SSM Pain Care

NEW PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Today's Date: _____

Date of Birth: _____

Primary Care Doctor's Name: _____
Phone number or fax: _____

The name of the doctor who referred you to us: _____
Phone number or fax: _____

Have you ever been seen at another pain clinic? If so,
a. When? _____
b. By whom? _____

Weight _____ pounds Height _____ inches

Allergies to Medications:

_____ _____ _____
_____ _____ _____

Current Medications:

Drug	Dose	Drug	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you on any blood thinners?

☐ Coumadin ☐ Heparin ☐ Pradaxa ☐ Fish oil ☐ Aspirin - if so, how much?_____
☐ Plavix ☐ Lovenox ☐ Pletal ☐ Other_____

History of Present Illness

Chief Complaint: (describe your pain problem)

_____
_____
_____

1. When did the pain first begin? _____ Year _____ Months _____ Weeks ago
☐ After an injury ☐ Spontaneously ☐ Gradually ☐ Other_____

2. What caused the pain? _____

3. If an injury, any third party representation?
☐ Work Comp ☐ Attorney Contact information:_____

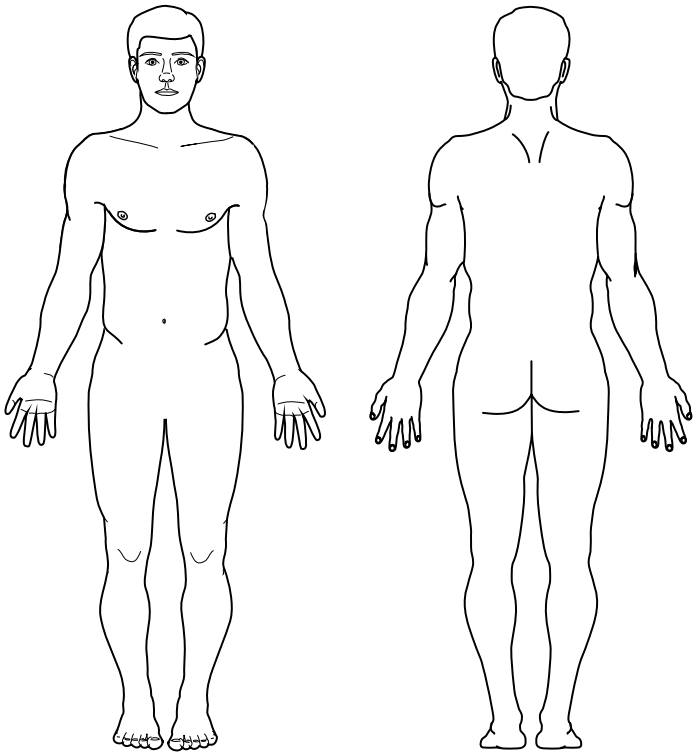
4. Where on your body does the pain start? _____

5. Does the pain travel, and if so, where? _____

6. Brief Pain Inventory

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). have you had pain other than these everyday kinds of pain today?
   ☐ Yes ☐ No

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



3. Please rate your pain by circling the one number that best describes your pain at its WORST in the last week.
   0 1 2 3 4 5 6 7 8 9 10
   No Pain — Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its LEAST in the last week.
   0 1 2 3 4 5 6 7 8 9 10
   No Pain — Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the AVERAGE.
   0 1 2 3 4 5 6 7 8 9 10
   No Pain — Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.
   0 1 2 3 4 5 6 7 8 9 10
   No Pain — Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?
   _____
   _____
   _____
   _____

8. In the last week, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

9. Circle the one number that describes how, during the past week, pain has interfered with your:

   A. GENERAL ACTIVITY
   0 1 2 3 4 5 6 7 8 9 10
   Does not interfere — Completely interferes

   B. MOOD
   0 1 2 3 4 5 6 7 8 9 10
   Does not interfere — Completely interferes

   C. WALKING ABILITY
   0 1 2 3 4 5 6 7 8 9 10
   Does not interfere — Completely interferes

   D. NORMAL WORK (includes both work outside the home and housework)
   0 1 2 3 4 5 6 7 8 9 10
   Does not interfere — Completely interferes

   E. RELATIONS WITH OTHER PEOPLE
   0 1 2 3 4 5 6 7 8 9 10
   Does not interfere — Completely interferes

   F. SLEEP
   0 1 2 3 4 5 6 7 8 9 10
   Does not interfere — Completely interferes

   G. ENJOYMENT OF LIFE
   0 1 2 3 4 5 6 7 8 9 10
   Does not interfere — Completely interferes

7. Which words best describe your pain? *(check all of the following that applies)*:

☐ shooting ☐ dull ☐ sharp ☐ burning
☐ throbbing ☐ aching ☐ electric shock

8. Which of the following best describes the quality of the pain? *(check the one that applies):*

☐ severe ☐ moderate ☐ mild

9. Which words best describe the timing of the pain? *(check all that apply):*

☐ constant ☐ mostly in the morning ☐ mostly in the evening
☐ intermittent ☐ mostly in the afternoon ☐ vary variable

10. As time goes on, is this pain getting:

☐ worse? ☐ about the same?
☐ better?

