Please complete the attached questionnaire before your appointment. It is confidential and will be part of your medical record. It asks for information about your current problems and your past medical history. This form will give your doctor a better understanding of your problem, and will allow him or her to spend more time discussing treatment plans with you.

Patient Name: _____

ID#: _____

Pain Management
Initial Visit Patient Information

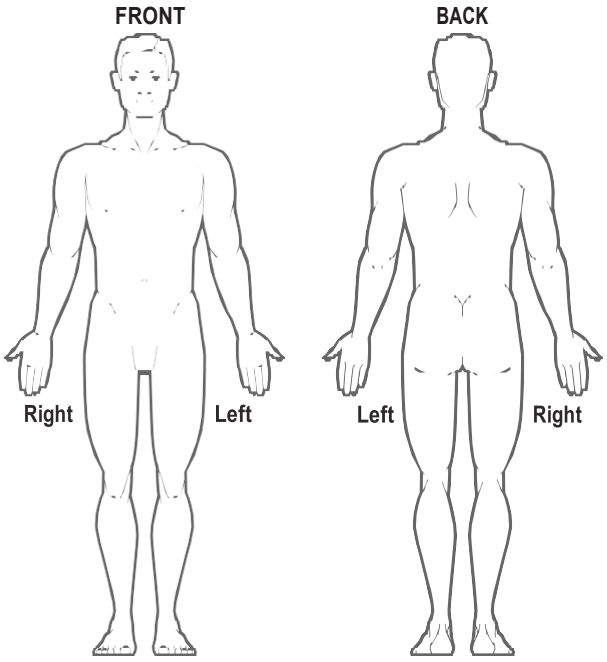
When you come for your first visit, **please bring this *completed* form** along with **any medical records, X-rays, CT or MRI scans, medication bottles** and other medical information related to your chronic pain problem. Should you have any questions, please do not hesitate to contact us.

Name _____ Phone # _____ Date of Birth _____

Primary Care Physician

Name _____ Phone # _____ Date of Birth _____

Address _____



Please shade in the areas where you feel pain.
Put an 'X' on the area that hurts the most.

What are your activity goals for your pain treatment?

1. _____
2. _____
3. _____

How long have you had chronic pain? month/year _____

Please describe events surrounding the onset of your pain.
(i.e., date of injury, activities that made it worse?)

_____
_____
_____
_____
_____
_____
_____
_____

In the last year, how many emergency room visits have you had for pain? o 0 o 1 o 2 o 3 o 5-10

WHICH WORDS DESCRIBE the *QUALITY* of your pain?

o Throbbing	o Cold/freezing	o Stabbing
o Cramping	o Hot/burning	o Itching
o Heavy/pressure	o Electric-shock	o Numbness
o Tingling/pins & needles	o Shooting	

Please check all *ACTIVITIES* that *MAKE YOUR PAIN WORSE*:

o Rest o Touch o Sitting o Standing o Bending o Lifting o Walking o Light exercise o Sex
o Warm compresses o Cold compresses o Relaxation techniques o Other: _____

Please check all *ACTIVITIES* that make your pain *BETTER*:

o Rest o Touch o Sitting o Standing o Bending o Lifting o Walking o Light exercise o Sex
o Warm compresses o Cold compresses o Relaxation techniques o Other:

Please check: *RELIEF (%)* you have had *IN THE LAST 24 HOURS* from medications and treatments:

o No relief o 10% o 20% o 30% o 40% o 50% o 60% o 70% o 80% o 90% o 100% complete relief

