Pain Management: New Patient Questionnaire

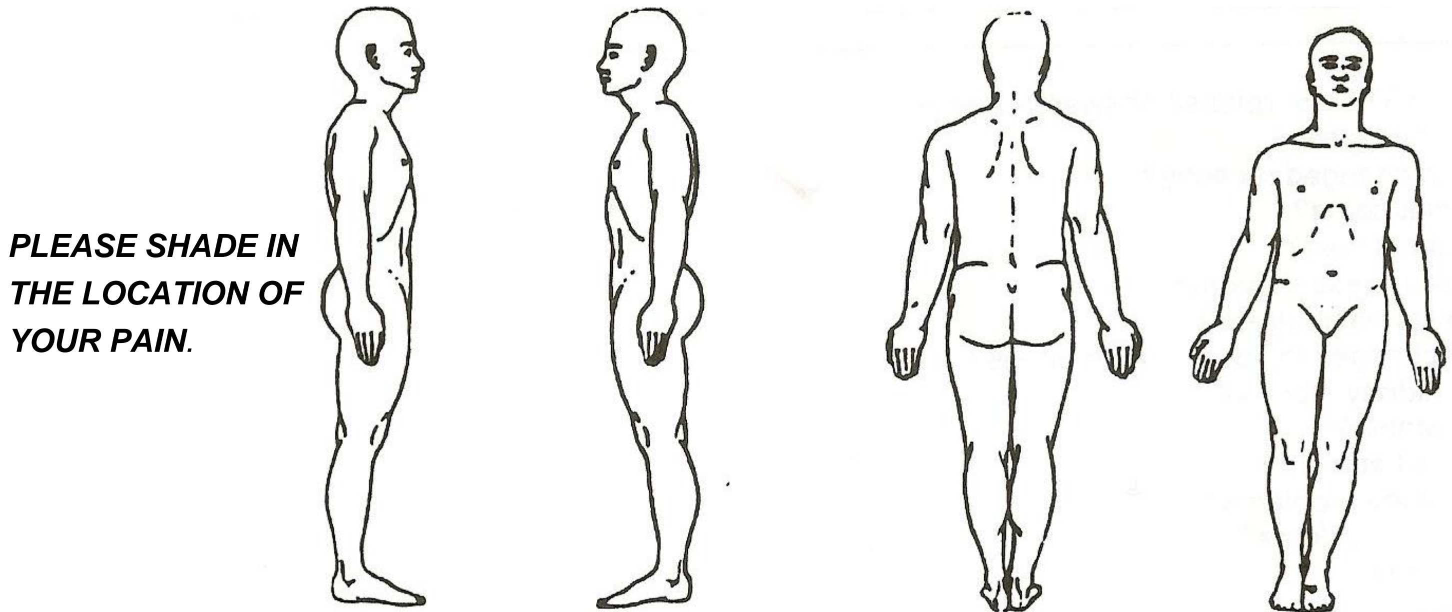
Exam Room # _____

Name		DOB		MRN		Service Date	
Referring Provider			Primary Care Physician				
Pharmacy: Name and Location			Accompanied by:				

NOTIFICATION: Please be aware that we participate in the **Prescription Monitoring Program** and can access your prescription record.

Where are you having pain? ____

PLEASE SHADE IN THE LOCATION OF YOUR PAIN.



When did the pain start? ____

Did you have a fall or an accident that caused the pain? □ yes □ no If yes, please describe the situation.

____

Have you had similar pain in the past? □ yes □ no If yes, what was done for the pain?

____

Were you injured on the job? □ yes □ no ______________________________

What is your current pain score? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

What is your worst pain score? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Please mark the word or words that describe your pain:

- ☐ Constant
- ☐ Intermittent (comes and goes)
- ☐ Sharp
- ☐ Dull
- ☐ Aching
- ☐ Throbbing
- ☐ Numbness
- ☐ Tingling
- ☐ Pins and Needles
- ☐ Stabbing
- ☐ Burning
- ☐ Shooting
- ☐ Muscle Spasms
- ☐ Muscle Tightness

What improves your pain? (i.e. medication, heat, cold, sitting, lying down, relaxation, etc.)

