COMPREHENSIVE PAIN MANAGEMENT, PLC

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Patient Questionnaire

Date _____ Time_____

Name _____ D.O.B. _____ Age _____

(Last) (First) (m.i.)

Primary Care Physician _____ Referring Physician _____

Address _____ Address _____

Phone (____) _____ Phone (____) _____

Please list all specialists you have consulted for this condition.

	Specialist	Date last Seen	Office Phone #
1. Pain Clinic	_____	_____	_____
2. Physical/Rehab	_____	_____	_____
3. Neurosurgery	_____	_____	_____
4. Orthopedic Surgery	_____	_____	_____
5. Neurology	_____	_____	_____
6. Rheumatologist	_____	_____	_____
7. Others (including ER)	_____	_____	_____

Chief Complaint _____

_____

When did your pain start? _____

How did it first start? _____

□ Auto accident □ work related □ surgery □ fall □ just happened □ other

Are you experiencing any functional limitations in your activities of daily living (ADLs) i.e. bathing, feeding, dressing, etc?

□ Yes □ No. If yes, please list _____

_____

Rate your overall functionality score in regards to ADLs:(0=Cannot perform any ADLs individually, 10=Fully functional independently)

0 1 2 3 4 5 6 7 8 9 10

On a scale of one to ten circle the corresponding number of your pain:

	None				Mild			Distressing			Excruciating
Pain at present	0	1	2	3	4	5	6	7	8	9	10
Pain at its best	0	1	2	3	4	5	6	7	8	9	10
Pain at its worst	0	1	2	3	4	5	6	7	8	9	10
Usual Pain	0	1	2	3	4	5	6	7	8	9	10

What is the quality of your pain? (Check all that apply)

□ Burning □ Aching □ Sharp □ Cramping □ Pounding

□ Pressure □ Shooting □ Squeezing □ Sporadic □ Tingling

□ Throbbing □ Numbing □ Other _____

Pain is: □ Constant □ Intermittent (on/off) □ less than 8 hours/day □ 8-16 hours per day

What increases the pain? (Check all that apply)

□ Bending □ Sitting □ Walking □ Standing □ Work □ Other _____

What decreases the pain? (Check all that apply)

□ Medication □ Rest □ Physical Therapy □ Lying down □ Heat □ Cold _____

□ Relaxation □ Injections □ Treatment in ER □ Not working □ other _____

Other associated systems? (Check all that apply)

□ Hair growth □ Nail beds □ Skin color □ Loss of bowel or bladder control

□ Paralysis □ Sweating □ Swelling □ Recent weight loss □ recent weight gain

□ Weight _____ □ Height_____

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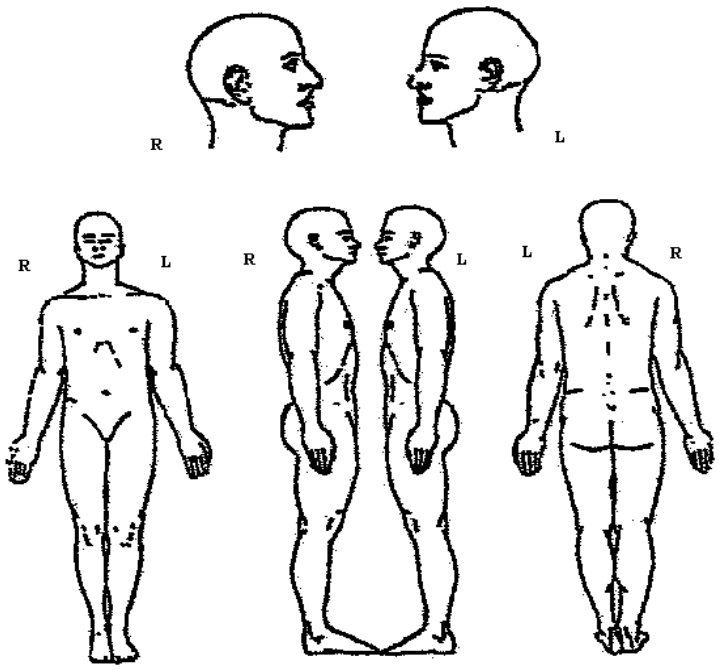
Does your pain keep you from falling asleep at night? □ Yes □ No

Does your pain wake you up at night? □ Yes □ No

Has your pain changed over time? □ Yes □ No. If yes, describe _____

Where is your pain? Show the location of your pain by shading the picture.



