Mind and Body Pain Clinic

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COMPREHENSIVE PAIN QUESTIONNAIRE

Last Name: _____First:_____ MI:_____

Date of Birth:_____ Age:_____

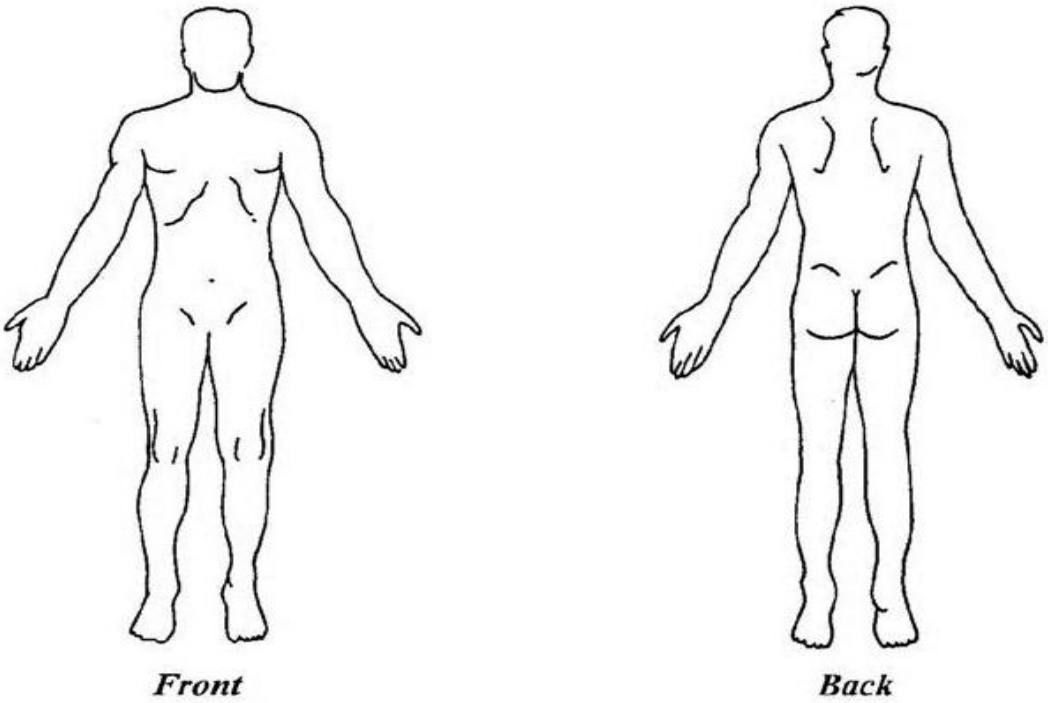
Height: _____ Weight:_____

CHIEF COMPLAINT:_____

_____

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_____

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

DURATION

How long have you had your current pain?

_____ Years
_____ Months
_____ Weeks
_____ Days

ONSET OF PAIN

How did your current pain start?

- ☐ Injury at work
- ☐ Injury not at work
- ☐ Motor vehicle accident
- ☐ Illness
- ☐ Due to other medical treatment
- ☐ Other: _____
  _____

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

Does your pain cause any of the following:

☐ Loss of bowel control ☐ Loss of bladder control ☐Loss of sleep

How many blocks can you walk before stopping due to pain?

_____ Blocks

How long can you sit before having to get up due to pain?

_____ Hours _____ Minutes

How long can you stand before having to sit down due to pain?

_____ Hours _____ Minutes

How often during the day do you have to lie down due to pain?

☐Never ☐Seldom ☐Sometimes ☐Often ☐ Constantly

During the past month, check the activities that you have avoided due to pain.

