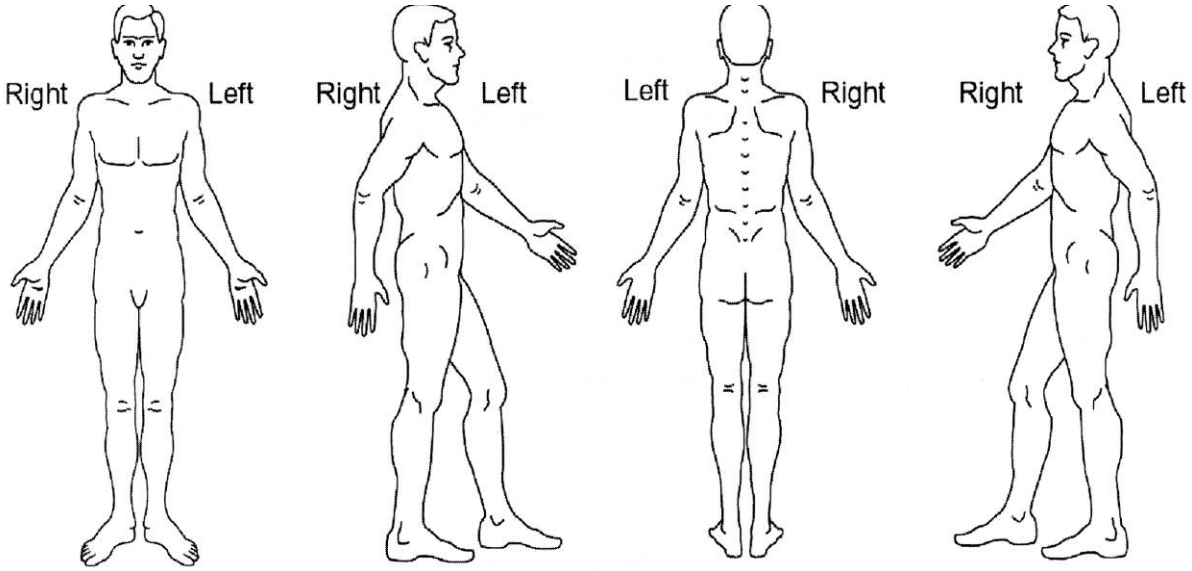
CENTER FOR PAIN MANAGEMENT

NEW PATIENT QUESTIONNAIRE

Referring Physician Name: _____ Tel: _____

Primary Care Physician Name: _____ Tel: _____

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



What is your pain right now? Circle the number that best reflects your pain level.

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0 1 2 3 4 5 6 7 8 9 10

No pain Mild Moderate Severe Very severe Worst possible

What does the pain feel like? Check all that apply:

_ Pressure	_Nagging	_Tender	_Burning	_Itching	_Pinching
_Tingling	_Numbing	_Cramping	_Stinging	_Splitting	_Heavy
_Pulsing	_Throbbing	_Crushing	_Squeezing	_Shooting	_Dull
_Aching	_Radiating	_Cutting	_Sharp	_Stabbing	

Do you have? Check all that apply

_Numbness _ Muscle spasms _Skin discoloration _Coldness _Skin sensitivity
_Tightness _Tingling _Pins and needles _ Weakness _Increased sweating

Does the pain make it hard for you to: Check all that apply
_Walk _Sleep _Sit _Work _Exercise _Eat _Be with family _Enjoy life _Have sex

When is the pain worse? Check all that apply

_ Morning (6-9am) _Late afternoon (3-6pm) _With activity
_Midmorning (9-Noon) _Evening (6-9pm) _Can't predict
_ Afternoon (12-3 pm) _ Late evening (9-Midnight) _Before next Dose of Meds Due
_ Night (12-6am)

How do you control flare-up pain? Check all that apply
_ Cold _ Heat _ Exercise _ Massage _Acupuncture _Sleep
_ Alcohol _Smoking _Food _ Hypnosis _Relaxation _Positioning
_ Self-medication

Rate your pain score for each question. 0=no pain, 10=worst pain (circle answer for each)

Rate your pain at its worst in the last 7 days	0 1 2 3 4 5 6 7 8 9 10
Rate your pain at its least in the last 7 days	0 1 2 3 4 5 6 7 8 9 10
Rate your pain on an average daily basis	0 1 2 3 4 5 6 7 8 9 10
Rate the highest pain level that you can function /live	0 1 2 3 4 5 6 7 8 9 10
(What number do you want your pain number to be?)	0 1 2 3 4 5 6 7 8 9 10

