



OC4501



NEW PATIENT QUESTIONNAIRE

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Thank you for completing this form prior to your appointment. Please use blue or black ink. If you have difficulty completing this questionnaire, please call us *before your appointment* so we can assist you.

Your name: _____

**PAIN HISTORY
PRESENT PAIN**

1. What is the main reason for your referral to the Comprehensive Pain Center?

2. When did your pain problems begin? _____ / _____ / _____

3. Under what circumstances did your pain begin? (*select one*)

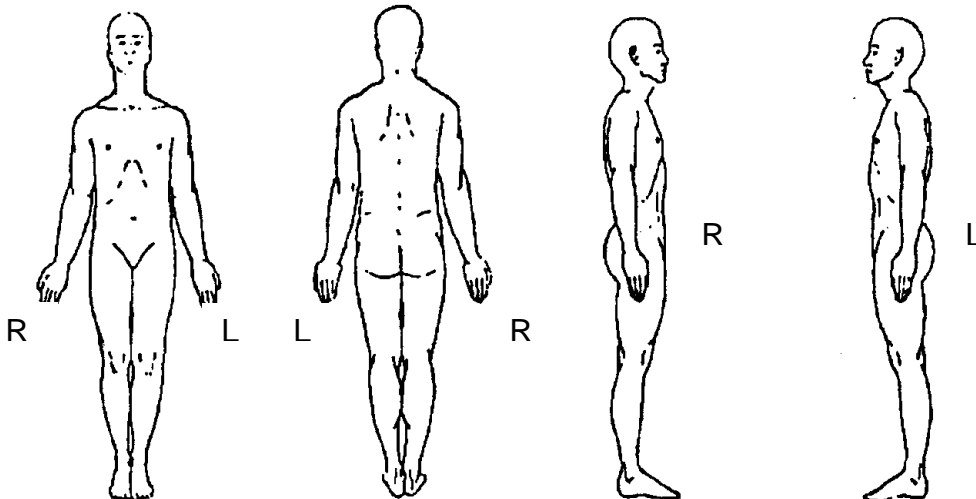
- Accident at work
- Accident at home
- Following surgery
- Pain just began with no known cause
- At work, but not an accident
- Motor vehicle accident
- Following illness
- Other (*describe*) _____

What happened? (*Please describe in more detail*) _____

4. Is your pain constant intermittent

5. In general, when is your pain the worst? Morning Afternoon Evening No typical pattern

6. Where is your pain? (*Shade the painful areas on the diagram below*)





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1. Please rate your pain by filling in the circle that describes how much pain you have **right now**:

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

2. Please rate your pain by filling in the circle that describes your pain at its **least** in the last 24 hours:

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

3. Please rate your pain by filling in the circle that describes your pain at its **worst** in the last 24 hours:

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

4. Please rate your pain by filling in the circle that describes your pain on the **average**:

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

5. In the last 24 hours, how much pain relief have pain treatments or medications provided? Please fill in the circle of the one percentage that most shows how much **relief** you have received:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
None Best possible relief

6. Fill in the circle that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

B. Mood	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

C. Walking Ability	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

D. Normal Work (includes both work outside the home and housework)	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

E. Relations with other people	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

F. Enjoyment of life	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

G. Sexual activity	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

H. Sleep	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes



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7. Please rank your main painful areas in order from worst to least painful. (*Fill in the bubbles*)

The worst is:

The next worst is:

- | | |
|---------------------------------------|---------------------------------------|
| ① Head, face, mouth | ① Head, face, mouth |
| ② Cervical (neck) region | ② Cervical (neck) region |
| ③ Upper shoulder and upper limbs | ③ Upper shoulder and upper limbs |
| ④ Thoracic (mid to upper back) region | ④ Thoracic (mid to upper back) region |
| ⑤ Abdominal region | ⑤ Abdominal region |
| ⑥ Lower back, lumbar spine, sacrum | ⑥ Lower back, lumbar spine, sacrum |
| ⑦ Lower limbs (legs, feet) | ⑦ Lower limbs (legs, feet) |
| ⑧ Pelvic region | ⑧ Pelvic region |
| ⑨ Anal, perineal, genital | ⑨ Anal, perineal, genital |
| ⑩ Generalized pain | |

