

Comprehensive Pain Management Initial Patient Questionnaire

General Information

(Please fill out *completely* and return to Pain Management at your consultation visit)

Name: _____
Last
First
Middle

• Chief complaint:

What is the main reason you are here?

History of Present Illness: (iv)

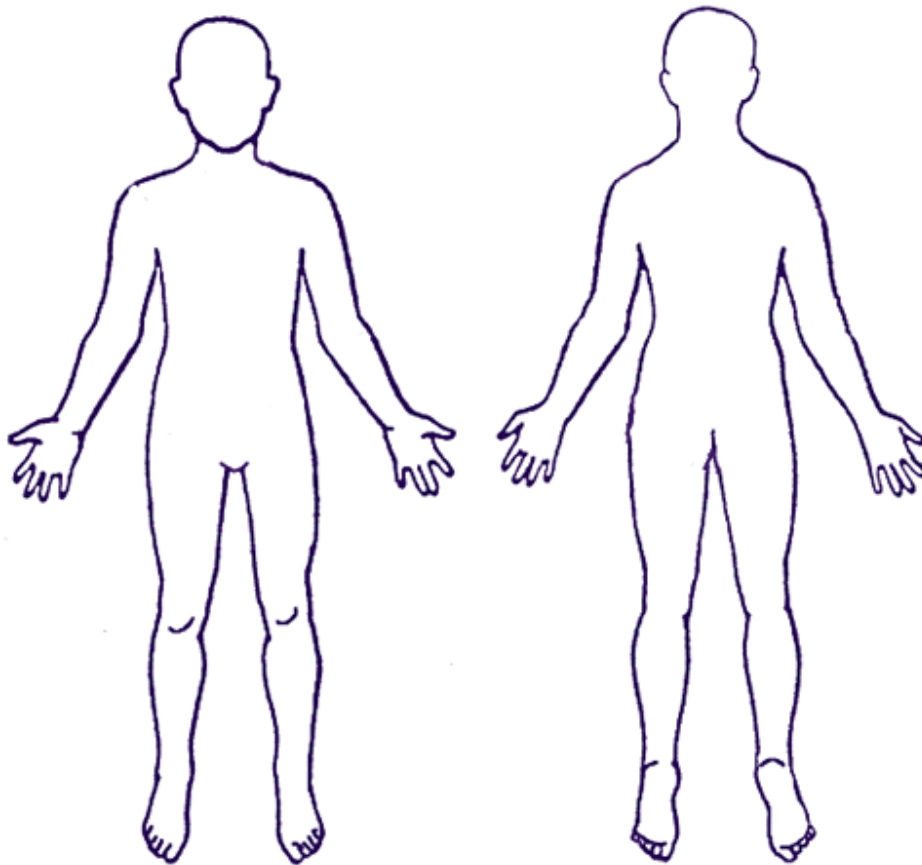
• **Location** (*Check all that apply*)

Leg	Low back	Mid back	Upper back	Head	Neck
Foot	Shoulder	Jaw	Chest	Buttock	Abdomen
Toes	Fingers	Arms/hand	Face	Other _____	

• **Quality** (*Describe your pain by checking all that apply*)

Burning	Stabbing	Electric	Pulling	Aching
Throbbing	Constant	Radiating	Gnawing	Dull
Sharp	Crushing	Tingling	Itching	Squeezing
Hot	Cold	Other _____		

**Please shade the painful areas,
circle areas of numbness and tingling
and place an "X" over the most painful area.**



• **Severity** (*Rate your pain on AVERAGE during the last week*)

0 1 2 3 4 5 6 7 8 9 10
 No pain at all Excruciating pain

• **Duration**

How did your pain begin? (*Please check most applicable*)

Injury at work Injury (not at work) Illness Non-injury
 Treatment caused Motor vehicle accident Undertermined
 other _____

How long have you been in pain? (*Please check most applicable*)

0-3 mos 13-24 mos 10-15 yrs
 4-6 mos 2-3 yrs 15-20 yrs
 7-9 mos 3-5 yrs more than 20 years
 10-12 mos 5-10 yrs

• **Timing**

If at all, how often does your pain increase above average? (*Please check most applicable*)

Never 2-5 times / day
 1-2 times/ month 6-10 times / day
 1-2 times / week Over 10 times / day
 Daily

When the pain worsens, how long does it last? (*Please check most applicable*)

A few minutes The rest of the day
 Less than 1 hour At least several days
 1-4 hours

• **Modifying Factors**

What situations/activities increase your pain? (*i.e. prolonged standing or sitting, stress*)

What situations/activities decrease your pain? (*i.e. lying down, relaxation techniques*)

• **Context**

Is there any specific time of day or year that the pain appears to worsen during?

