Mind and Body Pain Clinic

2516 Samaritan Drive, Ste. M
San Jose, CA – 95124
T –408.356.5900
F – 408.356.5902
www.mindandbodypain.com

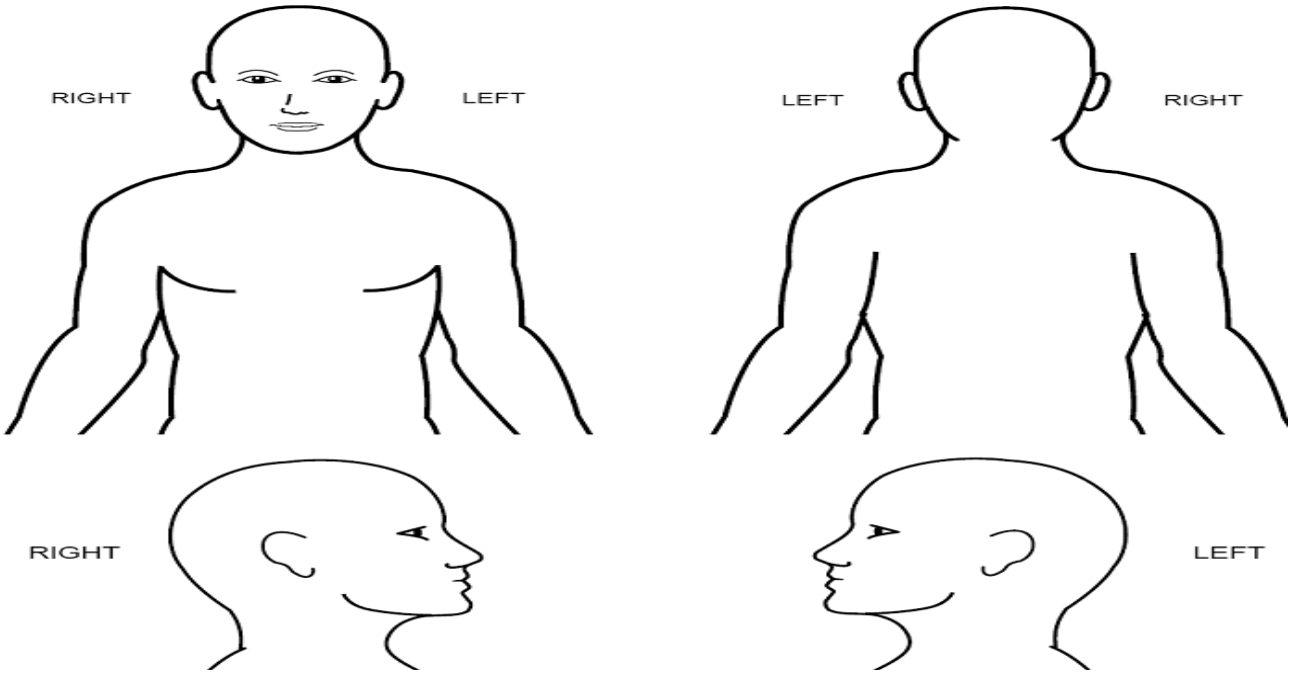
FOLLOW-UP PAIN QUESTIONNAIRE (for head and face pain)

Last Name: _____First:_____ MI:_____

REASON FOR F/U:_____

_____

PAIN LOCATION *Please describe the location of the pain (please mark on the diagram below):*



_____

PAIN QUALITY

How would you describe your pain?

☐ Burning	☐ Sharp	☐ Throbbing	☐ Cutting
☐ Aching	☐ Soreness	☐ Dull	☐ Pins and Needles
☐ Pressure	☐ Cramping	☐ Shooting	☐ Pressure

☐ Other_____

In general, during the past month, what has your pain been (please check one):

☐ Worsening ☐ Improving ☐ Unchanged

RATE YOUR PAIN

(0-10 scale where 0 is no pain and 10 is worst imaginable pain)

My pain today is _____/10

When under control, my pain is _____/10

My worst pain is _____/10

I could live with pain level of _____/10

TIMING OF PAIN

How often do you have the pain (please check one)

☐ Constantly (100% of the time)
☐ Nearly constantly (60-95% of the time)
☐ Intermittently (30-60% of the time)
☐ Occasionally (less than 30% of the time)

ACTIVITIES AND YOUR PAIN

When is the problem most severe?

☐ Morning ☐ Afternoon ☐ Evening ☐ Sleeping ☐ Eating ☐ No pattern

What is your worst symptom? _____

What makes it feel better? _____

What makes it feel worse? _____

REVIEW OF SYSTEMS

General
- ☐ Fever
- ☐ Loss of appetite
- ☐ Weight change
- ☐ Sweats
- ☐ Fatigue
- ☐ Insomnia

Eyes
- ☐ Vision loss
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye disease
- ☐ Glasses / contacts

ENMT
- ☐ Ringing in the ears
- ☐ Nose bleeds
- ☐ Hearing loss
- ☐ Sinus problems
- ☐ Mouth sores
- ☐ Swollen glands in head and neck

Cardiovascular
- ☐ Chest pain
- ☐ Swelling of feet or ankles
- ☐ Heart trouble
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Varicose veins

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal
- ☐ Nausea
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Blood in the stools

Hematological
- ☐ Bleeding tendency
- ☐ Anemia
- ☐ Recurrent infections

Musculoskeletal
- ☐ Muscle cramps
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Joint swelling/stiffness
- ☐ Weakness of muscles
- ☐ Difficulty walking

Skin
- ☐ Rash
- ☐ Change in hair/nails
- ☐ Change in skin color

Neurologic
- ☐ Frequent Headaches
- ☐ Tingling
- ☐ Seizures/convulsions
- ☐ Memory loss
- ☐ Paralysis / weakness
- ☐ Poor balance
- ☐ Fainting
- ☐ Tremors
- ☐ Dizzy or light headed
- ☐ Head injury

Psychiatric
- ☐ Nervousness
- ☐ Depression
- ☐ Hallucinations

Endocrine
- ☐ Heat or cold intolerance
- ☐ Excessive thirst
- ☐ Hormone or glandular problems

Genitourinary
- ☐ Frequent urination
- ☐ Sexual difficulty
- ☐ Blood in urine
- ☐ Urinary urgency
- ☐ Pain on urination
- ☐ Incontinence
- ☐ Kidney stones

Please list current MEDICATIONS

_____

_____

_____

_____

Do you take any opioid medications? (circle) Yes No

As a result of taking the opioids I can do the following: _____

_____

PHQ-9 Questionnaire

Patient Name _____ **Date** _____

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. **If you checked off any problem on this questionnaire so far, 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
0	1	2	3