ALASKA NATIVE MEDICAL CENTER

Pain Management Questionnaire

In order to make the most of your visit, we require this form to be completed to the best of your ability and sent to the Pain Management Clinic – a copy should be shared with your Primary Care Provider as well. **You will not be scheduled for an evaluation until this questionnaire is submitted.**

Once complete, please mail or fax a copy of the completed questionnaire to:

Alaska Native Medical Center
Pain Management Clinic
4315 Diplomacy Drive
Anchorage, AK 99508

Fax: 907-729-2526

ANMC's Pain Management Clinic does not prescribe medications. If you are in need of prescriptions, you should discuss this with your primary care provider.

Patient Name: _____ DOB: _____ Date: _____

Alaska Native Medical Center
4315 Diplomacy Drive
Anchorage, AK 99508
907-563-2662
855-482-4382
anmc.org

Patient Name: _____ DOB: _____

Pain Management Questionnaire

1. What is the main reason for your referral to the Pain Management Clinic?

2. What date did your pain begin?

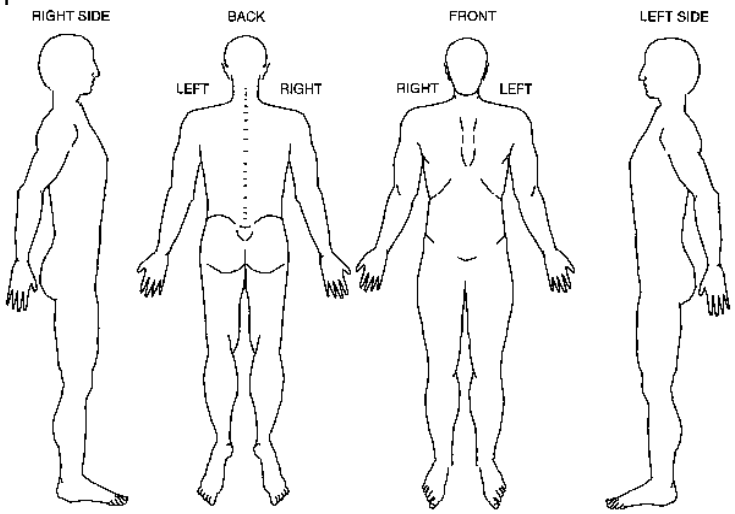
3. Under what circumstances did your pain begin (circle)?

Work accident	ATV/Snow Machine accident
Home accident	After an illness
After surgery	No known cause
Car accident	Other (Describe)_____

4. My pain is (circle):

Constant	Stinging
Intermittent	Burning
Sharp	Throbbing
Dull	Shooting
Achy	

5. Mark where your pain is located:



6. Please circle the treatments you have had for the area of your appointment.

Pain Medications	Chiropractic treatment
Injections	Massage therapy
Physical Therapy	Counseling
Surgery (please obtain records)	Orthotics/braces

7. Anything else you think would be helpful for us to know before your appointment.

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