☐ Going to work
☐ Performing household chores
☐ Having sexual relations
☐ Socializing with friends
☐ Doing yard work or shopping
☐ Exercising
☐ Recreation

RELIEVING AND AGGRAVATTING FACTORS

How do the following affect your pain? (Please check one for each item)

	Decrease	**Increase**	**No change**
Lying Down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercising	☐	☐	☐
Medications	☐	☐	☐
Relaxing	☐	☐	☐
Thinking about something else	☐	☐	☐
Coughing/sneezing	☐	☐	☐
Bowel movements	☐	☐	☐
Urination	☐	☐	☐

PAIN TREATMENTS (*Please check off all treatments that you have tried before and then complete the appropriate column to the right to the best of your ability.)*

Treatment	Date (approximate)	No Relief	Moderate Relief	Excellent Relief
Hospital bed rest		☐	☐	☐
Surgery		☐	☐	☐
Chiropractic		☐	☐	☐
Acupuncture		☐	☐	☐
Psychotherapy		☐	☐	☐
Biofeedback		☐	☐	☐
Nerve blocks/injections		☐	☐	☐
Traction		☐	☐	☐
Physical Therapy		☐	☐	☐
TENS unit		☐	☐	☐
Exercise		☐	☐	☐
Other _____		☐	☐	☐

DIAGNOSTIC STUDIES (*What diagnostic studies have you had?)*

☐ MRI
- Back Date: _____
- Neck Date: _____

☐ CT Date: _____
☐ EMG/NCS Date: _____
☐ X-rays Date: _____
☐ Others Date: _____

PRIOR CONSULTATIONS

Which physicians have you seen for your current condition – please give their names?

☐ Primary Care Physician_____ ☐ Neurosurgeon _____
☐ Neurologist_____ ☐ Physiatrist_____
☐ Orthopedic surgeon_____ ☐ Other_____

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

PAST MEDICAL HISTORY

Please check all current and past medical problems that apply to you:

- ☐ High Blood Pressure
- ☐ Asthma or wheezing
- ☐ Heart Attack
- ☐ Chronic cough
- ☐ Peripheral Vascular Disease
- ☐ Diabetes
- ☐ Seizure or epilepsy
- ☐ Chest pain
- ☐ Arthritis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Stroke/TIA
- ☐ Bleeding problems
- ☐ Cancer, please specify which kind _____
- ☐ Others: _____

PAST SURGICAL HISTORY

Type of Surgery	**Date** (approximate)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES ☐ I am allergic to Contrast dye

Please name all medications that you might be allergic to in the space below:

_____

FAMILY HISTORY (please list all medical problems that affect family members)

Father _____

Mother _____

Sibling _____

Other _____

SOCIAL HISTORY

Please respond appropriately to what applies and write N/A if not applicable to you.

Alcohol use: _____# of drinks per day _____# of days per week

Tobacco use: _____packs/week _____# of years smoked

Recreational Drug use: _____ Drug/s of choice

Marital status: ☐Single ☐Married ☐Widow ☐Separated ☐Divorced

Living arrangements: ☐ Living alone ☐ Living with spouse/partner
☐ Living with other ☐ Living with friends ☐ Living with children

EDUCATION

Your highest educational level achieved:

☐ Graduate or professional training (degree obtained)
☐ College graduate (degree obtained)
☐ Partial college training
☐ High school diploma
☐ GED or trade-technical social graduate
☐ Partial high school (10th grade through partial 12th)
☐ Partial junior high school (7th grade through 9th grade)
☐ Elementary school (6th grade or less)

EMPLOYMENT

Your current or former occupation:

☐ Skilled trade or clerical (e.g. carpenter, electrician, truck driver, secretary)
☐ Semi-skilled or unskilled (e.g. assembler, dishwasher, porter)
☐ Business executive or managerial
☐ Professional (e.g. lawyer, teacher, nurse, physician, psychologist)
☐ Homemaker
☐ Other

Current employment status (please check all that apply):

☐ Employed full-time
☐ Employed part-time
☐ Unemployed
☐ Homemaker
☐ Retired
☐ Student
☐ Unemployed because of pain
☐ Part-time because of pain

If you are currently unemployed, indicate how long you have been off work: (If employed, do not answer)

☐ 1-3 weeks
☐ 8-11 weeks
☐ 1-3 months
☐ 4-7 months
☐ 12-18 months
☐ 19-24 months
☐ 25 or more months