What medications have been used to try to treat your pain? (Check all that apply)

	☐ Helpful	☐ Not Helpful	List Name
☐ Nsaids (i.e. Motrin)	☐	☐	_____
☐ Muscle Relaxants	☐	☐	_____
☐ Antidepressants	☐	☐	_____
☐ Anticonvulsants	☐	☐	_____
☐ Narcotics	☐	☐	_____
☐ Anxiolytics	☐	☐	_____
☐ Other _____	☐	☐	_____

What Modalities have been tried to treat your pain? (Check all that apply)

	Location	Provider	Helpful
☐ Physical Therapy/Occupation Therapy	_____	_____	☐ Yes ☐ No
☐ TENS Unit	_____	_____	☐ Yes ☐ No
☐ Biofeedback/Manipulation Therapy	_____	_____	☐ Yes ☐ No
☐ Acupuncture	_____	_____	☐ Yes ☐ No
☐ Nerve Block	_____	_____	☐ Yes ☐ No
☐ Surgery	_____	_____	☐ Yes ☐ No
☐ Implantable Device	_____	_____	☐ Yes ☐ No
☐ Other _____	_____	_____	☐ Yes ☐ No

What diagnostic studies, such as x-rays, CT scans, MRI's, myelograms, EMG/NCV (electromyography and/or nerve conduction), Bone density test or bone scans have been done within the last five years? Please give study and date.

Study	Date preformed	Study	Date preformed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please have reports of these studies available on your first visit.

Type of Study (circle one)	Date	Do you have the report? (circle one)	Part of body studied	Location where test was performed
X-ray, CT/ Myelogram, MRI (C,T,L),EMG/NCV, bone scan, bone density, discography		Yes No		
X-ray, CT/ Myelogram, MRI (C,T,L),EMG/NCV, bone scan, bone density, discography		Yes No		
X-ray, CT/ Myelogram, MRI (C,T,L),EMG/NCV, bone scan, bone density, discography		Yes No		
X-ray, CT/ Myelogram, MRI (C,T,L),EMG/NCV, bone scan, bone density, discography		Yes No		
X-ray, CT/ Myelogram, MRI (C,T,L),EMG/NCV, bone scan, bone density, discography		Yes No		
X-ray, CT/ Myelogram, MRI (C,T,L),EMG/NCV, bone scan, bone density, discography		Yes No		

PAST OR CURRENT MEDICAL HISTORY (check all that apply)

☐ Diabetes
☐ Cancer_____________
☐ Kidney
☐ Viral Infection ______
__HIV __Hepatitis
☐ Stroke
☐ Seizure
☐ Migraine
☐ Fibromyalgia

☐ Lung Disease
☐ Asthma
☐ Emphysema
☐ Heartburn or peptic ulcer
☐ GI Bleeding
☐ High blood pressure
☐ Heart Disease
☐ Angina
☐ Other _______________

☐ Coronary artery
☐ CHF
☐ Arrhythmia
☐ Osteo Arthritis ☐ Rheumatoid Arthritis
☐ Bleeding problems
☐ Thyroid
☐ Pacemaker-Defibrillator
☐ Autoimmune

PAST SURGICAL HISTORY (List all)

Surgery Date

____ ________________
____ ________________
____ ________________
____ ________________
____ ________________

CURRENT MEDICATIONS (List all including over the counter medications)

_______________________ ________________________ __________________________
_______________________ ________________________ __________________________
_______________________ ________________________ __________________________
_______________________ ________________________ __________________________

***Are you currently taking any blood thinners (I.e., coumadin, warfarin,) ☐Yes ☐No**

LIST ALL NUTRITIONAL AND HERBAL SUPPLEMENTS

________________________ ________________________ __________________________
________________________ ________________________ __________________________

