PAIN MANAGEMENT

NEW PATIENT QUESTIONNAIRE

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PATIENT NAME: ________________________________

DOB: ________________________________

Patient Identification Information

CAUSES OF YOUR PAIN. Please answer all questions.

Event(s) surrounding the onset of your pain	Date Pain Began	Pain Intensity Today
________________	________	☐ Better ☐ Same ☐ Worse
________________	________	☐ Better ☐ Same ☐ Worse
________________	________	☐ Better ☐ Same ☐ Worse
________________	________	☐ Better ☐ Same ☐ Worse

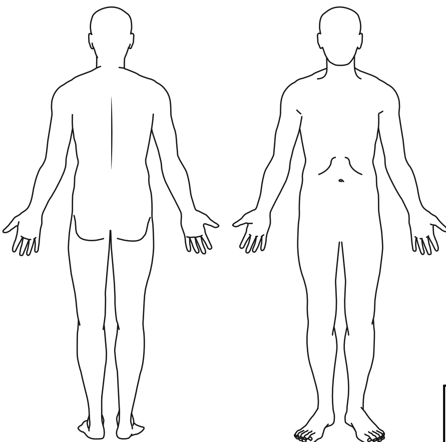
PAIN DESCRIPTION

How often is your pain: ☐ Continuous ☐ Intermittent, lasting ________________________

For each of the following, check "No" or "Yes" if that word applies to your pain.

Aching	☐ No	☐ Yes
Boring	☐ No	☐ Yes
Burning.	☐ No	☐ Yes
Crushing.	☐ No	☐ Yes
Dull	☐ No	☐ Yes
Excruciating . . .	☐ No	☐ Yes
Mild	☐ No	☐ Yes
Numbing	☐ No	☐ Yes
Pulsating	☐ No	☐ Yes
Severe	☐ No	☐ Yes
Sharp	☐ No	☐ Yes
Stabbing	☐ No	☐ Yes
Shooting	☐ No	☐ Yes
Throbbing	☐ No	☐ Yes
Tight band	☐ No	☐ Yes
Tingling	☐ No	☐ Yes

On the diagram, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.



BACK **FRONT**

Does your pain radiate? ☐ No ☐ Yes Where? ______________

Is weakness related to Your pain? . . . . ☐ No ☐ Yes Where? ______________

Check all the things that make your pain **worse**:

☐ Nothing ☐ Heat ☐ Cold ☐ Movement ☐ Walking ☐ Sitting
☐ Lying down ☐ Lifting ☐ Touching ☐ Other: ______________

Check all the things that make your pain **better**:

☐ Medications ☐ Rest ☐ Standing ☐ Sitting ☐ Walking
☐ Heat ☐ Cold ☐ Other: ________________________

Please rate your pain by checking the one number that best describes your pain at its ***worse* in the last week**.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worse Pain You Can Imagine**
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Please rate your pain by checking the one number that best describes your pain at its ***least* in the last week**.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worse Pain You Can Imagine**
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Please rate your pain by checking the one number that best describes your pain **on the average**.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worse Pain You Can Imagine**
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Please rate your pain by checking the one number that tell you how much **pain you have *right now*.**

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worse Pain You Can Imagine**
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

PRESCRIPTION DRUGS

Please be aware that we may **not** be able to provide you with medications that have been prescribed by another physician. It is the responsibility of that physician to continue providing you with that medication. We also ask that you bring all pill bottles for the medications you are currently taking to your visit. We will determine the best possible treatment plan for you, but this may not include the continuation of current prescriptions.

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PAIN DESCRIPTION *(continued)*

Please respond to each question or statement by marking one box per row.