• **Assoc. signs/symptoms**

What other symptoms occur directly associated to you pain? (*Please circle most applicable*)

Fevers Chills Sweating Numbness
 Tingling Weakness Nausea Vomiting
 Diarrhea Sensitivity to light Sensitivity to sound Sensitivity to touch
 Dizziness Shortness or breath Anxiety

Are you able to engage in activities you participated in prior to developing pain? (*Please circle*)

0 1 2 3 4 5 6 7 8 9 10
 Not at all All of the time

How many hours are you active and not reclining each day? _____ hrs

Does your pain require you to use a cane, walker, or wheelchair? (*Please circle*)

0 1 2 3 4 5 6 7 8 9 10
 Not at all All of the time

• Past Medical History: (i)

Please indicate any illness/medical conditions which you may have:

- | | | |
|---|---|--|
| Y/N Arthritis | Y/N Eye disorder | Y/N Obesity |
| Y/N AIDS/HIV | Y/N Headache (specify) | Y/N Organ Transplant |
| Y/N Bladder/Urinary disorder | Y/N Heart attack/myocardial infarction | Y/N Pacemaker |
| Y/N Bleeding problems | Y/N Heart disease | Y/N Peripheral vascular disease |
| Y/N Blood disease (Sickle cell, Anemia, Leukemia) | | Y/N Stomach problems
(Peptic ulcer disease) |
| Y/N Cancer | Y/N Hepatitis | Y/N Stroke /CVA |
| Y/N Chemical dependency | Y/N High cholesterol | Y/N Thyroid problems |
| Y/N Chronic pain | Y/N Hypertension (high blood pressure) | Y/N TIA |
| Y/N Congestive heart failure | Y/N Kidney problems (Renal disease) | Y/N TMJ |
| Y/N Diabetes | Y/N Liver disease | Y/N Other |
| Y/N Epilepsy | Y/N Lung disease | |

Past Surgical History:

(Please list all surgeries and dates):

Surgery	Physician	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

• Family Medical History: (i)

When applicable, please indicate which family member has been affected.

Disease	Relationship to you
Y/N Cancer	_____
Y/N Diabetes	_____
Y/N Heart disease	_____
Y/N Hypertension	_____
Y/N Liver disease	_____
Y/N Mental illness	_____
Y/N Respiratory disease	_____
Y/N Renal disease	_____

Indicate which of your family members had or are currently experiencing chronic pain. (Check any that apply)

- | | | | | |
|-------------|--------|------------|-----------|-------------|
| Father | Mother | Brother(s) | Sister(s) | Grandfather |
| Grandmother | Other | None | | |

• Social History: (i)

Do you **smoke**? _____No _____Yes # of packs per day _____ How long?

If you quit, how long has it been for?

Other tobacco (*circle*): Pipe, Cigar, Chewing Tobacco

How many cups of coffee of caffeinated beverages do you consume a day? _____

Indicate how many **alcoholic drinks** you have PER WEEK (i.e. 1 oz of liquor, 12 oz of beer, 1 glass of wine each equal one drink). (Check)

- | | | | | | |
|--------|----------|-----------|------------|------------|-----------------|
| 0/week | 1-5/week | 6-10/week | 11-15/week | 16-20/week | 21 or more/week |
|--------|----------|-----------|------------|------------|-----------------|

Recreational/Illegal Drug Use: (Circle. If "Yes", please indicate if you are currently using it)

- | | | |
|---------------|-------------|-------------|
| Y/N Marijuana | Y/N Cocaine | Other _____ |
|---------------|-------------|-------------|

