PAIN MANAGEMENT QUESTIONNAIRE

Date: _____ / _____ / _____

Patient Name: _____ DOB: _____ / _____ / _____

Referring Physician: _____

Primary Care Physician: _____

Pharmacy: _____

Have you had any imaging of the area you are here to have evaluated: □ Yes □ No

If Yes, When: _____ / _____ / _____

Where: _____

Reason for appointment/Reason you were referred:

□ Back Pain □ Neck Pain □ Arm/Leg Pain □ Shingles

□ Abdominal Pain □ Cancer □ Headaches □ CRPS □ Other: _____

****Please fill out the rest of this form only for the pain associated with the area you marked above****

- Have you had this pain before: □ Yes □ No If Yes, When: _____
- Please describe how your pain began: _____
- Do you have weakness of your extremities: □ Yes □ No
  If Yes, Where: □ Left Leg □ Right Leg □ Left Arm □ Right Arm
- Do you have numbness (inability to feel): □ Yes □ No
  If Yes, Where: _____
- Do you have tingling: □ Yes □ No If Yes, Where: _____
- Do you have loss of control of your: □ Bowel □ Bladder
  If Yes,
  Have you experienced this for a long time: □ Yes □ No
  Does it only happen with coughing/sneezing: □ Yes □ No
  Is it difficult to go: □ Yes □ No
  Have you had any accidents: □ Yes □ No If Yes, How often: _____

Patient Name: _____

- Does the pain interrupt your sleep: □ Yes □ No

- Have you had any un-purposeful □ Weight loss □ Weight gain
  If Yes, How much: _____ pounds When did this occur: _____

- Do you wake up at night sweating or soaking wet: □ Yes □ No
  If Yes, How often: _____ How long have you been experiencing: _____
- Have you been seen by another pain clinic in the past: □ Yes □ No
  If Yes, When: _____ / _____ / _____ - _____ / _____ / _____
  Who/Where: _____

- Have you had any previous pain management injections: □ Yes □ No
  If Yes, What type: _____ Did it help: □ Yes □ No
  _____ Did it help: □ Yes □ No
  _____ Did it help: □ Yes □ No

- Have you had physical therapy: □ Yes □ No
  If Yes, When: _____ / _____ / _____ - _____ / _____ / _____
  Who/Where: _____
  Did you learn a home therapy program: □ Yes □ No

- Have you seen a chiropractor: □ Yes □ No
  If Yes, When: _____ / _____ / _____ - _____ / _____ / _____
  Who/Where: _____

- Have you seen a pain psychologist: □ Yes □ No
  If Yes, When: _____ / _____ / _____ - _____ / _____ / _____
  Who/Where: _____
  Did you learn: □ Biofeedback □ Coping skills □ Relaxation methods

- Have you had acupuncture: □ Yes □ No
  If Yes, When: _____ / _____ / _____ Did it help: □ Yes □ No