Pain interference *In the past seven (7) days ...*	**Not at All**	**A Little Bit**	**Some-what**	**Quite a Bit**	**Very Much**
How much did pain interfere with your day-to-day activities?	☐	☐	☐	☐	☐
How much did pain interfere with your work around the home?	☐	☐	☐	☐	☐
How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
How much did pain interfere with your enjoyment of life?	☐	☐	☐	☐	☐
How much did pain interfere with the things you usually do for fun?	☐	☐	☐	☐	☐
How much did pain interfere with your enjoyment of social activities?	☐	☐	☐	☐	☐
How much did pain interfere with your household chores?	☐	☐	☐	☐	☐
How much did pain interfere with your family life?	☐	☐	☐	☐	☐

Pain Behavior *In the past seven (7) days ...*	**Had No Pain**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
When I was in pain I became irritable	☐	☐	☐	☐	☐	☐
When I was in pan I grimaced	☐	☐	☐	☐	☐	☐
When I was in pain I moved extremely slowly	☐	☐	☐	☐	☐	☐
When I was in pain I moved stiffly	☐	☐	☐	☐	☐	☐
When I was in pain I called out for someone to help me	☐	☐	☐	☐	☐	☐
When I was in pain I thrashed	☐	☐	☐	☐	☐	☐

PAIN TREATMENT(S)

Check the percentage of pain relief you would feel would make your treatment worthwhile.

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

How many emergency department visits have you had I the last year for pain?

☐ 0 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

In the last week, how much relief have pain treatments or medications provided? Please check the one percentage that most shows how much relief you have received.

No Relief ☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% **Complete Relief**

What other pain treatments have been tried before?

Description	**Date**	**Benefit: None**	**Some**	**Marked**
☐ Interventions: ________	________	☐	☐	☐
☐ Interventions: ________	________	☐	☐	☐
☐ Interventions: ________	________	☐	☐	☐
☐ Physical therapy: ________	________	☐	☐	☐
☐ Pain psychology/behavior therapy: ________	________	☐	☐	☐
☐ Massage: ________	________	☐	☐	☐
☐ Meditation: ________	________	☐	☐	☐
☐ Acupuncture/Acupressure: ________	________	☐	☐	☐
☐ Other complementary/: alternative therapies: ________	________	☐	☐	☐

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PAIN MEDICATION

Do you have some form of pain now that requires medication each and every day? ☐ No ☐ Yes

Did you take pain medications in the last seven (7) days? ☐ No ☐ Yes

If you take pain medication, how many hours does it take before the pain returns? Check one:

☐ One hour ☐ Two hours ☐ Three hours ☐ Four hours ☐ Five to twelve hours ☐ More than twelve hours

☐ Pain medication doesn't help at all ☐ I do not take pain medication

Do you have any side effects from your medications? ☐ No ☐ Yes

If yes, check all that apply:

☐ Constipation ☐ Itching ☐ Dry mouth ☐ Fatigue ☐ Lightheadedness ☐ Erectile problems

☐ Dizziness ☐ Vomiting ☐ Sleepiness ☐ Nausea ☐ Menstrual change ☐ Problems concentrating

☐ Confusion ☐ Tooth decay ☐ Appetite change ☐ Problems urinating

If prescribed opioid therapy:

Name and phone number of pharmacy listed on opioid bottle:

____

Name of doctor currently prescribing opioids: Prescribing doctor's phone number:

____

PAST PAIN MEDICATION: Have you ever taken the following pain-related medications in the PAST? Do not list current medications on this page.

Pain/Opioids		**Why did you stop?**		
Acetaminophen (Tylenol)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Actiq (fentanyl)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Butorphanol (Stadol)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Capsaicin cream	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Codeine (Tylenol #3)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Demerol	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Dextromethorphan	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Dilaudid	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Fentanyl Patch	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Fentora (fentanyl)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Hydrocodone (Vicodin)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Kadian	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Lidoderm Patch	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Methadone (Dolophine)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Morphine (MS Contin)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Oxycodone (Percocet)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Oxycontin	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Opana (oxyorphone)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Nucynta (tapentadol)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Pentazocine HCI (Talwin)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Propoxyphene (Darvocet)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Suboxone (buprenorphine)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work
Ultram (Tramadol)	☐ Yes	☐ Side effect(s)	______________________	☐ Didn't work

