yes**_____
您曾经有过自杀念头或自杀企图吗？ 有 没有 |如果是，请说明

Are you currently under treatment by a psychiatrist or psychologist? ☐ Yes ☐ No | Please explain if **Yes**_____
您当前正在接受心理医生或心理学家的治疗吗？ 有 没有 |如果是，请说明

Past Surgical History
既往手术史

Surgery 手术名	**Date 日期**

Family History (Please check all that apply**)**
家族病史 (请选中所有适用项)

	Chronic Pain 慢性疼痛	Alcohol Abuse 酒精滥用	Drug Abuse 滥用药物	Others Significant Medical Conditions 其他重大疾病
Father 父亲				
Mother 母亲				

Social History (Please check all that apply**)**
社交史（请选中所有适用项）

	Yes 是	No 否	Occasional 偶尔	Regular 定期	How Much and How Long 多少和多长时间
Smoking 抽烟					
Coffee 咖啡					
Alcohol 喝酒					
Drugs 药物					

	Employed 受雇	Self-employed 自雇	Unemployment 无业	If Retired, what's your previous occupation? 如果退休了，您以前的职业是什么？
Occupation 职业 (please describe) （请描述）				

Marital Status 婚姻状况	Single 单身	Married 已婚	Divorce 离婚	Widowed 丧偶
Who do you live with? 你跟谁住？				

MEDICATION ***药物***

Known Allergies: Are you allergic to any of the following?

已知的过敏：您是否对以下任何一种过敏？

			Details 细节	Reaction 反应
Medications 药物	Yes 是	No 否		
IV Contrast 显影剂	Yes 是	No 否		
Food 食物	Yes 是	No 否		
Latex 乳胶	Yes 是	No 否		

Current Medication (non-pain medications)

当前药物（非疼痛药物）

Non-Pain Medication **非止痛药名**	Dose 剂量	How often do you take it? 多久服用一次？

Please list the PAIN medications that you have tried for your pain in the past and their effectiveness

请列出您过去曾尝试过的止痛药及其效果

Pain Medication **止痛药名**	Dose 剂量	How often do you take? 多久服用一次？	Is it effective? Yes / No? 有效吗？是/否？

ALL STUDIES: Please mark any of the following tests you have had to investigate your pain

所有檢查：请标记您为调查疼痛而必须进行的以下任何测试

	Description 描述	Ordered by	Date 日期
X-ray X 光			
EMG/NCT 肌電圖/神经传导			
Myelogram 脊髓造影			
CT Scan 电脑断层扫描			
MRI 磁共振成像			

REVIEW OF SYSTEMS

Constitutional (Please check all that apply)

Fevers 发烧	Chills 寒意	Sweats 发汗	Fatigue 疲劳睡觉	Appetite loss 食欲不振	Weight loss 体重减轻

Eye (Please check all that apply)

Vision loss 视力下降	Light sensitivity 感光度	Double vision 双重视野	Discharge 分泌物	Blurred vision 模糊的视野	Eye pain 眼痛

ENMT (Please check all that apply)

Earache 耳痛	Ear discharge 耳分泌物	Ringing in the ears 耳鸣	Decreased hearing 听力下降	Frequent colds 经常感冒	Difficulty swallowing 吞咽困难
Nasal congestion 鼻塞	Nosebleeds 流鼻血	Bleeding gums 牙龈出血	Hoarseness 嘶哑	Sore throat 喉咙痛	

Cardiovascular (Please check all that apply)

Irregular heart beats 心律不齐	Leg cramps with exertion 腿抽筋	Swelling of hands or feet 手或脚肿胀	Fatigue 疲劳	Shortness of breath with exertion 劳累气短	Difficulty breathing at night 夜间呼吸困难
Lightheadedness 头昏眼花	Discoloration of lips or nails 嘴唇或指甲变色	Recent weight gain 最近体重增加	Palpitation 心悸	Difficulty breathing while lying down 躺下呼吸困难	Chest pain or discomfort 胸痛或不适

Respiratory (Please check all that apply)

Cough 咳嗽	Wheezing 喘息	Chest discomfort 胸部不适	Excessive snoring 过度打鼾	Coughing up blood 咳血	
Excessive sputum 痰液过多	Sleep disturbances due to breathing 呼吸导致的睡眠障碍	Shortness of breath 呼吸急促			

Gastrointestinal (Please check all that apply)

Vomiting 呕吐	Indigestion 消化不良	Heartburn 胃食道逆流	Nausea 恶心	Constipation 便秘	Bloody stools 血便
Excessive gas 气体过多	Abdominal pain 腹痛	Abdominal bloating 腹胀	Hemorrhoids 痔疮	Diarrhea 腹泻	
Black or tarry stools 黑便	Change in bowel habits 排便习惯改变	Change in appetite 食欲变化			

Musculoskeletal (Please check all that apply)

Joint pain 关节痛	Back or neck pain 背部或颈部疼痛	Muscle cramps 肌肉痉挛	Muscle weakness 肌肉无力	Muscle aches 肌肉疼痛	Joint stiffness or swelling 关节僵硬或肿胀
Loss of strength 力量下降					

Skin (Please check all that apply)

Suspicious lesions 异常	Night sweats 盗汗	Dryness 干燥	Itching 瘙痒	Rash 皮疹	
Flushing 发红	Poor wound healing 伤口愈合不良	Excessive perspiration 出汗过多	Change in hair or nail 头发或指甲改变	Changes in color of skin 皮肤颜色变化	

Neurologic (Please check all that apply)

Headaches 头疼	Poor balance 平衡不良	Seizures 癫痫发作	Excessive daytime sleeping 白天过度嗜睡	Difficulty with concentration 集中注意力困难	Sensation of room spinning 空间旋转的感觉
Tremors 发抖	Weakness or blackouts 虚弱或昏厥	Faints or blackouts 晕倒或昏厥	Visual disturbances 视觉障碍	Difficulty with speaking 说话困难	Disturbances in coordination
Tingling 刺痛	Memory loss 记忆丧失				

Psychiatric (Please check all that apply)

Anxiety 焦虑	Nervousness 紧张	Depression 沮丧	Memory change 记忆变化	Thoughts of suicide or violence 自杀或暴力的念头	Frightening versions or sounds 令人恐惧的影像或声音

Endocrine (Please check all that apply)

Weight change 体重变化	Heat or cold intolerance 不耐热或冷	Excessive thirst or hunger 过分的口渴或饥饿	Excessive sweating or urination 过分的出汗或排尿		

Hematologic-lymphatic (Please check all that apply)

Bleeding 流血	Fevers 发烧	Skin discoloration 皮肤变色	Abnormal bruising 异常瘀伤	Enlarged lymph nodes 淋巴结肿大	

Allergic-immunologic (Please check all that apply)

Seasonal allergies 季节性过敏	Hives or rash 荨麻疹或皮疹	HIV exposure 爱滋病接触	Persistent infections 持续感染		

Genitourinary (Please check all that apply)

Frequent urination 尿频	Blood in urine 血尿	Burning or pain on urinary 尿灼痛或疼痛	Urinary urgency 尿急	Foul urinary discharge 尿道分泌	Trouble starting urinary stream 排尿困难
Inability to empty bladder 无法排空膀胱	Flank pain 腰腹痛	Testicular pain or masses 睾丸疼痛或肿块	Genital rashes or sores 生殖器皮疹或疮	Inability to control bladder 无法控制膀胱	Missed periods 经期混乱
Unusual urinary color 尿液颜色异常	Pelvic pain 骨盆疼痛	Excessively heavy periods 经期过量			

Patient Signature: _____ **Date: _____**