Rate how pain has interfered with activities: 0= does not interfere, 10= completely interferes

General activity	0 1 2 3 4 5 6 7 8 9 10
Mood	0 1 2 3 4 5 6 7 8 9 10
Walking Ability	0 1 2 3 4 5 6 7 8 9 10
Sleep	0 1 2 3 4 5 6 7 8 9 10
Work outside home	0 1 2 3 4 5 6 7 8 9 10
Relationships	0 1 2 3 4 5 6 7 8 9 10
Work inside the home	0 1 2 3 4 5 6 7 8 9 10
Constipation	0 1 2 3 4 5 6 7 8 9 10
Enjoyment of life	0 1 2 3 4 5 6 7 8 9 10
Sexual relations	0 1 2 3 4 5 6 7 8 9 10

Is your pain: __Constant __ Unpredictable __With increased activity

If you have back pain how long can you: Sit: _____Stand:_____
Lay flat on your back: _____ Walk:_____

PAIN HISTORY:
When did your pain begin? _____
Was there a particular incident (injury, accident illness : _ No _ Yes, explain

_____
_____

DIAGNOSTIC HISTORY:

What tests (and dates) have you had to evaluate your pain?
__ MRI_____ __ Myelogram_____ __X-rays_____
__ Discogram _____ __ CT scan _____ __ EMB/NCV _____
__ Bone scan _____ __ Other _____

THERAPEUTIC HISTORY Have you seen other pain providers? __ No __ Yes
What procedures have been done to treat your pain?

__ Trigger point injections	__ Helpful	__ Not Helpful
__ Joint injections	__ Helpful	__ Not Helpful
__Nerve Blocks	__ Helpful	__ Not Helpful
__ Epidural Steroids	__ Helpful	__ Not Helpful
__ Radiofrequency Ablation	__ Helpful	__ Not Helpful
__ Botox (Botulinum toxin)	__ Helpful	__ Not Helpful
__ Spinal Cord Stimulation	__ Helpful	__ Not Helpful
__ Pain Pump	__ Helpful	__ Not Helpful
__ Other: _____	__ Helpful	__ Not Helpful

OTHER TREATMENTS:

__ Physical Therapy	__ Helpful	__ Not Helpful
__TENS unit	__ Helpful	__ Not Helpful
__ Traction	__ Helpful	__ Not Helpful
__ Heat therapy	__ Helpful	__ Not Helpful
__ Chiropractic treatment	__ Helpful	__ Not Helpful
__ Herbal / homeopathic	__ Helpful	__ Not Helpful
__ Bio-feedback	__ Helpful	__ Not Helpful
__ Acupuncture	__ Helpful	__ Not Helpful
__ Psychological programs	__ Helpful	__ Not Helpful
__ Other: _____	__ Helpful	__ Not Helpful

MEDICAL HISTORY:
Do you now, or have you ever had any of the following? If so, provide details.
__ No __ Yes Seizures or stroke _____
__ No __ Yes Heart problems _____
__ No __ Yes Lung or breathing problems _____
__ No __ Yes Kidney problems _____
__ No __ Yes High blood pressure _____
__ No __ Yes Diabetes or high blood sugar _____
__ No __ Yes GI problems (Ulcer, gastritis, hiatal hernia) _____
__ No __ Yes Liver problems or hepatitis _____

MEDICAL HISTORY (CONTINUED)
Do you now, or have you ever had any of the following? If so, please provide details.
__ No __ Yes Sleep Apnea _____
__ No __ Yes Depression or Anxiety _____
__ No __ Yes Cancer _____
__ No __ Yes Bleeding disorder or use of blood thinners _____
__ No __ Yes Allergy to contrast or dye _____
Are there any other medical conditions not listed above that you are currently seeing a doctor or taking medications for? _____

SURGICAL HISTORY Please list the SURGERIES you have had and the year they were done.
_____
_____
_____
_____

SOCIAL HISTORY
Occupation: _____
__Currently working __Retired __ Stopped due to pain __ Disabled
Highest Degree Earned: _____
Marital Status: __ Single __ Married __ Separated __ Divorced __ Domestic Partner
Children: Number: _____ Ages: _____

Tobacco use: __ Cigarettes __ Cigar __ Pipe __Never smoked
__current smoker __ former smoker __When quit? _____ __ Passive smoker