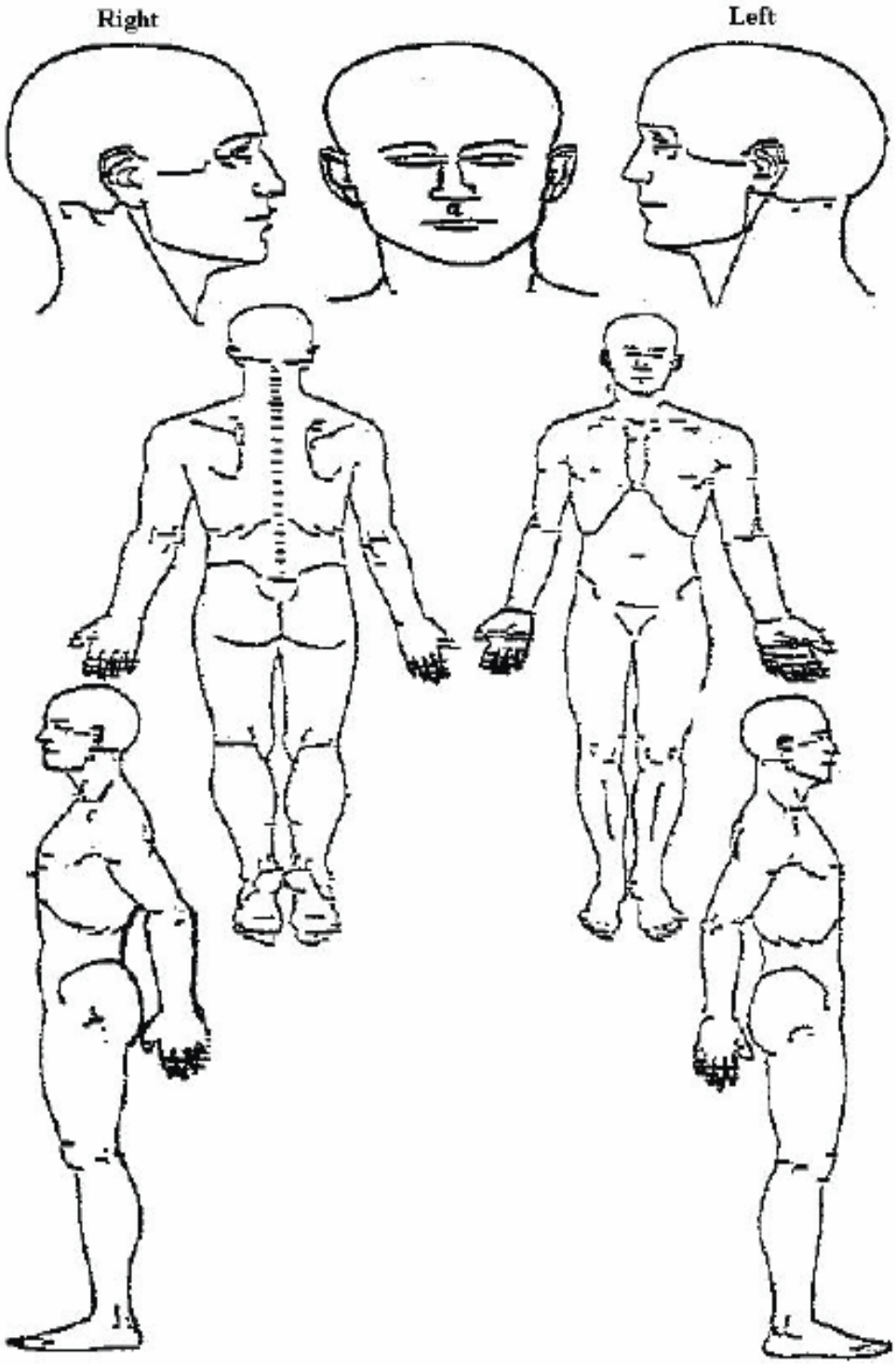
- Have you used a TENS unit (electrical stimulation of the skin): □ Yes □ No
  If Yes, When: _____ / _____ / _____ Did it help: □ Yes □ No

Patient Name: _____

Pain Location-

On the figures below, using the symbols lsited below, please mark the areas of your body where you feel:

Numbness = = = =	Stabbing / / / /	Burning x x x x
Pin & Needles o o o o	Aching ((((	Area where it hurts the most √



Patient Name: _____

Addressing the Personal Side of Living with Chronic Pain

As an individual living with persistent chronic pain every day, you are fully aware that your PAIN does NOT just affect you physically. Chronic pain touches every part of your life. Your pain affects you emotionally, mentally and spiritually. Living with pain has an impact on your roles in life, your relationships, your work, your hobbies, your recreational activities and the overall quality of your life. Therefore, for us to effectively address helping you manage your pain, please answer the following questions.

1. Have you struggled to manage your pain by using the "ole stiff upper lip" or "tough it out" method? □ Yes □ No
2. Have you lost your job, missed a significant amount of work or stopped physical or recreational activities? □ Yes □ No
3. Do you feel you have lost meaning and purpose in your life? □ Yes □ No
4. Has living with pain changed your roles in life as an employee, spouse, parent, etc.? □ Yes □ No
5. Do you feel you have failed or let other down by not being able to "DO" as you once did? □ Yes □ No
6. Do you feel your pain is often in control of your life:? □ Yes □ No
7. Do you find your moods bouncing around, at times you feel depressed, angry or anxious? □ Yes □ No
8. Do family/friends seem to struggle to understand what it is like for you to live with chronic pain? □ Yes □ No
9. Do you feel judged at times? □ Yes □ No
10. Do you struggle sometimes making a decision about an activity worrying that it will result in a "flare up"? □ Yes □ No
11. Have you noticed that as your stress level increases so does your pain? □ Yes □ No
12. Do you find it difficult to "relax" or "calm" yourself as you go through your day with pain? □ Yes □ No

Please share with us any comments you have regarding the screening questions or any personal concerns or difficulties you have living with your pain:

