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# Pain management

Thank you for arranging to visit one of our providers at Southwest Medical. In order to assist you in the timeliest manner, we ask that you complete this questionnaire before coming to your appointment. The information provided within this form will provide your physician a better understanding of your concerns and subsequently more time to discuss details and treatment plans. Please be as thorough as possible as this information will become part of your medical record.

When you arrive for your first visit, please make sure we receive this completed form as well as any other medical records, X-rays, CT, or MRI pertaining to your condition.

**Name:** _____

Address: _____

Phone (home): _____ Phone (work or other) _____

**Primary care physician:** _____

Address: _____

Phone: _____

**Referring physician:** _____

Address: _____

Phone: _____

**Primary insurance company:** _____

Member of subscriber number: _____ Group number: _____

Phone: _____

**Attorney's name (if applicable):** _____

Address: _____

Phone: _____

# About your pain

What is the primary reason for your visit or questions for your doctor today?

Where is your pain located? (Also, please draw the area on diagram on the next page)

How long have you had your painful condition?

Did your pain begin after a specific injury/event? (If yes, please describe the event below)

Briefly describe how your pain started:

Describe your present pain:

☐ Aching ☐ Dull ☐ Shooting ☐ Pressure ☐ Burning
☐ Throbbing ☐ Sharp ☐ Stabbing ☐ Cramping ☐ Electrical shock
☐ Stiffness ☐ Deep ☐ Pulsing ☐ Hot ☐ Cold
☐ Other (please describe): _____

Describe the timing of your pain:

☐ Constant ☐ Intermittent
☐ Other (please describe): _____

Does your pain radiate from one place to another? (i.e. back to legs, neck to arms)

What makes your pain worse?

If you have back or neck pain, which movement makes your pain worse?

☐ Bending forward (i.e. touching your toes) ☐ Bending backward (i.e. arching your back)
☐ Rotating/twisting ☐ Leaning to one side
☐ Other (please explain): _____

What do you do to ease or relieve your pain?

If you have headaches, how many days per month have they occurred over the last 3 months?

Do you experience any of the following?

☐ Numbness ☐ Weakness ☐ Temperature changes ☐ Bladder problems
☐ Tingling ☐ Balance problems ☐ Sweating changes ☐ Bowel problems
☐ Spasms ☐ Walking problems ☐ Hair/nail growth changes
☐ Limited motion ☐ Clumsiness ☐ Skin color changes

Please explain (i.e. location, frequency)

Please circle the number that best describes your baseline or constant level of pain over the past few days.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No pain | | | | | | | | | | Worst possible pain |