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PAST PAIN MEDICATION *(continued)*

Anti-Depressants		Why did you stop?	
Amitriptyline (Elavil)	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Cymbalta	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Desipramine	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Effexor	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Imipramine	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Nortriptyline (Pamelor)	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Prozac/Paxil	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Doxepin (Sinequan)	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Trazadoe (Desyrel)	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Wellbutrin	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Anti-Convulsants		**Why did you stop?**	
Depokote	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Lamictal	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Lyrica (Pregabalin)	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Neurontin	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Topamax	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Tegretol	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Muscle Relaxant			
Flexeril	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Skelaxin	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Soma	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Valium	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Zanaflex	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Anti-Anxiety			
Valium	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Xanax	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Anti-Inflammatory			
Celebrex	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Ibuprofen (Motrin, Advil)	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Mobic (meloxicam)	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Toradol (Ketorolac)	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work
Voltaren gel	☐ Yes	☐ Side effect(s) ____________________	☐ Didn't work

HOSPITALIZATION AND SURGICAL HISTORY

Have you ever had surgery or been hospitalized? ☐ No ☐ Yes *If yes,* list each below and give year.

Reason for surgery or Hospitalization	Year	Reason for Surgery or Hospitalization	Year
____________________	________	____________________	________
____________________	________	____________________	________
____________________	________	____________________	________

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REVIEW OF SYSTEMS

Please review the list below. If you currently, or have ever had a problem in any of these areas, please check "Yes". If not, please check "No".

Constitutional

Fever	☐ No	☐ Yes
Chills	☐ No	☐ Yes
Weight loss	☐ No	☐ Yes
Malaise/Fatigue	☐ No	☐ Yes
Excess sweating	☐ No	☐ Yes
Weakness	☐ No	☐ Yes

Skin

Rash	☐ No	☐ Yes
Itching	☐ No	☐ Yes

HENT

Headaches	☐ No	☐ Yes
Hearing loss	☐ No	☐ Yes
Ringing in ears	☐ No	☐ Yes
Ear Pain	☐ No	☐ Yes
Ear discharge	☐ No	☐ Yes
Nosebleeds	☐ No	☐ Yes
Congestion	☐ No	☐ Yes
Stridor	☐ No	☐ Yes

Eyes

Blurred vision	☐ No	☐ Yes
Double vision	☐ No	☐ Yes
Photophobia	☐ No	☐ Yes
Eye pain	☐ No	☐ Yes
Eye discharge	☐ No	☐ Yes
Eye redness	☐ No	☐ Yes

Cardiovascular

Chest pain	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes
Shortness of breath when lying down	☐ No	☐ Yes
Leg cramps	☐ No	☐ Yes
Leg swelling	☐ No	☐ Yes
Shortness of breath at night	☐ No	☐ Yes

Respiratory

Cough	☐ No	☐ Yes
Cough up blood	☐ No	☐ Yes
Sputum production	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes

Gastrointestinal

Heartburn	☐ No	☐ Yes
Nausea	☐ No	☐ Yes
Vomiting	☐ No	☐ Yes
Abdominal pain	☐ No	☐ Yes
Diarrhea	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Blood in stool	☐ No	☐ Yes
Tarry stools	☐ No	☐ Yes

Genitourinary

Pain or burning	☐ No	☐ Yes
when urinating	☐ No	☐ Yes
Urgency	☐ No	☐ Yes

Musculoskeletal

Muscle pain	☐ No	☐ Yes
Neck pain	☐ No	☐ Yes
Back pain	☐ No	☐
Joint pain	☐ No	☐ Yes
Falls	☐ No	☐ Yes

Endocrine/Hematology/Allergy

Easily bruise/bleed	☐ No	☐ Yes
Environmental allergies	☐ No	☐ Yes
Excessive thirst	☐ No	☐ Yes