_____

_____

_____

_____

Patient Name: _____

BACK PAIN

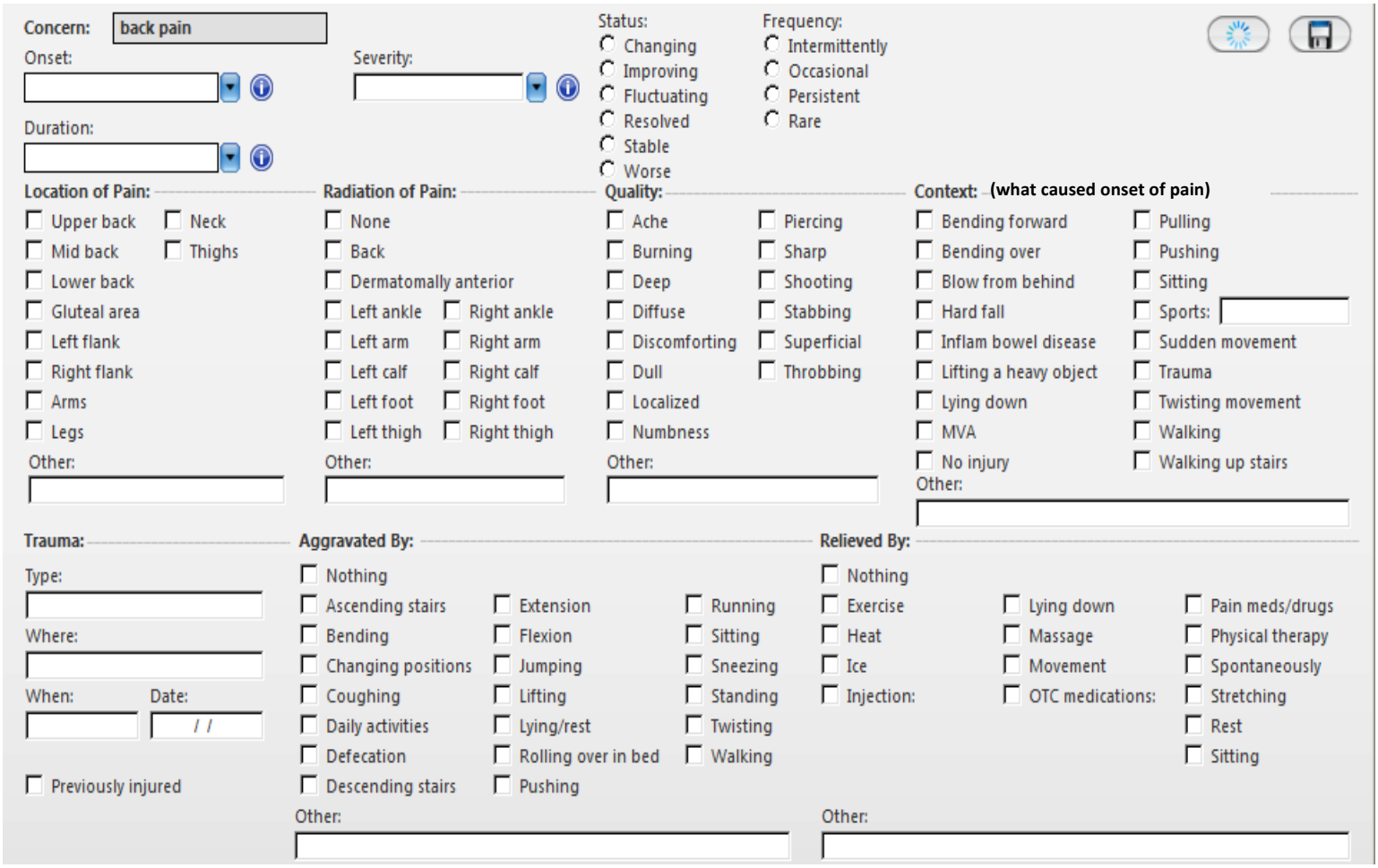
- **Is your walking limited: □ Yes □ No**

  If yes, how far can you walk without stopping to rest: _____ blocks / miles

- **Does bending over holding on to a shopping cart, etc. allow you to walk farther: □ Yes □ No**

- **What percentage in in the back: _____% What percentage is in the leg(s): _____%**