LIST ALL MEDICATION ALLERGIES AND REACTIONS

________________________ _______________________ __________________________
________________________ _______________________ __________________________
________________________ _______________________ __________________________

*Are you allergic to contrast dye (Toradol, Versed)? ☐ Yes ☐ No *Are you allergic to steroids? ☐ Yes ☐ No
*Are you allergic to local anesthetics? ☐ Yes ☐ No

Do you use recreational drugs or medications which were prescribed for someone else? □ Yes □ No
Have you ever had difficulties with spinal, epidural or local injection? □ Yes □ No
If yes, please explain_____
Are you or could you be pregnant at this time? □ Yes □ No
*Do you plan to become pregnant? □ Yes □ No
If it is possible that you are pregnant, please notify the physician.
Is there anything else that we should know that would assist us in treating your pain?
_____
_____
_____

OCCUPATION/LITIGATION/PSYCOLOGICAL

Are you currently employed? □ Yes □ No
If yes, what do you do? _____
What duties are involved? _____
How long have you been with this employer? _____ How many hours per week? _____
If no, date you last worked? _____
Who took you off work? _____ When will your "off work" slip expire? _____

Are you on Workers Compensation? □ Yes □ No Date started? _____
Are you on disability? □ Yes □ No
If yes, which type of do you have? (Check all that apply) □ Social Security Disability □ Long term disability
□ Short term disability □ other, please describe
What is your disability? _____
Are you involved with a lawsuit with Workers Compensation? □ Yes □ No
Are you involved in a lawsuit regarding an auto accident? □ Yes □ No
Are you involved in a lawsuit regarding a disability claim? □ Yes □ No
If you are involved in a lawsuit, who is it against? _____
Please describe the current state of litigation or settlement. _____
Do you have plans to pursue a legal or insurance settlement in the future? □ Yes □ No
How much work if any have you missed in the past month due to pain? _____
How has the pain affected your personality? (Check all that supply)

□ No effect	□Alert	□cheerful	□moody	□get along well
□Slightly upset	□irritable	□disagreeable	□dull	□complaining
□Moderately upset	□unhappy	□anxious	□uncooperative	□withdrawn
□Severely upset	□depressed	□bitter	□desperate	□angry
□Totally incapacitated	□panicked	□avoid everyone	□ severely withdrawn	

Since the pain, what are you concerned about? (Check all that apply now)

□ Loss of recreational activities	□ ability to earn income	□ memory/concentration difficulties
□ Poor sleep and daytime fatigue	□ sexual desire/interest or ability	□ unidentified medical problems
□ The pain last forever	□ other _____	

Are you currently depressed? □ Yes □ No
Have you ever seen a counselor, psychologist or psychiatrist? □ Yes □ No
(If yes, please include their name, office phone number and date last seen. _____
Are you interested in seeing a pain psychologist to help you deal with the pain? □ Yes □ No
What treatments have you had for emotional problems? (Check all that apply)
□ ECT □ Counseling □ Medication □ Group Therapy
□ Other (please describe) _____

Describe the most stressful experience in your ENTIRE LIFE up to now? _____
_____
_____
In additional to decreased pain, what do you hope to get from treatment? _____
_____
_____

SOCIAL HISTORY

□ Alcohol (how much) _____ (Has anyone complained about your drinking? □Yes □ No)

□ Recreational drug abuse □ Cigarettes (how much) _____ □ Appetite suppressants □ Cigar/pipe/tobacco
□ Prescription Drug Dependency

Marital Status: □ Married □ Single □ Divorced □ Widowed
Do you have living parents? □ Yes □ No Children or Dependants? □ Yes □ No List their ages_____

FAMILY MEDICAL HISTORY (check all that apply)

□ Diabetes □ Cancer □ High blood pressure □ Heart disease □ Stroke □ Asthma
□ Blood disease □ Epilepsy □ Alcoholism □ Allergies □ Nervous breakdown
□ Cause of death _____ □ other _____