____

What makes your pain worse? (i.e. walking, standing, lifting, bending, etc.)

____

What medications are you CURRENTLY taking for pain? ______________________________

____

What medications have you taken in the past for pain? (Motrin, Advil, Aleve, Tylenol, Relafen, Voltaren, Vicodin, Percocet, Norco, prednisone, steroids, Neurontin, amitriptyline, Flexeril, Robaxin etc.) ____

____

Do you take medications that thin out your blood or make you bleed easier such as Coumadin, plavix, aspirin, aggrenox, Xarelto, Lovenox, or Pradaxa? □ yes □ no ______________________________

Have you had physical therapy, acupuncture, or chiropractic manipulation? □ yes □ no If yes, please list when and where it was done. ____

Have you received care from another pain management clinic? □ yes □ no If yes, please list the name of the clinic and physician?____

Have you had injections to help with your pain? □ yes □ no If yes, please list the type of injection, when, and where it was done. ____

____

Which hand is dominant? left right ambidextrous (both hands)

Which of the following tests have been done to evaluate the pain area that you are being seen for today? X-ray MRI CT scan Ultrasound EMG other______________________

REVIEW OF SYSTEMS: Please mark any problems or symptoms you have from the list below.

CONSTITUTIONAL:	□ fever □ chills □ weight loss □ weight gain □ difficulty sleeping □ fatigue □ history of cancer
SKIN:	□ rash □ itching
HENT:	□ headache □ hearing loss
EYES:	□ blurred vision □ double vision □ glaucoma
CARDIOVASCULAR:	□ heart problems □ chest pain □ racing heart beat □ swelling in the legs
RESPIRATORY:	□ shortness of breath □ cough □ sleep apnea
GASTROINTESTINAL:	□ liver disease □hepatitis □ loss of bowel control □ diarrhea □ constipation □ stomach ulcer
GENITOURINARY:	□ loss of bladder control □ changes in bladder control □ kidney stones □ kidney disease
MUSCULOSKELETAL:	□ joint pain □ arthritis □ back pain □ neck pain
ENDO/HEME/I.D.	□ easy bleeding □ easy bruising □ thyroid disease □ diabetes □ infection
NEUROLOGICAL:	□ seizures □ stroke □ memory problems □ peripheral neuropathy □ head injury □ weakness □ saddle anesthesia (no sensation in the crotch region)
PSYCHIATRIC:	□ depression □ anxiety □ substance abuse

PERSONAL BACKGROUND:

What are your medical problems? ____

____

What surgeries have you had? ____

____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow Number of Children _______

What is your occupation? ___________________ ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired

If retired, previous occupation? ____________________

Are there limitations at work? ☐ yes ☐ no If yes, what are they? ________________________________

Describe job tasks that affect your pain. ____

Is there litigation involved? ☐ yes ☐ no Is this a worker's compensation case? ☐ yes ☐ no

Do you use tobacco products? ☐ yes ☐ no ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chew

Packs/Day _________ If former tobacco user, when did you quit? _______________

Do you drink alcohol? ☐ yes ☐ no If yes, how many drinks per week? ______________________

Do you use recreational drugs? ☐ yes ☐ no If yes, what type and how much? ____________________

Do you currently exercise? ☐ yes ☐ no If yes, what type? ___________________________________

Are you able to do the following activities of daily living yourself? Please check all that apply.

☐ Eat ☐ Bathe ☐ Toilet ☐ Dress ☐ Stand up from sitting position

What medical problems do your parents and siblings have?

	Mother	Father	Sister	Brother
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Arthritis-Rheumatoid	☐	☐	☐	☐
Arthritis-Osteo	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Skin Problems	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐
Vision Problems	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐

Allergies____

Contrast dye allergy: ☐ yes ☐ no Latex allergy: ☐ yes ☐ no

PLEASE REVIEW AND UPDATE THE ATTACHED MEDICATION LIST.

Are there changes? ☐ yes ☐ no