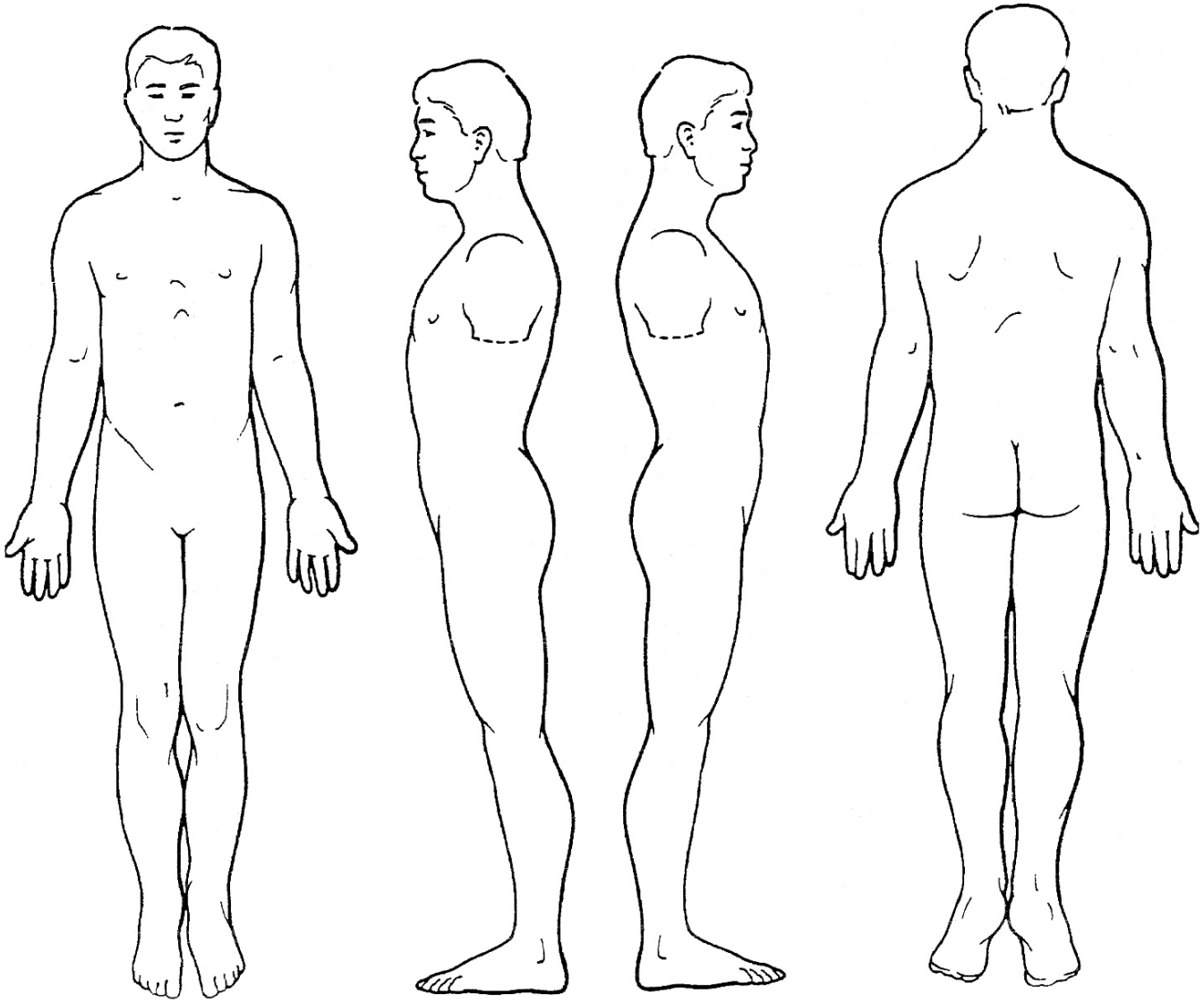
Please rate your worst pain.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No pain | | | | | | | | | | Worst possible pain |

On the average over the past few days, how many times did your worst pain occur?

1–2 3–4 5–6 7–8 More than 8

Mark on the drawing below the exact spot where your pain is located. Use a solid black dot (●). If the pain starts at that spot and radiates elsewhere (i.e. travels to another part of your body), draw a line from the spot where the pain starts and where it ends. If it is a whole area that is painful, shade that area.
Next to the places on the drawing where you showed pain, put an "E" if the pain is external (on the outside surface). If the pain is internal (inside the body) mark it with an "I." If the pain is both internal and external, mark it with an "EI."



## About your function

How far do you travel to visit this clinic? _____ Miles (approx) _____ Driving time (minutes)

How do you usually travel to this clinic? (i.e. drive car, bus, etc.)

_____

Please list aspects of your life you cannot perform normally because of your pain.

_____

How long (in minutes or hours) can you continuously:

_____ Sit _____ Stand _____ Walk

How would you describe your emotional health?

☐ Happy/cheerful ☐ Anxious ☐ Worried ☐ Optimistic
☐ Depressed ☐ Panicked ☐ Compulsive ☐ Desperate
☐ Angry ☐ Hopeless ☐ Frustrated ☐ Suicidal
☐ Other (please describe): _____

## Your thoughts about your pain

What do you feel is the cause of your pain?

_____

Do you feel there is something representing a continual threat to your health that has not been addressed or treated? If so, what do you feel this is?

_____

How would you describe the impact your pain has had on your life?