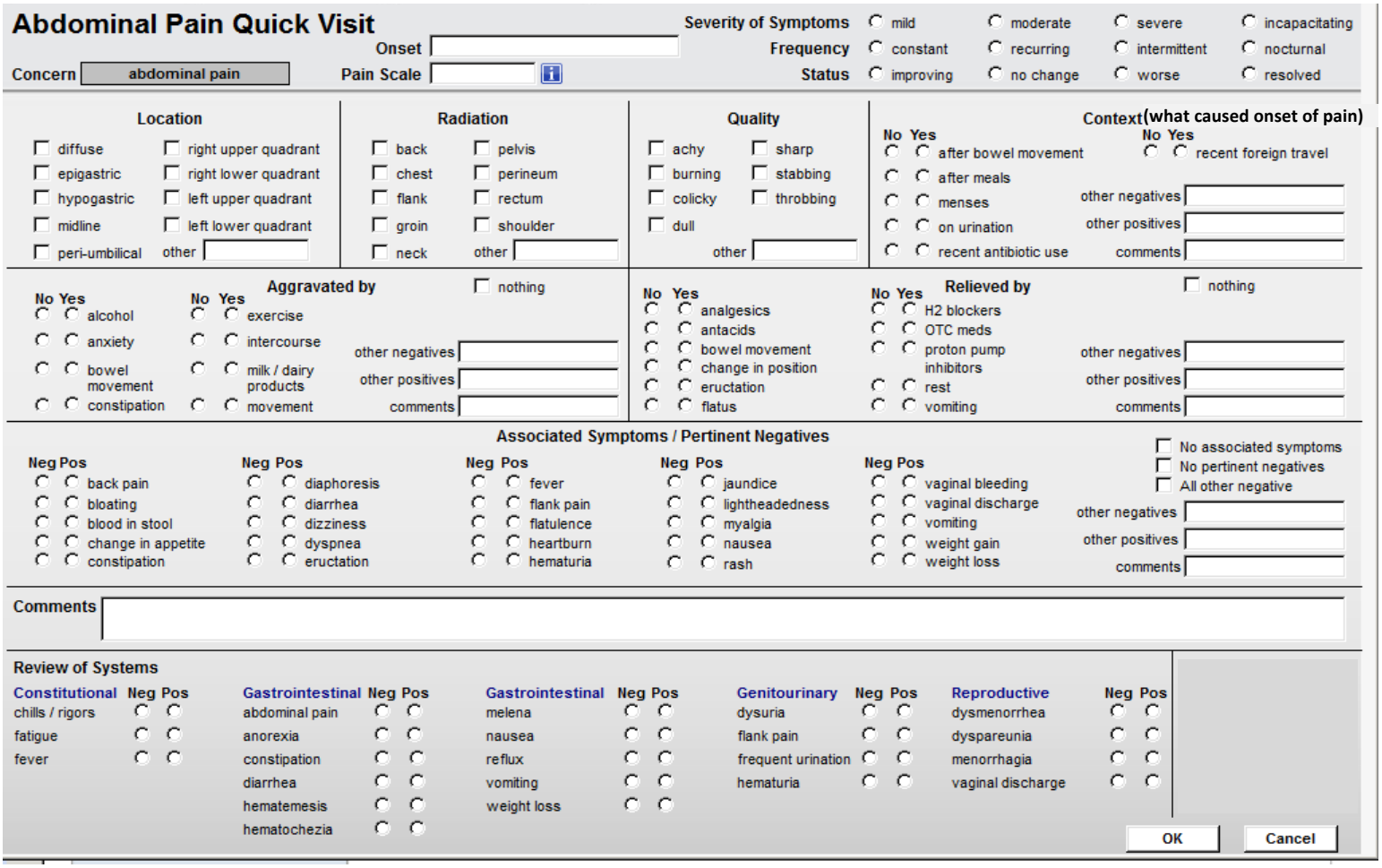
Please check all that apply.



Patient Name: _____

ABDOMINAL PAIN

Please check all that apply.