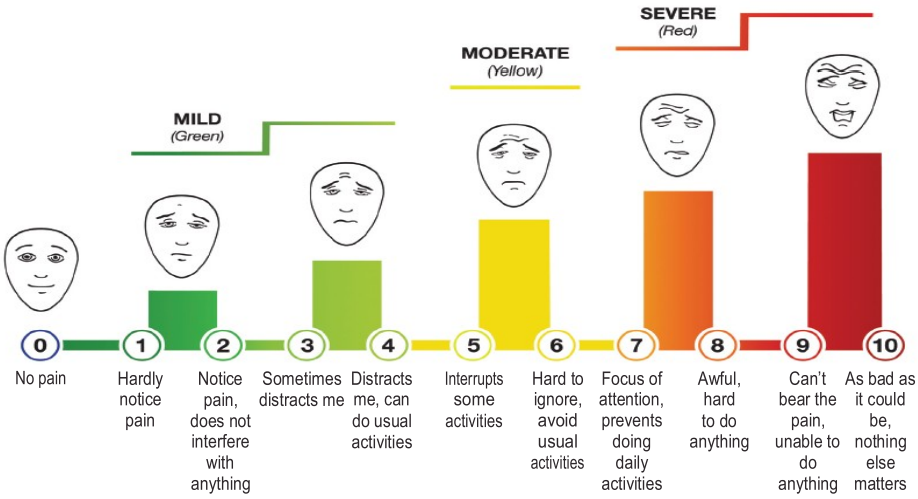
When you *TAKE YOUR MEDICATION*, how many *HOURS OF RELIEF* do you get?

_____ hours o No help at all o I do not take pain medications

Does your pain affect your sleep? o Yes o No **Does your pain cause depression?** o Yes o No

Does your pain cause anxiety? o Yes o No

Defense and Veterans Pain Rating Scale*



*The PMTF recommended a Department of Defense and VHA Pain Assessment Tool to improve actionable information for patient encounters across Military Treatment Facilities. (Line of Action 1, Standards and System Improvements)

Please check the number that indicates your **WORST PAIN LEVEL** over the last week:

o No pain 0 o 1 **o** 2 **o** 3 **o** 4 **o** 5 **o** 6 **o** 7 **o** 8 **o** 9 **o 10 WORST you can imagine**

Please check the number that indicates your **LEAST PAIN LEVEL** over the last week:

o No pain 0 o 1 **o** 2 **o** 3 **o** 4 **o** 5 **o** 6 **o** 7 **o** 8 **o** 9 **o 10 WORST you can imagine**

Please check the number that indicates your **AVERAGE PAIN LEVEL** over the last week:

o No pain 0 o 1 **o** 2 **o** 3 **o** 4 **o** 5 **o** 6 **o** 7 **o** 8 **o** 9 **o 10 WORST you can imagine**

Please check the number that indicates your **CURRENT PAIN LEVEL** right now:

o No pain 0 o 1 **o** 2 **o** 3 **o** 4 **o** 5 **o** 6 **o** 7 **o** 8 **o** 9 **o 10 WORST you can imagine**

Please help us understand *HOW PAIN HAS INTERFERED WITH* your:

A. General activity

o **Does not interfere 0** o 1 o 2 o 3 o 4 o 5 o 6 o 7 o 8 o 9 o **10 completely interferes**

B. Mood

o **Does not interfere 0** o 1 o 2 o 3 o 4 o 5 o 6 o 7 o 8 o 9 o **10 completely interferes**

C. Walking ability

o **Does not interfere 0** o 1 o 2 o 3 o 4 o 5 o 6 o 7 o 8 o 9 o **10 completely interferes**

D. Ability to perform tasks at home or at work

o **Does not interfere 0** o 1 o 2 o 3 o 4 o 5 o 6 o 7 o 8 o 9 o **10 completely interferes**

E. Relations with other people

o **Does not interfere 0** o 1 o 2 o 3 o 4 o 5 o 6 o 7 o 8 o 9 **o 10 completely interferes**

F. Sleep

o **Does not interfere 0** o 1 o 2 o 3 o 4 o 5 o 6 o 7 o 8 o 9 o **10 completely interferes**

G. Enjoyment of life

o **Does not interfere 0** o 1 o 2 o 3 o 4 o 5 o 6 o 7 o 8 o 9 o **10 completely interferes**

Other symptoms: *PLEASE CHECK* those you've had *DURING THE PAST MONTH*:

General
- o Fever
- o Chills
- o Weight loss
- o Weight gain
- o Fatigue
- o Weakness
- o Sweating

Skin
- o Rash
- o Itching

Head/Ears/Nose/Throat
- o Headache
- o Hearing change
- o Ears ringing
- o Ear pain
- o Ear drainage
- o Nosebleeds
- o Congestion

Eyes
- o Blurred vision
- o Double vision
- o Sensitivity to light
- o Eye pain
- o Eye drainage
- o Eye redness

Cardiovascular
- o Chest pain
- o Rapid heartbeat
- o Irregular heartbeat
- o Lying down → short of breath
- o Leg swelling