8. What makes your pain worse? (*Circle all that apply*)

- | | | | |
|----------------------------------|----------------------|-----------------|---------|
| bending backward | bending forward | climbing stairs | cold |
| cough/sneeze | driving | exercise | heat |
| lifting | light touch | sexual activity | sitting |
| standing | stressful situations | walking | work |
| other: (<i>describe</i>) _____ | | | |

9. What relieves the pain? (*Circle all that apply*)

- | | | | |
|----------------------------------|-------------|------------|------------------|
| bath/shower | exercise | heat | ice |
| lying down | medications | meditation | physical therapy |
| relaxation | sitting | standing | walking |
| other: (<i>describe</i>) _____ | | | |

PAST PAIN

10. Have you ever been treated at another pain management center or program? No Yes

If yes, where? _____ when? _____

What did they do? _____

11. In the past 12 months (year), how many times have you been to the emergency room for your pain?

- 1 2 3 4 5 6 7 8 9 10



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12. Have you been hospitalized because of pain? No Yes

If yes, how many times?

1 2 3 4 5 6 7 8 9 10

13. Have you ever had the following types of treatment for your pain problem, and what was the result?

Indicate Pain Therapies tried	Yes tried	Not tried	Improved	No change	Worse	Comments
Medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Drug Detoxification	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Epidural steroid injections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Facet joint injections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Trigger point injections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Nerve (e.g., lumbar sympathetic, stellage ganglion, etc.) blocks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other injections (Specify: _____)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Spinal cord stimulation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Medication pump	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Radiation treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Physical therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Manipulations/ Mobilizations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Traction Exercise/ Aerobic conditioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Passive (heat, ice, gentle massage, ultrasound)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Aqua/water/pool therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Trigger point therapy/ deep tissue massage/ acupressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Occupational therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Acupuncture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Chiropractic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Orthotics (corrective shoe inserts)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Prosthetics (e.g. braces, supports, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
TENS or other electric stimulation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Biofeedback / relaxation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Yoga	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hypnosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Group therapies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Psychological counseling for pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	



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16. Describe any side effects/reactions you have had to the above medications: _____

17. List any **drug, food, or environmental allergies**, and indicate what is the adverse effect/reaction:

18. List all other pain medications that you have tried **in the past** (check all that apply)

YES TRIED	NAME OF MEDICATION	Maximum Dose	Length of Therapy	IF STOPPED, WHY?	
				Side Effects	Not Effective
	Pain Medicines				
	Butorphanol (Stadol)				
	Codeine, Tylenol #3, #4, 222				
	Fentanyl lollipops (Actiq)				
	Fentanyl patches (Duragesic)				
	Fentanyl tablet (Fentora)				
	Hydrocodone (Vicodin, Lortab, Norco)				
	Hydromorphone (Dilaudid)				
	Methadone (Dolophine)				
	Morphine (Avinza, Kadian, MS Contin, MSIR)				
	Meperidine (Demerol)				
	Oxycodone (Percocet, Oxycontin)				
	Propoxyphene (Darvon)				
	Other				
	Anti-Seizure Medicines				
	Carbamazepine (Tegretol)				
	Gabapentin (Neurontin)				
	Lamotrigine (Lamictal)				
	Oxycarbazepine(Trileptal)				
	Tiagabine (Gabatril)				
	Topiramate (Topamax)				
	Zonisamide (Zonegram)				
	Pregabalin (Lyrica)				
	Valproic acid (Depakole)				
	Other				