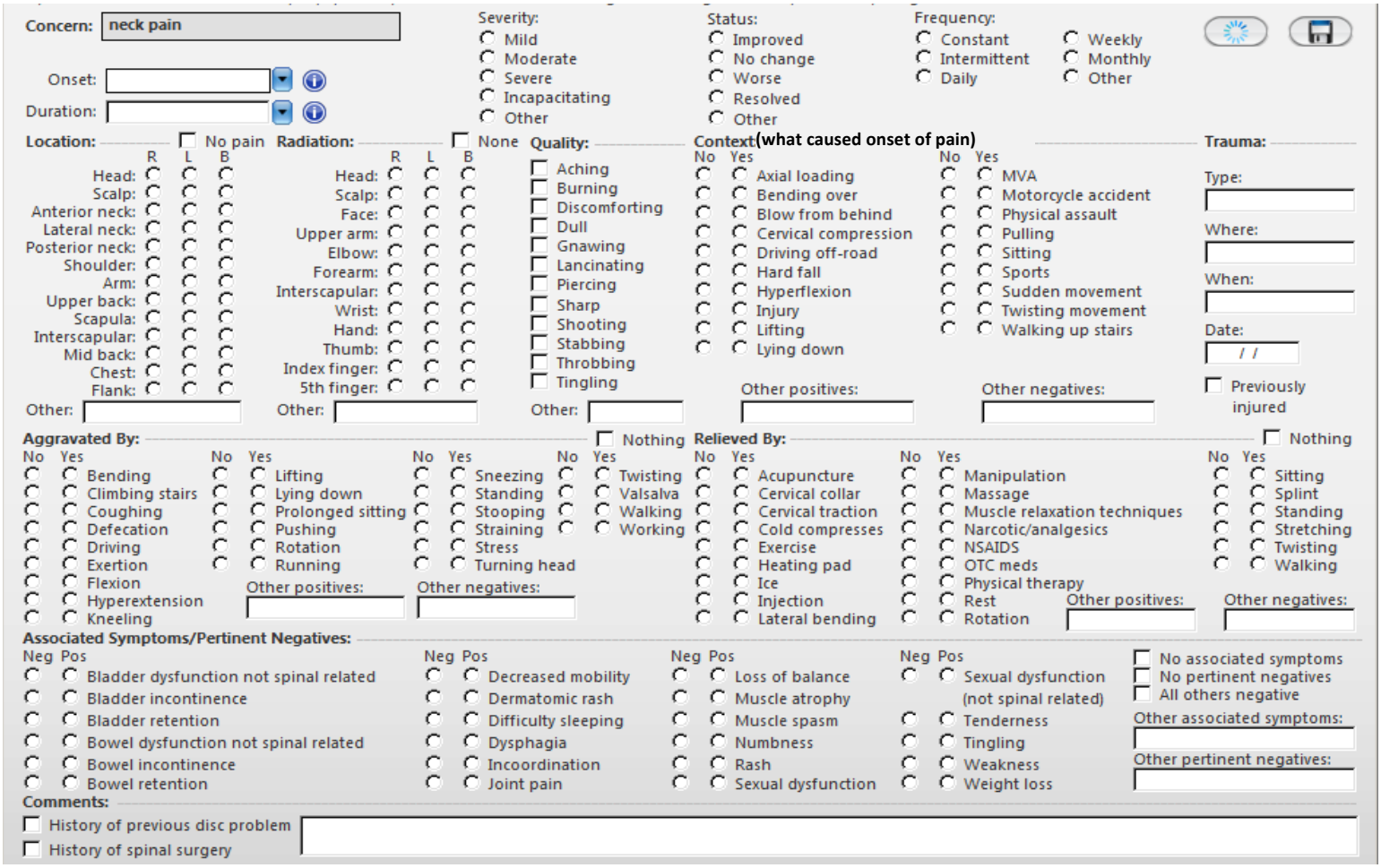


Patient Name: _____

NECK PAIN

- **What percentage in in the neck: _____%**
- **What percentage is in the arm(s): _____%**

Please check all that apply.