☐ Annoying ☐ Limiting ☐ Devastating
☐ Very annoying ☐ Very limiting
☐ Other (please describe): _____

What do you feel is the appropriate treatment for your condition?

_____

What are your goals for treatment or change in your life?

_____

# Previous evaluations

Please list other healthcare providers you have seen for this problem (past or present):

Please indicate any previous diagnostic tests done to evaluate your condition?

| | Dates | Results |
|---|---|---|
| ☐ Plain X-rays | | |
| ☐ CT scan (CAT scan) | | |
| ☐ MRI | | |
| ☐ EMG/n erve conduction studies | | |
| ☐ Functional capacity evaluation (FCE) | | |
| ☐ EEG (electroencephalogram) | | |
| ☐ Other | | |

Please list any surgeries you have had related to your pain:

| Date | Surgery | Surgeon | Reason for surgery | Results |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Additional comments about previous evaluations?

# Previous therapies

Please indicate your experience with the following therapies?

| No | Yes | Treatment | Improved | No change | Worse | Comment |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Physical therapy | | | | |
| ☐ | ☐ | Occupational therapy | | | | |
| ☐ | ☐ | Aquatic/pool therapy | | | | |
| ☐ | ☐ | Passive modalities (heat, ice, ultrasound, massage) | | | | |
| ☐ | ☐ | Mobilizations | | | | |
| ☐ | ☐ | Traction | | | | |
| ☐ | ☐ | Exercises/aerobic conditioning | | | | |
| ☐ | ☐ | TENS unit | | | | |
| ☐ | ☐ | Orthotics (i.e. corrective foot/shoe inserts) | | | | |
| ☐ | ☐ | Prosthesis (braces, supports, etc.) | | | | |
| ☐ | ☐ | Chiropractic | | | | |
| ☐ | ☐ | Deep tissue massage | | | | |
| ☐ | ☐ | Psychological counseling (for pain management) | | | | |
| ☐ | ☐ | Drug detoxification | | | | |
| ☐ | ☐ | Acupuncture | | | | |
| ☐ | ☐ | Bed rest | | | | |
| ☐ | ☐ | Biofeedback or relaxation therapy | | | | |
| ☐ | ☐ | Radiation treatment | | | | |
| ☐ | ☐ | Interventional therapies: (performed by ...) | | | | |
| ☐ | ☐ | *Trigger point injections* | | | | |
| ☐ | ☐ | *Epidural steroid injections* | | | | |
| ☐ | ☐ | *Facet joint injections* | | | | |
| ☐ | ☐ | *Medial branch blocks (lumbar, cervical)* | | | | |
| ☐ | ☐ | *Selective nerve blocks* | | | | |
| ☐ | ☐ | *Spinal cord stimulation* | | | | |
| ☐ | ☐ | *Intrathecal delivery system (pump)* | | | | |

Please indicate other therapies not included on the above list as well as your experience:

Please circle the number of times you had to visit the following providers for your pain in the last 6 months:

| | | | | | |
|---|---|---|---|---|---|
| Emergency room | 1 | 2–3 | 4–6 | 7–10 | More than 10 |
| Primary care physician or specialist | 1 | 2–3 | 4–6 | 7–10 | More than 10 |
| Alternative provider (chiropractor, homeopath, naturopath, acupuncturist) | 1 | 2–3 | 4–6 | 7–10 | More than 10 |

## Allergies

Please list medication allergies (include reaction):

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## Previous medications

Please indicate which medications you have used in the past (include side effects and whether still taking):