11. Which of the following symptoms is this pain associated with (check all that applies):

☐ numbness ☐ weakness ☐ nausea/vomiting
☐ tingling ☐ headache ☐ bowel/bladder dysfunction

12. Which of the following make the pain worse? *(check all that applies):*

☐ coughing ☐ sexual activity ☐ touch
☐ sneezing ☐ weather changes ☐ rolling in bed
☐ exercise ☐ bright lights ☐ moving from sitting to standing
☐ walking ☐ noise ☐ taking stairs
☐ sitting ☐ cold ☐ stress/fatigue
☐ standing ☐ driving
☐ lying down ☐ menstrual cycle

13. Which factors seem to relieve the pain? *(check all that applies):*

☐ sitting ☐ sexual activity ☐ walking
☐ standing ☐ heat ☐ ice
☐ lying down ☐ massage ☐ relaxation
☐ alcoholic drinks ☐ medicines

14. Which of the following previous treatments have you tried? *(check all that applies):*

☐ physical therapy ☐ cold therapy ☐ relaxation training
☐ chiropractic care ☐ bedrest ☐ occupational therapy
☐ acupuncture ☐ surgery ☐ cortisone injection
☐ biofeedback ☐ traction ☐ heat
☐ psychologist ☐ nerve blocks ☐ epidural steroid injection
☐ TENS unit ☐ trigger point injections ☐ Other: _____

15. Have you ever had any previous physical therapy? If so,

When:_____

Where: _____

16. List all the past medications you have taken for your pain problem:

_____

_____

_____

Past Medical History:

17. In your past, have you ever had any of the following health problems? *(check all that apply or write in):*

Cardiovascular:

- ☐ None
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Angina (chest pain)

Other _____

Endocrine:

- ☐ None
- ☐ Thyroid disease
- ☐ Diabetes

Other _____

Cancers:

- ☐ None
- ☐ Breast
- ☐ Prostate
- ☐ Skin

Other _____

Hematological:

- ☐ None
- ☐ Anemia
- ☐ Sickle cell

Other _____

Autoimmune:

- ☐ None
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ TMJ
- ☐ Fibromyalgia

Other _____

Renal:

- ☐ None
- ☐ Kidney stones
- ☐ Kidney infections

Other _____

Genitourinary:

- ☐ None
- ☐ Prostate problems
- ☐ Urinary incontinence
- ☐ Bladder infections

Other _____

Central nervous system:

- ☐ None
- ☐ Headaches
- ☐ Migraines
- ☐ Stroke
- ☐ Nerve damage

Other _____

Gastrointestinal:

- ☐ None
- ☐ Peptic ulcer
- ☐ Irritable bowel syndrome
- ☐ Diverticulosis
- ☐ Reflux esophagitis

Other _____

Pulmonary:

- ☐ None
- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Pneumonia

Other _____

Infectious disease:

- ☐ None
- ☐ Hepatitis
- ☐ Mononucleosis

Other _____

Psychiatric:

- ☐ None
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ ECT treatments
- ☐ Alcoholism
- ☐ Drug addiction

Other _____

Past Surgical History:

18. Have you had any surgeries in the past? Please list (even if they seem unrelated to your pain problem)

Date	Procedure	Doctor	Facility

Family History:

19. How is the general health of your family? Please write in any serious health problems or diseases. Also, please indicate if any of your family has ever had similar pain problems as you.

Mother _____ Brother_____

Father _____ Sister _____

Social History - Tell us a little about yourself.

Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Are you pregnant or do you plan to become pregnant? ☐ Yes ☐ No

How many children have you had? _____ children

Who do you live with at home? _____

How far did you get in your education? _____ level.

