HSHS St. Anthony's Memorial Hospital

CENTER FOR INTERVENTIONAL PAIN MANAGEMENT PAIN QUESTIONNAIRE

*Your First Visit With The Pain Center Physician is a Consultation, You May or May Not Receive an Injection on the First Visit. Thank You.

*Please fill out form completely.

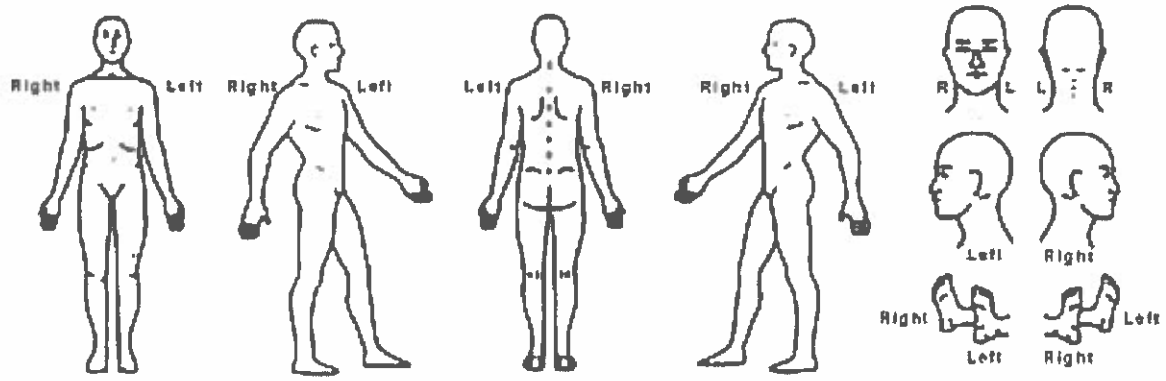
Name:_____ Date of Birth:_____Age_____

Address _____ Sex: Male_____ Female_____

_____ Home Phone:_____

Referring Physician:_____ Primary Physician_____

Please use the diagram below to mark the areas of your pain.



1. Chief Complaint (main reason for Visit Today)? _____

2. Where is your pain? (Please list most severe First)

A _____ B _____

C _____ D _____

3.When did the pain begin? (Date)_____

4. How did the pain start? /What do you think caused it?

_____

5. Does the pain radiate (travel) anywhere? ❑ no, If yes where?

_____

Office Use: Height_____ Weight_____ BMI_____

Vitals: BP_____ HR_____ RR_____ SAT_____TEMP_____

Pacemaker _____ Blood thinner_____

Date:_____ Time: _____ Nurse Signature: _____

6. On a Scale of 0–10 please indicate (circle) the amount of pain you experience. '0' being no pain at all and '10' being the most severe pain you have ever experienced.

Today: 0 1 2 3 4 5 6 7 8 9 10
The best your pain gets: 0 1 2 3 4 5 6 7 8 9 10
The worst it gets: 0 1 2 3 4 5 6 7 8 9 10

7.Describe what your pain feels like:

❑ Burning ❑ Shooting ❑ Throbbing ❑ Crushing ❑ Dull
❑ Electrical ❑ Sharp ❑ Achy ❑ Pulling ❑ Cramping
❑ Toothache like ❑ Stabbing ❑ Hot ❑ Numbness ❑ Tingling
❑ Other(describe):_____

8.Please describe the course of your pain during the day:

❑ Constant ❑ Intermittent ❑ Constant but varies ❑ Hour to Hour and/or ❑ Day to day

9.Your pain is worse in the:

❑ Morning ❑ Daytime ❑ Evenings ❑ Middle of the night ❑ Varies

10. What makes the pain worse?

❑ Sitting ❑ Walking ❑ Lifting ❑ Bending backward
❑ Standing ❑ Driving ❑ Laughing ❑ Bending forward
❑ Climbing stairs ❑ Straining ❑ Sneezing ❑ Coughing
❑ Laying flat ❑ Sex ❑ Using the bathroom
❑ Other_____

11. What makes it better?

❑ Medication ❑ Massage ❑ Laying down ❑ Sitting
❑ Ice ❑ Leaning forward ❑ Rest ❑ Heat
❑ Standing ❑ Applying Pressure ❑ Leaning backward ❑ Walking
❑ Other (Please explain)_____

12. Are there other symptoms with your pain?

❑ New or progressive weakness ❑ Night sweats ❑ Dropping things ❑ Sweating
❑ Constipation ❑ Headaches ❑ Dizziness ❑ Fever ❑ Chills
❑ Urinary incontinence ❑ Bowel incontinence ❑ Urinary retention ❑ Numbness
❑ Other Please explain _____

13. Have you had any of the following over the painful area?

❑ Swelling ❑ Blanching of the skin ❑ Light touch causes pain
❑ Redness ❑ Hair or nail changes
❑ Blue Discoloration ❑ Rash

14. Has this problem affected your job?_____

_____

15. How has this problem affected you socially?_____

_____

16. Can you still perform activities of daily living? ❑ Yes ❑ No?If no please explain

_____

17. Is nutrition affected by pain or medications? ❑ Yes ❑ No

18. Is your sleep disturbed by your pain? ❑ Yes ❑ No If yes please answer the following?

❑ I usually go to bed at _____ o'clock.
❑ I first wake up at _____ o'clock.
❑ I usually get about_____ hours of sleep.

19.Past treatments for your pain?