| Yes tried | Not tried | Name | Still taking | If stopped, why? Side effects | Not effective |
|---|---|---|---|---|---|
| **Pain killers** | | | | | |
| ☐ | ☐ | Fentanyl Transmucosal (Actiq) | | | |
| ☐ | ☐ | Fentanyl Transdermal (Duragesic) | | | |
| ☐ | ☐ | Tylenol with codeine | | | |
| ☐ | ☐ | Hydrocodone (Vicodin, Lortab, Norco) | | | |
| ☐ | ☐ | Hydromorphone (Dilaudid) | | | |
| ☐ | ☐ | Methadone (Dolophine, Methadose) | | | |
| ☐ | ☐ | Morphine | | | |
| ☐ | ☐ | *MS-Contin* | | | |
| ☐ | ☐ | *Avinza* | | | |
| ☐ | ☐ | *Kadian* | | | |
| ☐ | ☐ | *MSIR* | | | |
| ☐ | ☐ | Meperidine (Demerol) | | | |
| ☐ | ☐ | Oxycodone | | | |
| ☐ | ☐ | *Oxycontin* | | | |
| ☐ | ☐ | *Percocet* | | | |
| ☐ | ☐ | Propoxyphene (Darvon, Darvocet) | | | |
| ☐ | ☐ | Butorphanol (Stadol) | | | |
| ☐ | ☐ | Buprenorphine (Buprenex, Subutex) | | | |
| ☐ | ☐ | Oxymorphone (Opana) | | | |
| ☐ | ☐ | Tramadol (Ultram, Ultracet) | | | |

| Yes tried | Not tried | Name | Still taking | If stopped, why? Side effects | Not effective |
|---|---|---|---|---|---|
| **Antineuropathics** | | | | | |
| ☐ | ☐ | Carbamazepine (Tegretol) | | | |
| ☐ | ☐ | Gabapentin (Neurontin) | | | |
| ☐ | ☐ | Pregabalin (Lyrica) | | | |
| ☐ | ☐ | Lamottrigine (Lamictal) | | | |
| ☐ | ☐ | Oxycarbazepine (Trileptal) | | | |
| ☐ | ☐ | Tiagabine (Gabatril) | | | |
| ☐ | ☐ | Tipiramate (Topamax) | | | |
| ☐ | ☐ | Zonisamide (Zonegram) | | | |
| ☐ | ☐ | Lidocaine Transdermal (Lidoderm Patch) | | | |
| **Muscle relaxants** | | | | | |
| ☐ | ☐ | Baclofen (Lioresal) | | | |
| ☐ | ☐ | Carisoprodol (Soma) | | | |
| ☐ | ☐ | Clonazepam (Klonopin) | | | |
| ☐ | ☐ | Cyclopenzaprine (Flexeral) | | | |
| ☐ | ☐ | Diazepam (Valium) | | | |
| ☐ | ☐ | Metaxolone (Skelaxin) | | | |
| ☐ | ☐ | Methocarbamol (Robaxin) | | | |
| ☐ | ☐ | Tizanidine (Zanaflex) | | | |
| **Anti-inflammatories** | | | | | |
| ☐ | ☐ | Celecoxid (Celebrex) | | | |
| ☐ | ☐ | Ibuprofin (Motrin, Advil) | | | |
| ☐ | ☐ | Meloxicam (Mobic) | | | |
| ☐ | ☐ | Diclofenac (Voltaren) | | | |
| ☐ | ☐ | Nabumetoned (Relafen) | | | |
| ☐ | ☐ | Piroxecam (Feldene) | | | |
| ☐ | ☐ | Naproxen (Naprosyn, Aleve) | | | |
| ☐ | ☐ | Roficoxib (Vioxx) | | | |
| ☐ | ☐ | Valdecoxib (Bextra) | | | |
| ☐ | ☐ | Baclofen (Lioresal) | | | |
| **Antidepressants** | | | | | |
| ☐ | ☐ | Amitriptyline (Elavil) | | | |
| ☐ | ☐ | Buproprion (Wellbutrin) | | | |
| ☐ | ☐ | Citalopram (Celexa) | | | |
| ☐ | ☐ | Desipramine (Norpramine) | | | |