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YES TRIED	NAME OF MEDICATION	Maximum Dose	Length of Therapy	IF STOPPED, WHY?	
				Side Effects	Not Effective
	Muscle Relaxants				
	Baclofen (Lioresal)				
	Carisoprodol (Soma)				
	Clonazepam (Klonopin)				
	Cyclobenzaprine (Flexeril)				
	Diazepam (Valium)				
	Metaxolone (Skelaxin)				
	Methocarbamol (Robaxin)				
	Tizanidine (Zanaflex)				
	Other				
	Anti-Depressants				
	Bupropion (Wellbutrin)				
	Citalopram (Celexa)				
	Desipramine (Norpramin)				
	Desvenlafaxine (Pristiq)				
	Duloxetine (Cymbalta)				
	Escitalopram (Lexapro)				
	Fluoxetine (Prozac)				
	Hyp. perforatum (St John's Wort)				
	Milnacipran (Savella)				
	Mirtazepine (Remeron)				
	Nefazodone (Serzone)				
	Nortriptyline (Pamelor)				
	Paroxetine (Paxil)				
	Sertraline (Zoloft)				
	Trazadone (Deseryl)				
	Venlafaxine (Effexor)				
	Other				
	Anti-Anxiety/ other mood stabilizers				
	Alprazolam (Xanax)				
	Chlordiazepoxide (Librium)				
	Clonazepam (Klonopin)				
	Lithium (Eskalith)				
	Olazepine (Zyprexa)				
	Phenelzine (Nardil)				
	Quetiapine (Seroquel)				
	Risperidone (Risperdal)				
	Other				
	<i>Continued on next page</i>				



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YES TRIED	NAME OF MEDICATION	Maximum Dose	Length of Therapy	IF STOPPED, WHY?	
				Side Effects	Not Effective
	Sleep				
	Temazepam (Restoril)				
	Triazolam (Halcion)				
	Tylenol-PM				
	Zaleplon (Sonata)				
	Zolpidem (Ambien)				
	Other				
	Anti-inflammatories				
	Celecoxib (Celebrex)				
	Ibuprofen (Advil, Motrin)				
	Meloxicam (Mobic)				
	Naproxen (Aleve, Naprosyn)				
	Nabumetone (Relafen)				
	Rofecoxib (Vioxx)				
	Valdecoxib (Bextra)				
	Other				
	Other				
	Acetaminophen (Tylenol)				
	Pramipexole (Mirapex)				
	Pyridostigmine (Mestinon)				
	Lidocaine patch (Lidoderm)				
	Other				



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19. Past Medical History and Review of Systems

PLEASE CIRCLE ANY MEDICAL CONDITION OR SYMPTOMS

System		Comments:
<i>Cardiovascular:</i>	Angina, heart disease, heart attack, irregular rhythm, high blood pressure, vascular blood flow problems, blood clots, embolism, murmurs, other Chest pain, palpitations	
<i>Respiratory:</i>	Obstructive disease, asthma, chronic bronchitis, TB, Wheezing, shortness of breath, cough	
<i>Gastrointestinal:</i>	Stomach ulcers, hiatal hernia, pancreatitis, bowel problems, bleeding, gallbladder problems, hepatitis / liver disease, acid reflux/GERD, Crohn's, colitis, irritable bowel syndrome, Constipation, diarrhea, abdominal pain, heartburn	
<i>Genitourinary:</i>	Kidney, bladder, prostate, infections, bleeding, sexually transmitted disease, kidney stones, urinary continence Urinary symptoms: frequency, leaking, pain	
<i>Musculoskeletal:</i>	Fibromyalgia, osteoarthritis, rheumatoid arthritis, fractures Cramping, spasm, muscle pain	
<i>Skin</i>	Skin disorder, breast diseases Rash, skin growth, itching, nail changes	
<i>Neurological:</i>	Stroke, seizure, epilepsy, headache, neuropathy, nerve injury, memory problems, movement disorder, spinal cord injury, unconsciousness Numbness, weakness, changes in vision, coordination problems, memory loss	
<i>Psychiatric:</i>	Anxiety, depression, nervous breakdown, hallucinations. Alcohol or other drug abuse.	
<i>Endocrine:</i>	Diabetes, obesity, thyroid abnormality, adrenal abnormality Heat or cold intolerance, change in thirst, change in appetite	
<i>Allergic / Immunologic:</i>	Auto immune disorder i.e. Lupus, Sjögren's, hay fever immune deficiency, Raynaud's syndrome	
<i>HEENT</i>	Eye, ear, nose, throat diseases, conditions, or symptoms	
<i>Cancer?heme</i>	Cancer, type? _____, anemia, hematologic problem Bruising, swollen lymph nodes	
<i>Constitutional:</i>	Recurrent fevers, weight change, heat / cold intolerance, chronic fatigue, night sweats, difficulty with sleep	
	Pregnancy (Date of last period _____)	



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20. How much sleep do you average each night? _____ hours

21. Is your sleep disturbed at night? No Yes

22. Have you been told (e.g., by a bed partner) that you snore, hold your breath, or gasp for breath a lot when sleeping? No Yes