Respiratory
- o Cough
- o Productive cough
- o Coughing blood
- o Short of breath w/exertion
- o Wheezing

Gastrointestinal
- o Heartburn
- o Nausea
- o Vomiting
- o Abdominal pain
- o Diarrhea
- o Constipation
- o Blood in stool
- o Black stool

Urinary
- o Pain
- o Urgency
- o Frequency
- o Urinary incontinence
- o Blood in urine
- o Flank pain
- o Pelvic pain

Musculoskeletal
- o Muscle aches
- o Low back pain
- o Neck pain
- o Joint pain
- o Falls

Bleeding/Allergies
- o Bruise easily
- o Bleed easily
- o Environmental allergies
- o Increased thirst

Neurologic
- o Dizziness
- o Tremor
- o Change in sensation
- o Change in speech
- o Focal weakness
- o Changes in alertness

Psych
- o Depression
- o Suicidal thoughts
- o Hallucinations
- o Nervous/anxious
- o Irritability
- o Insomnia
- o Memory problems

Have you ever had (currently or in the past):

- o Yes o No Treatment for **mood, anxiety and/or sleep disorders**?
- o Yes o No **Nightmares or flashbacks from prior traumatic experiences**?
- o Yes o No **Alcohol, illicit drug or prescription medication misuse/addiction**?
- o Yes o No Problems with **compulsive behaviors such as gambling, eating disorder, etc.**?
- o Yes o No **Hospitalization for anxiety or depression**?

If yes, please explain _____

_____

Pain management Procedures You have Undergone:

	How Many?	Dates Performed
o Trigger point injections		
o Medial branch nerve blocks		
o Radiofrequency nerve ablation or rhizotomy		
o Epidural steroid injection		
o Caudal steroid injection		
o Spinal cord stimulator		
o Facet joint injection		
o Sacroiliac joint injection		
o Stellate ganglion block		
o Lumbar sympathetic block		
o Intercostal nerve block		
o Knee genicular nerve block		
o Occipital nerve block		
o Botox injection		
o Kyphoplasty/vertebroplasty		

How many physicians have been involved in the treatment of your pain?

o 0-3 o 4-5 o 6-10 o11-15 o16-20

How many emergency room visits have you had in the last year for pain?

o 0 o 1 o 2 o 3 o 5-10

Have you ever been discharged from a pain clinic for any reason?

If yes, please explain _____

Past Medications That You've Tried – please indicate dosage, benefits and side effects

Medication	Dose/Frequency	Benefits? Side effects?
Anti-inflammatory NSAIDs		
o Ibuprofen (Motrin, Advil)		
o Naproxen (Aleve, Naprosyn, Anaprox)		
o Meloxicam (Mobic)		
o Celecoxib (Celebrex)		
o Toradol (Ketorolac)		
Narcotic Pain Medications		
o Propoxyphene (Darvocet)		
o Ultram (Tramadol)		
o Codeine (Tylenol #3)		
o Meperidine (Demerol)		
o Hydromorphone (Dilaudid)		
o Fentanyl (Duragesic) patch		
o Morphine (MS Contin, Kadian, Avinza)		
o Hydrocodone (Lorcet, Lortab, Vicodin)		
o Methadone (Dolophine)		
o Oxycodone ER (Oxycontin)		
o Oxycodone (Percocet, Roxycodone)		
o Butorphanol (Stadol)		
o Pentazocine (Talwin)		
o Buprenorphine (Suboxone, Subutex)		
Membrane Stabilizers		
o Gabapentin (Neurontin)		
o Pregabalin (Lyrica)		
o Valproate (Depokote)		
o Carbamazepine (Tegretol)		
o Topiramate (Topamax)		
o Lamotrigine (Lamictal)		
Anti-depressants		
o Amitriptyline (Elavil)		
o Imipramine (Tofranil)		
o Desipramine (Norpramin)		
o Doxepin (Sinequan)		
o Nortriptyline (Pamelor)		
o Milnacipran (Savella)		
o Duloxetine (Cymbalta)		
o Venlafaxine (Effexor)		
o Desvenlafaxine (Pristiq)		
o Fluoxetine (Prozac)		
o Paroxetine (Paxil)		
o Trazodone (Desyrel)		
o Bupropion (Wellbutrin)		
Local or Topical (applied to skin)		
o Diclofenac (Voltaren) gel		
o Lidoderm patch		
o Flector patch		
o Capsacin		
o Salonpas, Icy Hot, Bengay or Tiger Balm		