| Yes tried | Not tried | Name | Still taking | If stopped, why? Side effects | Not effective |
|---|---|---|---|---|---|
| **Antidepressants (continued)** | | | | | |
| ☐ | ☐ | Escitalopram (Lexapro) | | | |
| ☐ | ☐ | Fluoxetine (Prozac) | | | |
| ☐ | ☐ | Imipramine (Trofranil) | | | |
| ☐ | ☐ | Mirtazepine (Remeron) | | | |
| ☐ | ☐ | Nefazedone (Serzone) | | | |
| ☐ | ☐ | Nortriptyline (Pamelor) | | | |
| ☐ | ☐ | Sertraline (Zoloft) | | | |
| ☐ | ☐ | Trazedone (Deseryl) | | | |
| ☐ | ☐ | Venlafaxine (Effexor) | | | |
| ☐ | ☐ | Duloxetine (Cymbalta) | | | |
| **Anti-anxiety** | | | | | |
| ☐ | ☐ | Alprazolam (Xanax) | | | |
| ☐ | ☐ | Chlodiazepoxide (Librium) | | | |
| ☐ | ☐ | Lithium (Eskalith) | | | |
| ☐ | ☐ | Olazepine (Zyprexa) | | | |
| ☐ | ☐ | Phenelzine (Nardil) | | | |
| ☐ | ☐ | Respiridone (Risperdal) | | | |
| **Sleep** | | | | | |
| ☐ | ☐ | Temazepam (Restoril) | | | |
| ☐ | ☐ | Triazolam (Halcion) | | | |
| ☐ | ☐ | Zaleplon (Sonata) | | | |
| ☐ | ☐ | Zolpidem (Ambien) | | | |
| ☐ | ☐ | Trazedone (Deseryl) | | | |

# Current medications

Please list ALL of your current medications (include over-the-counter medicines and vitamins/supplements):

| Medication | Dose | Frequency | Date started | Prescribing physician |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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# Past medical history

Please indicate any medical problems now or in the past:

### Head and neck
- ☐ Glaucoma
- ☐ Eye/vision problems
- ☐ Hearing/balance problems
- ☐ Nose/sinus problems
- ☐ Throat/neck problems
- ☐ Jaw/teeth problems
- ☐ Other:_____

### Skin
- ☐ Rashes
- ☐ Sores/ulcers
- ☐ Eczema/allergic dermatitis
- ☐ Other:_____

### Lungs and chest
- ☐ Shortness of breath
- ☐ Cough
- ☐ Chest pain
- ☐ Asthma/emphysema
- ☐ Hay fever/allergies
- ☐ Pneumonia
- ☐ Other:_____

### Cardiovascular
- ☐ High blood pressure
- ☐ Heart surgery
- ☐ Artificial heart valves
- ☐ Chest pain/angina
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Irregular heart beat
- ☐ Blood clots in legs or arms
- ☐ Mitral valve prolapse
- ☐ Non-healing sores
- ☐ Poor circulation
- ☐ Leg or arm swelling
- ☐ Other:_____

### Gastrointestinal
- ☐ Acid reflux
- ☐ Ulcers
- ☐ Difficulty swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Loss of bowl control
- ☐ Red or black stools
- ☐ Nausea or vomiting
- ☐ Stomach upset with medications
- ☐ Irritable bowel syndrome
- ☐ Liver problems/hepatitis
- ☐ Other:_____

### Genitourinary
- ☐ Kidney stones
- ☐ Urinary tract infections
- ☐ Kidney failure/dialysis
- ☐ Difficulty urinating
- ☐ Loss of bladder control
- ☐ Sexual dysfunction
- ☐ Other:_____

### OB/GYN
- ☐ Pelvic pain
- ☐ First menstrual period at age: _____
- ☐ Last menstrual period at age: _____
- ☐ Menstrual problems
- ☐ Pains associated with menstruation
- ☐ Menopause

### Nervous system
- ☐ Headache
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke
- ☐ Brain injury
- ☐ Spinal cord injury
- ☐ Tremor
- ☐ Double vision
- ☐ Loss of consciousness
- ☐ Multiple sclerosis
- ☐ Peripheral neuropath
- ☐ Peripheral nerve injury
- ☐ Other:_____

### Spine
- ☐ Neck injury or pain
- ☐ Back injury or pain
- ☐ Disc disease
- ☐ Fracture
- ☐ Scoliosis
- ☐ Other:_____

### Muscle/bones/joints
- ☐ Broken bones
- ☐ Arthritis
- ☐ Joint swelling or stiffness
- ☐ Very flexible (“double–jointed”)
- ☐ Muscle pain
- ☐ Fatigue
- ☐ Morning stiffness
- ☐ Other:_____

### Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Suicide attempts
- ☐ Psychiatric hospitalization
- ☐ Psychological counseling
- ☐ Victim of abuse
- ☐ Addiction problems
- ☐ Other:_____

### Hematological/immunologic
- ☐ Easy bruising
- ☐ Bleeding problems
- ☐ Anemia
- ☐ Previous blood transfusion
- ☐ Immunodeficiency
- ☐ Transplant patient
- ☐ Swollen glands
- ☐ Cancer
- ☐ HIV

### Endocrine/metabolic
- ☐ Diabetes: insulin vs. non-insulin
- ☐ Hypothyroid (low)
- ☐ Hyperthyroid (high)
- ☐ Other:_____

### Other

_____

### Previous surgeries other than listed for pain. Include dates (month/year)

_____

## Sleep history

On the worst night during the last 2 weeks, how badly was your sleep affected by your pain?

☐ Not affected at all
☐ I didn't lose sleep but needed medication for assistance
☐ It prevented me from sleeping more than 4 hours
☐ I had only 2-4 hours of sleep
☐ I had less than 2 hours sleep

☐ Yes ☐ No Have you been told you snore a lot?
☐ Yes ☐ No Have you been told you gasp for breath at night?
☐ Yes ☐ No Are you a restless sleeper?
☐ Yes ☐ No Do you often have problems with restlessness of your legs keeping you awake?

## About your life

What is your present or previous occupation?

_____

Do you work: ☐ Full time ☐ Part time ☐ Light or limited duty
Explain: _____

How long have/had you been at this job? _____

How much do/did you enjoy your job? _____

Have you been off of work because of your pain in the past? ☐ Yes ☐ No
If so, how many times and for how long? _____

How many hours per day does your job require you to:

☐ Sit _____ ☐ Stand _____ ☐ Walk _____
☐ Drive _____ ☐ Reach _____ ☐ Bend/stoop _____
☐ Carry, push, pull (how much?) _____ ☐ Lift (how much? _____
☐ Work at computer (how long?) _____

Please answer the following questions if you are not working outside the home.

When did you last work? _____

Why did you stop? _____

How do you spend your day? _____

What is your source of income? _____

Do you plan to: ☐ Return to your previous job ☐ Take a different job ☐ Not return to work
☐ Other: _____

Is this a worker's compensation case? If yes, where are you in your case? (i.e. total temporary disability, permanent and stationary)

_____

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you have any children? If so, list with ages.

Who lives at home with you? _____

Did you have a happy childhood? ☐ Yes ☐ No

Have you ever been physically or sexually abused? ☐ Yes ☐ No

Do you feel threatened in your current environment? ☐ Yes ☐ No

Do you ever seriously consider or attempt suicide? ☐ Yes ☐ No

Do you have a suicide plan at the moment? ☐ Yes ☐ No

Do you currently:

| | | | If yes, how much/how long? | If no, did you in the past? | | If yes, how much/how long? |
|---|---|---|---|---|---|---|
| Smoke | ☐ Yes | ☐ No | | ☐ Yes | ☐ No | |
| Drink alcohol | ☐ Yes | ☐ No | | ☐ Yes | ☐ No | |
| Use other drugs | ☐ Yes | ☐ No | | ☐ Yes | ☐ No | |
| Use caffeine | ☐ Yes | ☐ No | | ☐ Yes | ☐ No | |

Do you ever consume alcohol to help with your pain? ☐ Yes ☐ No

Have you or others ever thought you have a problem with your alcohol use? ☐ Yes ☐ No

Have you or your doctors ever thought you had a problem with pain medications? ☐ Yes ☐ No

Thank you for your cooperation. Please sign below. If you are unable to sign, please have a parent, guardian, or responsible party sign and indicate the reason you are unable to sign.

_____ _____

Signature Date and time

_____ _____

Printed name Relation to patient if unable to sign

Reason patient is unable to sign: _____

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