Neurological

Dizziness	☐ No	☐ Yes
Tingling	☐ No	☐ Yes
Tremor	☐ No	☐ Yes
Sensory change	☐ No	☐ Yes
Speech change	☐ No	☐ Yes
Focal weakness	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Loss of consciousness	☐ No	☐ Yes

Psychiatric

Depression	☐ No	☐ Yes
Suicidal ideas	☐ No	☐ Yes
Substance abuse	☐ No	☐ Yes
Hallucinations	☐ No	☐ Yes
Nervous/Anxious	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes

WORK

Are you currently employed? ☐ No ☐ Yes

If yes: What do you do? ______________________

How many hours per day? _______________

If no: How long have you been out of work? ______________

What is your occupation? ________________________

Is unemployment due to pain? ☐ No ☐ Yes

Have you ever been in the military? ☐ No ☐ Yes

Are you currently on Disability? ☐ No ☐ Yes

Are you applying for Disability? ☐ No ☐ Yes

Are you receiving Worker's Compensation? ☐ No ☐ Yes

Are you applying for Worker's Compensation? ☐ No ☐ Yes

Do you have litigation pending against an employer or individual due to an accident or injury? ☐ No ☐ Yes

SOCIAL HISTORY

List your hobbies: ____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of children: _________ Ages: ____

Check highest level of education completed: ☐ Grade school ☐ High school ☐ Some college ☐ College ☐ Trade school ☐ Graduate/Professional school

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PHYSICAL FUNCTION. Please respond to each item by marking one box per row.

Does your health now limit you in:	**Not at All**	**Very Little**	**Somewhat**	**Quite a lot**	**Cannot Do**
doing vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?	☐	☐	☐	☐	☐
walking more than a mile?	☐	☐	☐	☐	☐
climbing one flight of stairs?	☐	☐	☐	☐	☐
lifting or carrying groceries?	☐	☐	☐	☐	☐
bending, kneeling, or stooping?	☐	☐	☐	☐	☐

Are you able to:	**Without any Difficulty**	**With a Little Difficulty**	**With Some Difficulty**	**With Much Difficulty**	**Unable to Do**
do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
dress yourself, including tying shoelaces and doing buttons?	☐	☐	☐	☐	☐
shampoo your hair?	☐	☐	☐	☐	☐
wash and dry your body?	☐	☐	☐	☐	☐
get on and off the toilet?	☐	☐	☐	☐	☐

SLEEP. Please mark one box:

In the past seven (7) days …	**Very Poor**	**Poor**	**Fair**	**Good**	**Very Good**
do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐

In the past seven (7) days …	**Not At All**	**A Little Bit**	**Somewhat**	**Quite a Bit**	**Very Much**
My sleep was refreshing	☐	☐	☐	☐	☐
I had a problem with my sleep	☐	☐	☐	☐	☐
I had difficulty falling asleep	☐	☐	☐	☐	☐

FAMILY MEDICAL HISTORY

Do you have a family history of pain? ☐ No ☐ Yes

If yes, explain: ____

Does anybody in your family have a history of drug misuse/addiction? ☐ No ☐ Yes

If yes, explain: ____

SOCIAL

Do you currently smoke? ☐ No ☐ Yes

If yes: Packs per day? _____. For how many years? _______

Were you a smoker in the past? ☐ No ☐ Yes

If yes: for how many years? _____. Year you quit? _______

Do you use alcohol? ☐ No ☐ Yes

If yes, on average, how many drinks do you have **per week**?

☐ 3 or less ☐ 4-7 ☐ 8-12 ☐ 13 or more

Was there ever a time in your life when you may have had an alcohol problem? ☐ No ☐ Yes

Did you ever, or do you now use street drugs? ☐ No ☐ Yes

If yes, list: ______________________________________

Have you ever been addicted to prescription drugs? ☐ No ☐ Yes

Have you ever been in a treatment program for alcohol or drug abuse? ☐ No ☐ Yes

If yes, explain: ___________________________________