REVIEW OF SYSTEMS (check all that apply)

CONSTITUTIONAL SYMTOMS

□ Fatigue □ General weakness □ Tiredness □ Dizziness □ Poor appetite □ Heavy appetite
□ Poor sleep □ Heavy sleep □ Cold hands □ Cold feet □ Cold back □ Cold abdomen
□ Fevers □ Chills □ Sweat easily □ Strong thirst □ Childhood illness _____
□ Other _____

HEAD

□ Fainting spells □ Concussions/Contusions □ Facial pain □ Migraines □ other _____

EYES

□ Eye pain □ Poor vision □ near sighted □ far sighted □ Floaters □ Blurred Vision □ Cataracts
□ Other _____

EARS, NOSE, MOUTH AND THROAT

□ Poor hearing □ ringing in ears □ Nose Bleeds □ Sinus □ TMJ □ Gum problems □ Dry throat
□ Dry mouth □ Lip/tongue sores □ Mucus/copious saliva □ other _____

CARDIOVASCULAR

□ Chest pain □ Palpitation/fluttering □ Phlebitis □ Shortness of breath
□ Night sweats □ Blood clots □ other _____

RESPIRATORY

□ Cough □ Coughing up blood □ Sputum □ Tight chest □ Pain with breathing □ other _____

GASTROINTESTINAL

□ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas
□ Belching □ Stomach cramps □ abdominal pain □ rectal pain □ Irritable bowel
□ Laxative Use: _____/week; type _____ □ Bowel movements: frequency_____ form_____
□ Other _____

GENITOURINARY

□ Pain on urination □ Frequency □ Urgency to urinate □ Blood in urine □ Enlarged prostate
□ Impotency □ Other _____ □ Wake up to urinate (/night)

PREGNANCY AND GYNECOLOGY

□ Age of first menses _____ □ Age at last menses _____ □ PMS □ Period (duration: day's _____; cycle: day's _____)
□ Irregular flow □clots _____ □Menstrual cramps □ hot flashes □ Menopause
□ Number of pregnancies □ Number of births □ Premature births □ Miscarriages □ Birth control □ Other _____

MUSCULOLOSKELETAL

□ Tendonitis □ Spasms □ Joint pain □ Fibromyalgia □ other _____

NEUROLOGICAL

□ Numbness □ Localized weakness □ Paralysis □ Tremor □ Poor coordination

□ Closed head injury □ Spasticity □ Poor memory □ other _____

INTEGUMENTARY (SKIN AND/OR BREAST)

□ Skin rashes □ Itching □ Hives □ Eczema □ Pimples □ Ulceration □ Purpura
□ Hair loss □ Change in hair/skin □ other _____

ENDOCRINE

□ Intolerance to stress □ Change in sexual characteristics □ intolerance to heat □ Palpitation
□ Nervousness □ Intolerance to cold □ other _____

HEMATOLOGICAL/LYMPHATIC

□ Easy bruising □ Enlarged lymph nodes □ Difficulty clotting □ History of blood transfusions
□ Edema/swelling □ other _____

ALLERGIC/IMMUNOLOGICAL

□ Frequent colds □ frequent infections □ Difficulty healing open wounds
□ Environmental allergies (seasonal □ Yes □ No) □ on immune enhancing/depressant medication □ Other _____

PSYCHIATRIC

□ Joyful	□ Creative	□ Introspective	□ Sad/grief	□ Willful/ambitious
□ Inhibited	□ Excited/explosive	□ Worried/obsessed	□ Fearful	□ Confident
□ Indecisive	□ Impulsive	□ easily stressed	□ other _____	

PERSONAL PREFERENCE

Favorite season	□ Spring	□ Summer	□ Fall	□ Winter	
Period of the day	□ Sunrise	□ Afternoon	□ Sunset	□ Night	
Favorite flavor	□ Sour/citrus	□ Bitter/roasted	□ Sweet	□ Spicy/flavorful	□ Salty
Color affinity	□ Blue/green	□Red	□ Yellow/earth	□ White	□ Black/dark blue