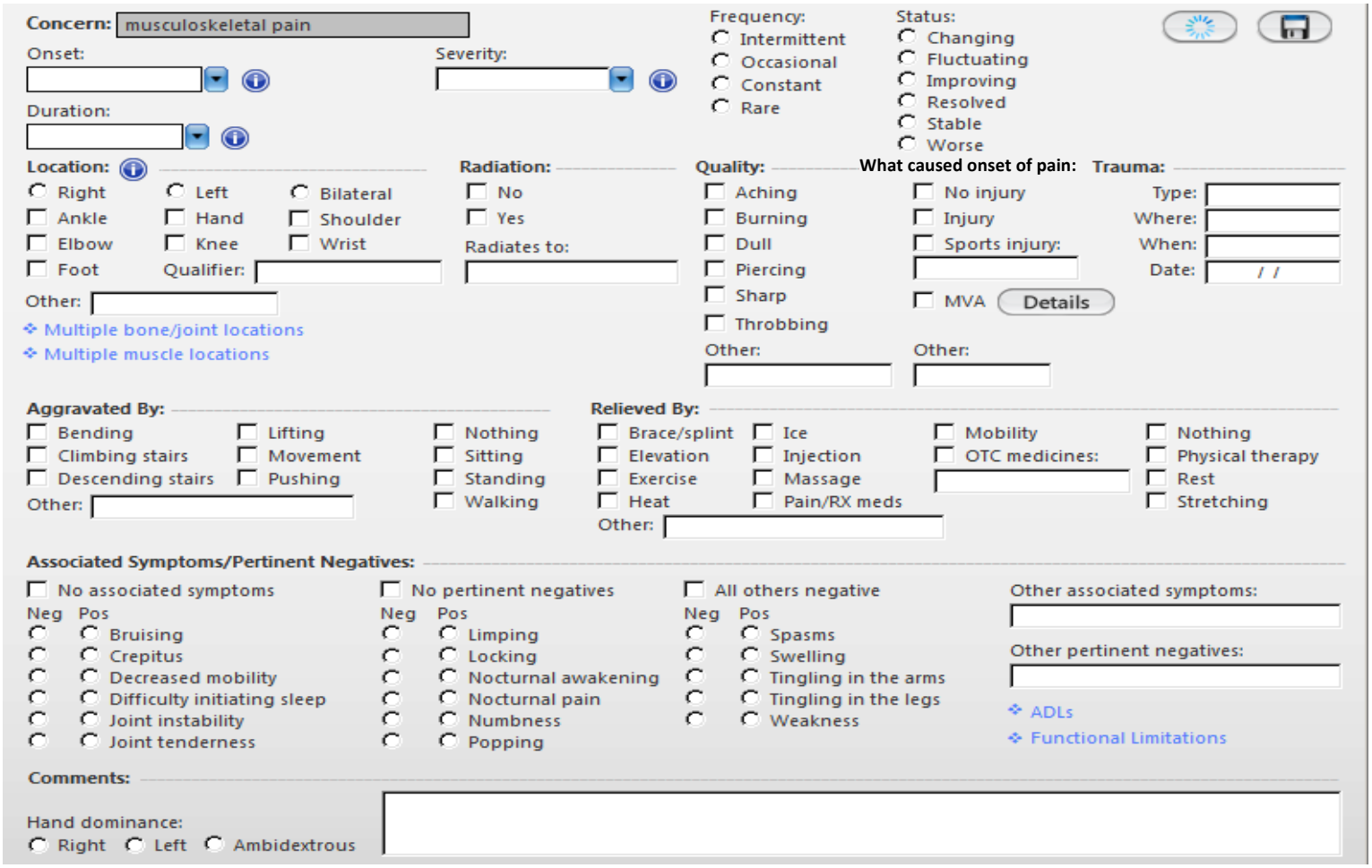


Patient Name: _____

ARM/LEG PAIN

- **Does your affected extremity change color: □ Yes □ No**
- **Does your affected extremity feel: □ warmer □ colder**
- **Does your affected extremity swell: □ Yes □ No**
- **Does light touch worsen your pain (putting on socks, sheets on the bed): □ Yes □ No**
- **Have you noticed □ hair □ nail growth on the affected extremity: □ Yes □ No**

Please check all that apply.