Smokeless tobacco __ Never
__ Current __ Former __When did you quit? _____

Alcohol use: __ Beer __ Wine __ Liquor __ Drinks per week _____

Recreational drug use
__Never __ Former __ Current Drug(s) used: _____

DUI: __ Yes __ No
Alcohol or Drug treatment program: __Yes __ No
Have you ever been treated in an Alcohol or drug treatment program? __ Yes __ No
Have you attended? __ AA or any other programs : _____
Do you have an attorney because of a medical problem? __ Yes __ No

SOCIAL HISTORY (CONTINUED)
Were you ever verbally or physically abused: __Yes __No
Do you exercise? __ No __ Yes __Rarely __ 1-2 times/week __ 3-4 times/week __ 5 or more
What do you do for exercise? _____

1. Family history of substance abuse:	Alcohol	__ Yes __ No
	Illegal drugs	__ Yes __ No
	Prescription drugs	__ Yes __ No
2. Personal History of substance abuse?	Alcohol	__ Yes __ No
	Illegal drugs	__ Yes __ No
	Prescription drugs	__ Yes __ No
3. Age between 116 and 45 years old?		__ Yes __ No
4. History of preadolescent sexual abuse/		__ Yes __ No
5. Psychological disease?		__ Yes __ No
• ADD,ADHA, Obsessive-compulsive disorder, Bipolar or Schizophrenia		__ Yes __ No
• Depression		__ Yes __ No

SLEEP HISTORY

Do you snore?	__ Yes __ No
Are you excessively tired during the day?	__ Yes __ No
Have you been told that you stop breathing or gasp for breaths during sleep	__ Yes __ No
Do you have a history of hypertension?	__ Yes __ No
Is your neck size > 17 in male or > 16 in female	__ Yes __ No

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some

of these things recently, try to work out how they have affected you. Use the following scale to choose the most appropriate number for each situation:

0 – No chance of falling asleep
1 – Slight chance of falling asleep
2 – Moderate chance of falling asleep
3 – High chance of falling asleep

Situation:	**Chance of falling asleep:**				
Sitting and reading	0	1	2	3	4
Watching TV	0	1	2	3	4
Sitting inactive in a public (theater/meeting etc)	0	1	2	3	4
As a passenger in a car for an hour without break	0	1	2	3	4
Lying down to rest in the afternoon	0	1	2	3	4
Sitting and talking to someone	0	1	2	3	4
Sitting quietly after lunch without alcohol	0	1	2	3	4

FAMILY HISTORY

Problem	Father	Mother	Son	Daughter	Sibling
_Anxiety	__	__	__	__	__
_ Arthritis	__	__	__	__	__
_ Back/Neck Surgery	__	__	__	__	__
_ Chronic Fatigue	__	__	__	__	__
_ Chronic Pain	__	__	__	__	__
_ Depression	__	__	__	__	__
_ Diabetes	__	__	__	__	__
_ Fibromyalgia	__	__	__	__	__
_ IBS	__	__	__	__	__
_ Mental illness	__	__	__	__	__
_ Migraines	__	__	__	__	__
_ Neurological DX	__	__	__	__	__
_ Rheumatolical DX	__	__	__	__	__
_ Skeletal Disorder	__	__	__	__	__
_ Abdominal Pain	__	__	__	__	__

REVIEW OF SYSTEMS: Have you experienced any of the following in the past month?

General:
_ Fatigue
_ Loss of appetite
_ Weight loss
_ Poor sleep
_ Fever / chills
_ Night sweats

Cardiovascular:
_ Chest pain
_ Swelling in legs

Urinary:
_ Urinary incontinence
_ Pain or burning

Muscoloskeletal:

Hematologic/Lymphatic:
_ Joint Pain

bruising/bleeding

_ Joint Swelling
_ Muscle pain

Psychiatric:
_ Depression
_ Anxiety
_ Difficulty with thinking/memory
_ Other mental illness

Eyes,Ears,Nose,Throat:
_ Blurred vision
_ Difficulty hearing
_ Hoarseness
_ Difficulty swallowing

Respiratory:
_ Cough
_ Wheezing
_ Shortness of breath

Genito-Reproductive:
_ Decreased sexual desire
_ Decreased ability to achieve erection

Neurological:
_ Loss of balance/coordination
_ Seizures

_ Stroke
_ Paralysis of arms
_ Paralysis of legs
_ Loss of balance/coordination

Gastrointestinal:
_ Nausea
_ Vomiting
_ Bowel incontinence
_ Constipation

Skin:
_ Dryness
_ Itching
_ Rash
_ Ulcers

Endocrine:
_ Cold intolerance
_ Heat intolerance

_ Easy

_ Use of blood thinners

Allergic/Immunologic:
_ Seasonal Allergies

Check the Pain medications that you have used to treat your pain currently or in the past and check whether the medication is helpful or not.