SUBSTANCE ABUSE

Do you have a history of alcoholism?	Yes	No
Heroin abuse?	Yes	No
Cocaine abuse?	Yes	No
Methamphetamine abuse?	Yes	No
IV drug abuse?	Yes	No
Prescription drug abuse?	Yes	No
Have you ever been in a detoxification program for drug abuse?	Yes	No
Have you ever been in a detox program for alcohol abuse?	Yes	No
Alcoholics Anonymous?	Yes	No
Narcotics Anonymous?	Yes	No

LEGAL ISSUES

Please indicate any of the following claims you have filed related to your pain problem

☐ Workers' compensation
☐ Personal injury/liability (unrelated to work)
☐ Social Security Disability Insurance (SSDI)
☐ Other insurance
☐ None

ATTORNEY'S NAME AND CONTACT INFORMATION

_____

_____

_____

PSYCHOLOGICAL TREATMENT

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? Yes No
If yes, when?

_____

Have you ever considered suicide? Yes No
If yes, when?

_____

MEDICATIONS

Indicate the prescription medications you are taking by checking the box. To the best of your ability, please write the dosage and how many times a day you take the pills next to each medication.

<u>If you have taken a medication in the past but are not taking it now, please draw a line through it.</u>

- ☐ Actiq
- ☐ Adapin (Doxepin)
- ☐ Amrix (Cyclobenzaprine)
- ☐ Anaprox (Naproxen)
- ☐ Anexsia (Hydrocodone)
- ☐ Ativan
- ☐ Avinza
- ☐ Axert
- ☐ Baclofen (Lioresal)
- ☐ Buprenorphine
- ☐ BuSpar
- ☐ Celebrex
- ☐ Codeine
- ☐ Cymbalta (Duloxetine)
- ☐ Darvocet
- ☐ Darvon
- ☐ Desyrel (Trazadone)
- ☐ Dilaudid (Hydromorphone)
- ☐ Elavil (Amytriptyline)
- ☐ Empirin with codeine
- ☐ Endocet
- ☐ Feldene
- ☐ Fentanyl
- ☐ Fiorinal
- ☐ Fiorinal with codeine
- ☐ Flexeril
- ☐ Frova
- ☐ Halcion
- ☐ Ibuprofen (Motrin/Advil)
- ☐ Imitrex (Sumatriptan)
- ☐ Indocin
- ☐ Kadian (morphine)
- ☐ Klonopin (Clonazepam)
- ☐ Lexapro
- ☐ Lidoderm 5%
- ☐ Limbrel
- ☐ Lioresal
- ☐ Lortab
- ☐ Lyrica (pregabalin)
- ☐ Methadone
- ☐ Mobic (Meloxicam)
- ☐ Morphine
- ☐ MS Contin
- ☐ Naprelan (Naprosyn)
- ☐ Naprosyn
- ☐ Norco (Hydrocodone)
- ☐ Norflex (Ophenadrine)
- ☐ Norpramin (Desipramine)
- ☐ Opana (IR/ER)
- ☐ Oxycodone
- ☐ Oxycontin
- ☐ Pamelor (Nortriptyline)
- ☐ Percocet (Oxycodone)
- ☐ Percodan (Oxycodone)
- ☐ Provigil
- ☐ Prozac
- ☐ Restoril (Temazepam)
- ☐ Ritalin
- ☐ Robaxin
- ☐ Roxicodone
- ☐ Sinequan (Doxepin)
- ☐ Skelaxin
- ☐ Soma
- ☐ Tegretol
- ☐ Tofranil (Imipramine)
- ☐ Topamax
- ☐ Toradol
- ☐ Tylenol with codeine
- ☐ Tylox (Oxycodone)
- ☐ Valium
- ☐ Vicodin (Hydrocodone)
- ☐ Vicoprofen (Hydrocodone)
- ☐ Ultracet (tramadol)
- ☐ Ultram (tramadol)
- ☐ Xanax (Alprazolam)
- ☐ Zanaflex (Tiznidine)
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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