Patient Name: _____

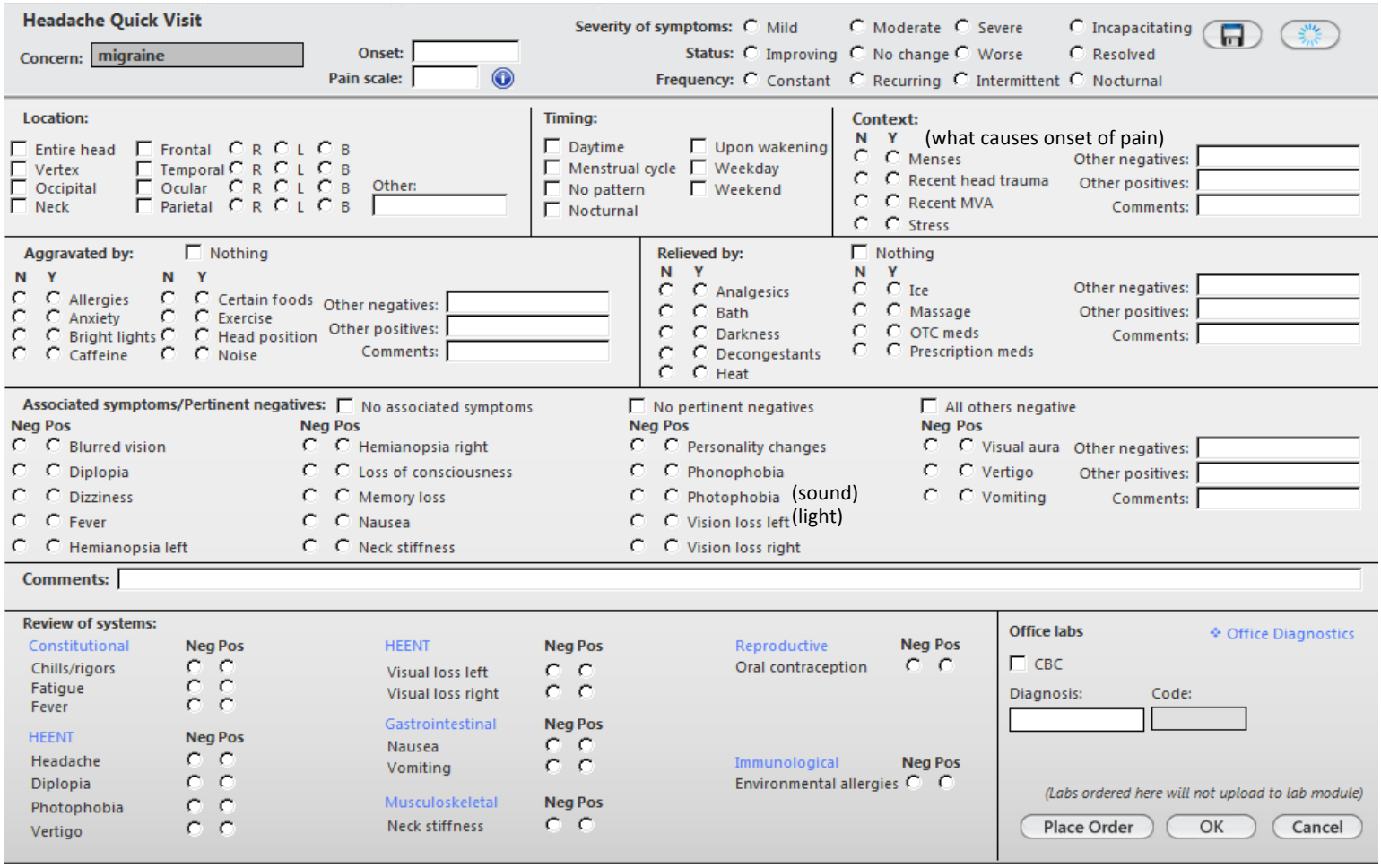
HEADACHES

- **Are there any signs that your headache is going to happen: □ Yes □ No**

  If Yes, what are the signs: _____

- **How many hours do your headaches typically last? _____**

Please check all that apply.



Patient Name: _____

(0 = No pain / 10 = Pain as bad as you can imagine)

PAIN LEVELS:

Current Pain Level: | Least Pain Level: | Worst Pain Level: | Pain Goal:

IS PATIENT TAKING:

Blood Thinners?

Who Manages Blood Thinners?

Supplements?

Antibiotics?

DOES PATIENT HAVE:

Allergy to Contrast Dye, Latex, or Shellfish?

Liver Problems? (Hep C)

Diabetes?

MEDICATIONS-

Please list ALL medications, including herbal and over-the-counter:

Drug	Dose	Prescribing Provider

ALLERGIES-

Drug/Item	Reaction

Patient Name: _____

REVIEW OF SYSTEMS-

Please mark all current or chronic conditions:

Constitutional
- □ Chills
- □ Fatigue
- □ Fever
- □ Malaise (out of sorts)
- □ Night sweats
- □ Weight gain
- □ Weight loss
- □ Other: _____

HEENT
- □ Ear discharge
- □ Ear pain
- □ Eye discharge
- □ Eye pain
- □ Hearing loss
- □ Nasal discharge
- □ Sinus pressure
- □ Sore throat
- □ Visual changes
- □ Other: _____

Respiratory
- □ Chronic cough
- □ Cough
- □ Known TB exposure
- □ Shortness of breath
- □ Wheezing
- □ Other: _____

Cardiovascular
- □ Chest pain
- □ Claudication (leg cramping)
- □ Edema (swelling)
- □ Palpitations
- □ Other: _____

Gastrointestinal
- □ Abdominal pain
- □ Blood in stools
- □ Change in stools
- □ Constipation
- □ Diarrhea
- □ Heartburn
- □ Loss of appetite
- □ Nausea
- □ Vomiting
- □ Other: _____

Genitourinary-FEMALE
- □ Dysuria (painful urination)
- □ Hematuria (bloody urine)
- □ Polyuria (excessive urination)
- □ Urinary frequency
- □ Urinary incontinence
- □ Urinary retention
- □ Other: _____

Reproductive-FEMALE
- □ Abnormal Pap
- □ Dysmenorrhea (painful periods)
- □ Dyspareunia (painful intercourse)
- □ Hot flashes
- □ Irregular menses
- □ Vaginal discharge
- □ Other: _____