Medication Generic name (Brand name)	Currently taking	Helpful	Not helpful	List side effects

_Tramadol (Ultram , Ultram ER)
_____

_ Tapentadol (Nucynta) _____
_ Hydrocodone (Vicodin, Norco) _____
_ Oxycodone (Percocet, Roxicet) _____
_ Meperidine (Demerol) _____
_ Morphine IR (MSIR) _____
_ Fentanyl (Actiq, Fentora) _____
_ Codeine (Tylenol 3#, 4#) _____

LONG ACTING OPIOIDS

_ CR Oxycodone (Oxycontin) _____
_ LA morphine (AMS Contin, Kadian
Avinza, Oramorph) _____
_ Methadone (Dolophine) _____
_ Fentanyl patch (Duragesic) _____
_ LA Oxmorphone(Opana ER) _____
_ Levorphanol (Levodromoran) _____
_ Buprenorphine (Butrans) _____
_ Buprenorphine/Naloxone (suboxone) _____

ANTICONVULSANTS

_ Gabapentin (Neurontin) _____
_ Pregabalin (Lyrica) _____
_ Carbamazepine (Tegretol) _____
_ Topiramate (Topamax) _____
_ Levetiracetam (Keppra) _____

BENZODIAZEPINES

_ Diazepam (Valium) _____
_ Alprazolam (Xanax) _____
_ Lorazepam (Ativan) _____
_ Clonazepam (Klonopin) _____
_ Chlordiazepoxide (Librium) _____

Medication Generic name (Brand name)	Currently taking	Helpful	Not helpful	List side effects

MUSCLE RELAXANT

_ Cyclobenzaprine (Flexeril) _____
_ Carisoprodol (Soma) _____
_ Metaxalone (Skelaxin) _____
_ Methocarbamol (Robaxin) _____
_ Tizanidine (Zanaflex) _____
_ Orphenadrine (Norflex) _____
_ Baclofen _____

ANTIDREPRESSANTS

_ Amitriptyline (Elavil) _____
_ Nortripyline (Pamelor) _____
_ Desipramine (Norpramin) _____

_ Imipramine (Tofranil) _____
_ Doxepin _____
_ Trazadone _____

SNIR

_ Duloxetine (Cymbalta) _____
_ Venlafaxine (Effexor) _____
_ Malnaciprin (Savella) _____

TOPICALS

_ Lidoderm patch _____
_ Flector/ Penssaid patch _____
_ Topical creams _____

Migraine

_ Ergotamine (Cafergot, DHE 45) _____
_ Midrin
_ Naratriptan (Amerge) _____
_ Frovatriptan (Frova)
_____
_ Sumatriptan (Imitrex) _____
_ Rizatriptan (Maxalt) _____
_ Fioricet _____

SLEEP AIDS

_ Diphenhydramine (Nytol)
_____
_ Temazepam (Restoril)
_____
_ Traizolam (Halcion) _____
_ Zapleplon (Sonata) _____
_ Zolpidem (Ambien) _____

Medication Generic name (Brand name)	Currently taking	Helpful	Not helpful	List side effects

_ Ramelteon (Rozerem) _____
_ OTC Sleep aid: _____

STIMULANTS

_ Modafini (Provigil) _____
_ Amphetamine (Adderall) _____
_ Methylphenidate (Ritalin, Concerta) _____
_ Atmoxetine (Strattera) _____

ATYPICAL

_ Olanzapine (Zyprexa) _____

_ Haloperidol (Haldol) _____

_ Ziprasidone (Geodon) _____

Are you taking medication to prevent your blood from clotting? __ No __ Yes

__ Warfarin (Coumadin) __ Enoxaparin (Levonox) __ Dalteparin (Fragmin) __ heparin __ Clopidogrel (Plavix) __ Ticlopidine (Ticlid) __ Fondaparinux (Arixtra) __ Cilostazol (pletal)

Have you ever stopped these medications for medical procedures? __ No __ Yes

Thank you for taking the time to fill out this document.
The information above is accurate to the best of my knowledge.

Patient Signature **Date**