Describe your occupation status:

- ☐ Employed. What work do you do? _____
- ☐ Retired. What occupation did you have? _____
- ☐ Unemployed.
- ☐ Disabled. What was the cause of your disability?_____
- ☐ If married, describe spouse's occupation: _____

Are you being treated under Workmen's Compensation? ☐ Yes ☐ No

Are you currently receiving disability benefits? ☐ Yes ☐ No

Are you involved in legal action related to your pain problem or considering it in the future? ☐ Yes ☐ No

If yes, describe your current state of litigation:

_____

_____

Habits: Please check or write in all that applies:

Tobacco

☐ No tobacco ☐ Quit smoking for _____ years _____ packs/day of smoking

Alcohol

☐ No alcohol ☐ Social consumption of alcohol _____ beverages/day containing alcohol

Caffeine

☐ No caffeine _____ beverages/day containing caffeine

Exercise

☐ None ☐ Rarely ☐ Regularly

Drugs

Do you use or have you ever used recreational drugs? ☐ No ☐ Yes

If yes, which drugs? _____

Have you ever undergone drug or alcohol rehabilitation? ☐ No ☐ Yes

If yes, which drugs? _____

Have you ever misused or abused prescription drugs? ☐ No ☐ Yes

If yes, which drugs? _____

20. Have you had any of the following tests performed within the last 24 months?

Test	Date	Facility where it was tested	Results
X-ray			
CT Scan			
MRI			
EMG			
Myelogram			

Review of Systems:

21. Are you experiencing any of the following symptoms with regularity that is different than what you listed before? If so, *please check*.

General:
☐ weight gain/loss
☐ appetite changes
☐ fever/chills
☐ disturbed sleeping habits

Eye:
☐ eye infections
☐ blurred vision
☐ double vision
☐ blindness

Psychiatric:
☐ depression
☐ mood swings
☐ anxiety

ENT:
☐ hearing loss
☐ dizziness
☐ hoarseness
☐ sore throat
☐ bloody nose
☐ sinusitis

Cardiac:
☐ chest pains
☐ heart murmur
☐ skipped beats

Genitourinary:
☐ bladder incontinence
☐ difficulty urinating

Endocrine:
☐ hot or cold flashes

Respiratory:
☐ cough
☐ coughing up blood
☐ wheezing
☐ shortness of breath
☐ difficulty in breathing with exertion

Gastrointestinal:
☐ constipation
☐ diarrhea
☐ bloody stools
☐ nausea/vomiting
☐ bowel incontinence

Hematological:
☐ easy bruisability
☐ difficulty in clotting of the blood

Neurologic:
☐ headaches
☐ dizziness
☐ falling
☐ seizures
☐ numbness
☐ tremor

Skin:
☐ lacerations
☐ abrasions
☐ pustules
☐ nodules
☐ tumors
☐ breast changes

22. Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:	_____	_____	_____	_____

TOTAL: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

23. Drug and Alcohol Screening:

1. Do you drink alcohol?
   - ☐ NO. *Go to question 2.*
   - ☐ YES:
     - ☐ Do you feel you are a normal drinker? That is, you drink but NEVER get drunk.
     - ☐ Do you feel your friends think you are a normal drinker?
     - ☐ Have you ever attended a meeting for Alcoholics Anonymous (AA)?
     - ☐ Have you ever lost friends or girlfriends/boyfriends because of drinking?
     - ☐ Have you ever gotten in trouble at work because of drinking?
     - ☐ Have you ever neglected your obligations, your family, or work for two or more days in a row because of drinking?
     - ☐ Have you ever had delirium tremens (DTs), severe shaking, heard voices, or seen things that weren't there after heavy drinking?
     - ☐ Have you ever gone to anyone for help about your drinking?
     - ☐ Have you ever been in a hospital because of drinking?
     - ☐ Have you ever been arrested for drunk driving or driving after drinking?

2. Do you currently use "recreational" drugs or have you ever experimented with drugs?
   When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed.
   - ☐ NO.
   - ☐ YES:
     Which drugs?
     - ☐ marijuana
     - ☐ cocaine
     - ☐ heroin
     - ☐ amphetamines
     - ☐ barbiturates
     - ☐ ephedra
     - ☐ PCP or angel dust
   - ☐ In the last three months, have you ever felt that you should cut down on your drug use?_____
   - ☐ In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down on your drug use? _____
   - ☐ In the last three months, have you felt guilty or bad about how much you use drugs? _____
   - ☐ In the last three months, have you been waking up wanting to use drugs? _____

24. Attestment

To the best of my knowledge, the information I recorded in this Patient Questionnaire is accurate and complete.

Patient Signature: _____ Date: _____