Genitourinary-MALE
- □ Dribbling
- □ Dysuria (painful urination)
- □ Hematuria (bloody urine)
- □ Polyuria (excessive urination)
- □ Slow stream
- □ Urinary frequency
- □ Urinary incontinence
- □ Urinary retention
- □ Other: _____

Reproductive-MALE
- □ Erectile dysfunction
- □ Penile discharge
- □ Sexual dysfunction
- □ Other: _____

Integumentary
- □ Breast discharge
- □ Breast lump
- □ Brittle hair
- □ Brittle nails
- □ Hair loss
- □ Hirsutism (male pattern hair in women)
- □ Hives
- □ Pruritis (itching)
- □ Mole changes
- □ Rash
- □ Skin lesion
- □ Other: _____

Neurological
- □ Dizziness
- □ Extremity numbness
- □ Extremity weakness
- □ Gait disturbance
- □ Headache
- □ Memory loss
- □ Seizures
- □ Tremors
- □ Other: _____

Psychiatric
- □ Anxiety
- □ Depression
- □ Insomnia
- □ Other: _____

Metabolic/Endocrine
- □ Cold intolerance
- □ Heat intolerance
- □ Polydipsia (excessive thirst)
- □ Polyphagia (excessive hunger)
- □ Other: _____

Musculoskeletal
- □ Back pain
- □ Joint pain
- □ Joint swelling
- □ Muscle weakness
- □ Neck pain
- □ Other: _____

Hematologic/Lymphatic
- □ Easy bleeding
- □ Easy bruising
- □ Lymphadenopathy (enlarged lymph nodes)
- □ Other: _____

Immunologic
- □ Contact allergy
- □ Environmental allergies
- □ Food allergies
- □ Seasonal allergies
- □ Other: _____

Patient Name: _____

PREVIOUS SURGERIES-

Please be as specific as possible:

Surgery	Date	Location/Physician

MEDICAL HISTORY-

Please be as specific as possible:

Condition	Management	Treatment Outcome

FAMILY HISTORY-

- Is your mother living: □ Yes □ No
  If Yes, Age: _____ If No, Age at death: _____
  List all medical problems: _____

- Is your father living: □ Yes □ No
  If Yes, Age: _____ If No, Age at death: _____
  List all medical problems: _____

- Siblings:
  □ Brother □ Sister Living: □ Yes □ No
  If Yes, Age: _____ If No, Age at death: _____
  List all medical problems: _____

  □ Brother □ Sister Living: □ Yes □ No
  If Yes, Age: _____ If No, Age at death: _____
  List all medical problems: _____

  □ Brother □ Sister Living: □ Yes □ No
  If Yes, Age: _____ If No, Age at death: _____
  List all medical problems: _____

Patient Name: _____

SOCIAL-

- Have you had any recent social changes (marriage, divorce, employment, etc.): □ Yes □ No
  If Yes, describe: _____
- Are you married: □ Yes □ No
  If Yes, How Long: _____ Name of spouse: _____
- Is your spouse deceased: □ Yes □ No If Yes, When: _____ / _____ / _____
- Have you been divorced: □ Yes □ No If Yes, How many times: _____
- Are you currently employed: □ Yes □ No If Yes, How long: _____
  Occupation: _____
- Are you receiving disability: □ Yes □ No
- Is this pain being treated by a workers compensation claim: □ Yes □ No
- Have you taken any legal action in regards to your pain: □ Yes □ No
- Have you ever been abused: □ Yes □ No If Yes, □ Physical □ Sexual □ Emotional

HABITS-

- Do you smoke: □ Yes □ No □ Quit When: _____ / _____ / _____
  If Yes, Packs per day: _____ Years: _____
- Do you smoke a pipe: □ Yes □ No □ Quit When: _____ / _____ / _____
  If Yes, How much: _____ Years: _____
- Do you chew tobacco: □ Yes □ No □ Quit When: _____ / _____ / _____
  If Yes, How much: _____ Years: _____
- Do you drink alcohol: □ Yes □ No □ Quit When: _____ / _____ / _____
  If Yes, How much: _____ Years: _____
- Do you use illegal drugs: □ Yes □ No □ Quit When: _____ / _____ / _____
  If Yes, How much: _____ Years: _____
  What types: _____
- Do you consume caffeine: □ Yes □ No
  If Yes,
  - □ Coffee _____ cups/day
  - □ Tea _____ cups/day
  - □ Soda _____ cups/day
  - □ Energy Drinks _____ cups/day