Past Medications That You've Tried – please indicate dosage, benefits and side effects

Medication	Dose/Frequency	Benefits? Side effects?
Benzodiazepines (minor tranquilizers)		
o Diazepam (Valium)		
o Clonazepam (Klonopin)		
o Alprazolam (Xanax)		
o Lorazepam (Ativan)		
Muscle Relaxants		
o Baclofen (Lioresal)		
o Carisoprodol (Soma)		
o Cyclobenzaprine (Flexeril)		
o Methocarbamol (Robaxin)		
o Metazalone (Skelaxin)		
o Tizanidine (Zanaflex)		

Past Medical History

Past Surgical History

Allergies

Are you allergic to iodine or IV contrast dye? o Yes o No

FAMILY HISTORY:

Please list family members' illnesses (cancer, diabetes, psych, substance use, etc.)

o Yes o No Any family members have/had **alcohol, illicit drug or prescription med misuse/addiction**?

o Yes o No Problems with **compulsive behaviors** such as **gambling, eating disorder, etc.**?

o Yes o No Does **anyone in your household take prescription pain medications**?

o Yes o No Does **anyone in your household use illicit drugs**?

SOCIAL HISTORY:

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

Who lives at home with you?

Family support: o Strong o Average o Minimal o None

Your **sources of enjoyment and/or support** (family, friends, hobbies)?

What are your **sources of stress** (family, finances, etc.)?

Employment:

Are you currently employed? o Yes o No Occupation _____ #Hrs/Day _____ #Days/Week _____

If no, **when did you last work?**_____ What was your **most recent job**? _____

Are you currently receiving disability benefits? o Yes o No If yes, since when?_____

Are you involved with Workers' Compensation? o Yes o No If yes, is there **litigation pending**? o Yes o No

Marital Status: o Single o Married o Separated o Divorced o Widowed

Education: Please check the highest level of education you have completed.

o Grade school o High school o Junior college o Trade school o Some college o Graduated college
o Graduate/professional school

SUBSTANCE USE:

o Yes o No **Do you smoke cigarettes?** If yes, how many packs per day?_____How many years? _____

If you are a former smoker, when did you quit? _____ How many packs per day? _____ How many years? _____

o Yes o No **Do you use alcohol?** About how often?_____For how many years? _____

o Yes o No **Do you use illegal drugs?** About how often?_____For how many years? _____

o Yes o No **Have you ever had a problem w/alcohol, illicit drugs or prescription meds?** If yes, please explain:

_____

_____

_____

HAVE YOU EVER:

oYes oNo Had prescription pain **medications lost or stolen**?

oYes oNo **Shared your prescription pain medications** with others (family, friends)?

oYes oNo **Taken more prescription pain medication than prescribed**, or run out early?

oYes oNo Taken prescription pain medications to **relieve non-pain symptoms** (anxiety, sleep)?

oYes oNo Consumed prescription pain **medications that were not prescribed to you** (from family, friend)?

oYes oNo **Altered a prescription pain pill for enhanced effect** (such as crushing a time-release tablet)?

oYes oNo Been in a **treatment program for alcohol or drug abuse**?

oYes oNo Attended a **12-step meeting such as Alcoholics Anonymous** (AA) or **Narcotics Anonymous** (NA)?

oYes oNo Had a **DUI** or **been arrested for using or selling illicit drugs**?

oYes oNo Had a drug **overdose**?

oYes oNo Had **someone express concern about your overuse** of prescription pain medications, drugs or alcohol?

oYes oNo Been **discharged from a pain clinic for any reason**? If yes, please explain:

_____

IF YOU ANSWERED 'YES' TO ANY OF THE ABOVE, PLEASE EXPLAIN:

_____

_____

_____

Name of last physician or clinic where you received treatment for chronic pain: _____

Why are you no longer being treated there? _____

_____

Thank you for completing this form.
We look forward to the opportunity to participate in your care.

WHITE-WILSON
MEDICAL CENTER, P.A.