Previous Surgery for pain? Please list surgery(s) ,date(s), Surgeon(s)

_____

_____

Is your pain the same as before surgery or different? _____

20. Have you had pain injections before? ❑ Yes ❑ No

If yes please list below and dates if known:

a. _____ d. _____
b. _____ e. _____
c. _____ f. _____

21. Have you done Physical Therapy for this pain? ❑ Yes ❑ No Date of last PT_____
– If yes how many days/week and how many weeks did you do? _____

22. Have you tried:

TENS unit?	❑ Yes ❑ No	Biofeedback?	❑ Yes ❑ No	Chiropractor?	❑ Yes ❑ No
Back Brace ?	❑ Yes ❑ No	Ice/Heat?	❑ Yes ❑ No	Massage?	❑ Yes ❑ No
Acupuncture?	❑ Yes ❑ No	Meditation	❑ Yes ❑ No	Psychotherapy	❑ Yes ❑ No

23. Have you seen anyone else for your pain?

Neurology Rheumatology Physiatrist Orthopedist Neurosurgery

Other pain physician? Etc? Please list_____

_____.

24. Are you involved in any litigation or lawsuit regarding your pain? ❑ Yes ❑ No

25. Are you seeking workman's compensation because of your pain? ❑ Yes ❑ No

26. Are you on disability? ❑ Yes ❑ No Reason?_____
Trying to get on disability? ❑ Yes ❑ No

27. Was the pain result of a Motor Vehicle accident? ❑ Yes ❑ No
Is there an auto insurance claim? ❑ Yes ❑ No

Diagnostic Studies for your pain? (circle all that apply and dates and where you got them)
X-ray_____MRI_____CT_____
EMG_____Bone Scan_____Myleogram_____
Ultrasound_____Other_____

Medical History:
a. Allergies (Please list all known allergies and type of reaction) : _____
_____.
b. Current Pain Medications: _____
_____.
Previous Pain Medication:_____.
_____.
Current Home Medications:_____.
_____.
Herbal:_____.
Blood Thinners? (Circle any that apply): Coumadin Plavix
Heparin, Aggrenox, Xeralto, Pletal, Elaquis,
Other?_____

Past Medical History/Medical Illnesses: Circle all that apply

Cardiovascular:
High blood pressure, Chest Pain, Heart attack, Heart failure Irregular heart Beat,
Pacemaker/defibillator, Stroke/CVA, Mitral valve prolapse, High Cholesterol

Nervous System:
Neuropathy, Seizures, Meningitis, Congenital Spine Defect, Dementia

Respiratory System:
Asthma, COPD, Emphysema, Pneumonia, Snoring, Sleep Apnea

Gastrointestinal system:

Stomach Ulcer, GERD /Acid Reflux, Hiatal Hernia, Cirrhosis, Irritable bowel syndrome

Metabolic Disease:

Diabetes , Hypothyroid, Hyperthyroid, Liver disease, Bleeding problems, Easy bruising

Genitourinary:

Pregnancy, Kidney failure/problems, Kidney stones, Urinary urgency/frequency

Musculoskeletal:

Rheumatoid Arthritis, Osteoarthritis, Joint Problems, Chronic fatigue

Infectious Disease:

Chronic infections, Hepatitis, AIDS/HIV

Psychiatric:

Depression, Anxiety, Suicidal thoughts/attempts, ADD, Bipolar, Schizophrenia, Personality disorder, History of abuse

Cancer – (Site)_____

Any Metal in your body?_____

Other Health Problems:_____

Surgical History: (List dates, list those not for this problem)

_____.

_____.

_____.

Family History

Has any member of your immediate family (mom, dad, sibling, child) had the following?

	Yes	No	Which relative?
High Blood Pressure?			
Diabetes?			
Heart Problems?			
Lung Problems?			
Stroke?			
Kidney disease?			
Cancer? (what kind?, who)			
Inherited disease (sickle cell, Huntingtons, etc?)			
Other?			

Age of parents at their death? ❑ N/A Mother_____ ❑ N/A Father_____

Does your pain problem run in your family? Yes No

Social History

Single Married Divorced Widowed Children ___#_____

Occupation/Employer:_____

Status? Full time, Part time, Retired, Unemployed

Smoking Tobacco ❑Yes ❑ No Chewing Tobacco ❑ Yes ❑ No

Marijuana ❑Yes ❑ No

Alcohol ❑Yes ❑ No

Illegal drugs? If so what type_____ How do you use it?_____

Is there a family history of addiction? ❑Yes ❑ No What type?_____

Review of Systems: Circle all that you currently have:

General:

Weight loss, Weight gain, Fatigue, Appetite change, fever, Sleep disturbance

Skin:

Bruising, rashes, plaques, color change, lesions, dryness

Head Eyes

Headache, blurry vision, eye pain

ENT:

Ears ringing, sinus problems, sore throat, nasal congestion, hoarseness

Respiratory:

Cough, shortness of breath, wheezing

Cardiovascular:

Chest pain, palpitations, fainting, leg swelling, leg cramps, aneurysms

Hematology:

Anemia, Easy bruising or bleeding problems

GI:

Heartburn, nausea, constipation, diarrhea, ulcer, reflux

Urinary:

Blood in urine, painful urination, frequency, urgency, loss of bladder control

Musculoskeletal:

Joint pain, arthritis, spasm, cramping, joint swelling, redness, stiffness

Neurological:

Stroke, weakness, seizure, numbness, blackout, memory loss

Psychological:

Depression, mania, anxiety, sleep problems, suicidal thoughts

Endocrine:

Thyroid problems, heat / cold intolerance, nervousness, diabetes

Other:_____

Pharmacy: Name_____ Phone #_____

Address_____ City_____ State_____

I, understand, have completed this form. The information that I have provided is true and accurate to the best of my knowledge.

_____ _____ X_____

Date Time Patient/Legal Guardian

X_____ _____

Person signing on patients behalf/relationship Reason patient unable to sign