\Legal Problems: (Circle)

Y/ N Driving while intoxicated (DWT)

Arrests (specify)_____

How well are you coping with your pain today? (Circle)

0 1 2 3 4 5 6 7 8 9 10
Lowest Highest

How would you rate your feelings of depression today? (Circle)

0 1 2 3 4 5 6 7 8 9 10
Lowest Highest

How would you rate your feelings of anxiety today? (Circle)

0 1 2 3 4 5 6 7 8 9 10
Lowest Highest

How would you currently rate your mood? (Circle)

0 1 2 3 4 5 6 7 8 9 10
Severely Depressed Neutral Overjoyed

Is this a change for you? Yes / No

Have you ever been so depressed/discouraged that you thought about hurting or killing yourself? Yes / No

Have you ever lost a relative to suicide? Yes / No *If yes; who, when, and your reaction:*_____

Were you ever sexually or physically abused as a child or adult? (Circle)

0 1 2 3 4 5 6 7 8 9 10
Not at all All of the time

Review of Systems (x), (i+ii) abnormal findings & pertinent negatives

• **General:** (Circle "Y" or "N")

Y / N Recent **Wt. Loss** _____ lbs. Wt. Gain _____ lbs.
Y / N **Fever**

(Circle "Y" or "N" for any abnormalities, and then circle appropriate symptom if applicable)

• **HEENT (ENT/mouth):**

Y / N Head: headaches, head injury, migraines
Y / N Ears: discharge, hearing changes, ringing in the ear
Y / N Nose: Chronic sinusitis, decreased smell, excessive rhinorrhea, nosebleeds, nasal fracture
Y / N Throat: Oral cavity tenderness/lesion, frequent sore throats, trouble swallowing, hoarseness
Y / N Neck: Injury, masses, pain, stiffness

• **Eyes:**

Y / N Blurriness, cataracts, double vision, other **visual changes** _____

• **Cardiovascular:**

Y / N **Chest pain**, Angina, **palpitations**, dizziness
Y / N CHF, **edema in feet**, **shortness of breath with exertion**, orthopnea, PND
Y / N Phlebitis, TIA's, CVA (stroke), hypertension, claudication, cyanosis

• **Respiratory:**

Y / N Asthma, bronchitis, COPD,
Y / N **Wheeze**, **chronic cough**, shortness of breath, rapid breathing, sleep apnea
Y / N Bloody sputum, , tuberculosis,

• **Gastrointestinal:**

Y / N Constipation, clay stools, diarrhea, trouble swallowing, gallbladder disease, vomiting blood, bloody stools, hemorrhoids, hepatitis, hernias, indigestion, jaundice, nausea, vomiting, pancreatitis, rectal bleeding

• **Genito-urinary:**

Y / N painful urination, blood in urination, urgency discharge, frequency, hesitancy, incontinence, chronic urinary tract infections, STD, prostatitis, kidney stones

• **Musculoskeletal:**

Y / N joint swelling, joint redness, joint pain, gait (walking problems)

• **Integumentary (skin) or breast:**

Y / N rash, itching, sores, abscess, discharge, breast enlargement, pain, prior surgery or biopsy

• **Neurology:**

Y / N Numbness, tingling, joint pain, muscle spasms, tremors, nervousness, **syncope**, **dizziness**, vertigo, weakness

• **Psychiatric:**

Y / N **Depression**, anxiety disorder, panic disorder

• **Endocrine:**

Y / N Hot/cold intolerance, extreme thirst, frequent urination, anemia, excessive bruising or bleeding, diabetes, thyroid problems

• **Hematology/lymphatic:**

Y / N Bleeding tendency, easy bruising, lymph node swelling

• **Allergic/Immunologic:**

Y / N Allergies to medicine, food, seasonal allergies, other?

If so, what? And please describe reaction: _____

Sleep:

Total # of hours of sleep/night _____ **Number of sleep interruptions** _____

What wakes you up? _____

What do you do when unable to return to sleep? _____

Appetite:

What is your appetite like? _____ **Is this a change for you? Yes / No**

How long has it been this way?

Patient Signature _____ Date _____

Reviewed by _____ Date _____