23. List all prior hospitalizations and/or surgeries

Date	Reason/ Procedure or Surgery (in detail)

24. Do you have any medical devices implanted in your body? (Pacemaker, portacath, pump, rods, prosthesis, etc.) No Yes



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FAMILY HISTORY

25. Have any close (biological) family members had any of the following? *(If yes, fill in appropriate bubble)*

	Mother	Father	Sister	Brother	Maternal Grand mother	Maternal Grand father	Paternal Grand mother	Paternal Grand father
Alcohol/Drug	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anesthesia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genetic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GI	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genitourinary (GU)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lipids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychiatry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-contributory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Additional Family History	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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PSYCHOLOGICAL AND SUBSTANCE USE

26. Have you ever had thoughts of:
suicide or harming yourself? No Yes
harming someone else? No Yes

27. Please mark the appropriate answer to the following questions.

	Never	Seldom	Sometimes	Frequently	Always
During the past month, have you been tense or anxious?					
During the past month, have you been depressed or discouraged?					
During the past month, have you been irritable and upset?					
When you are in pain, how often is your husband/wife/other family supportive and encouraging?					
When you are in pain, how often does your husband/wife/other family ignore you or become angry?					

28. Have you been under the care of a mental health professional? No Yes - *when, how often?*

29. Are you, or have you ever been, involved with any of the following?

Current Use	Past Use	Item	Comments (how much and how many years?)
<input type="radio"/>	<input type="radio"/>	Marijuana use If yes, do you have a medical marijuana card?	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/>	<input type="radio"/>	Cocaine	
<input type="radio"/>	<input type="radio"/>	Methamphetamine	
<input type="radio"/>	<input type="radio"/>	Heroin	
<input type="radio"/>	<input type="radio"/>	Other illicit/street drug use	



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30. No Yes

- Have you ever felt the need to cut down on your drinking?
- Have you ever felt annoyed by people complaining about your drinking?
- Have you ever felt guilty about your drinking?
- Do you ever drink an eye-opener in the morning to relieve the shakes?
- Do you drink alcohol to decrease or relieve pain?

SOCIAL AND WORK

31. Marital Status

- Married Divorced Separated
- Cohabiting, not married Widowed Never married, not cohabitating

32. Partner Status

- Same sex partner Opposite sex partner No partner

33. Education *(fill in the corresponding bubble)*

- 8th grade or less Some high school High school graduate or GED
- Some college Associate's degree Bachelor's degree
- Technical or trade school graduate
- Completed graduate or professional school degree (e.g., Master's, Ph.D., M.D., etc.)

34. Employment: *(Select the best description for you)*

- Homemaker Not working due to pain Not working due to other reasons
- On leave from work Retired due to pain Retired not due to pain
- Working full time Working part time

35. How many people live in your household? (including yourself) _____

36. Do you have children? No Yes *(list along with age and health)*

37. Describe your current occupation and duties (if working)

38. Has your job changed because of your painful condition (if working) No Yes – how?

39. In the past six months, how many full days of work have you missed because of pain?

- < 5 days 6-14 days 3-4 weeks > 1 month



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40. On a scale from 0 to 10, how satisfying do/did you find your current/last/most recent job?

(Please circle the number)

Not satisfying 1 2 3 4 5 6 7 8 9 10 Very satisfying

41. On a scale from 0 to 10, how financially satisfying do/ did you find your current/last/most recent job?

(Please circle the number)

Not satisfying 1 2 3 4 5 6 7 8 9 10 Very satisfying

42. What exercise or recreational activities do you enjoy? _____

43. Are you, or have you ever been, involved with any of the following?

Disability:

- Not receiving or seeking disability
- Not receiving but seeking or planning to seek disability
- Receiving disability

Litigation/Lawsuit(s):

- No (and not intending) pain-related litigation/lawsuit or legal involvements
- Currently in pain-related litigation/lawsuit or pain-related legal involvements
- Past litigation/lawsuit or legal involvements related to pain condition

Motor vehicle accidents:

- Pain not related to motor vehicle accident
- Pain related to motor vehicle accident and settlement pending
- Pain related to motor vehicle accident but no settlement pending or necessary

Do you have any other litigation or lawsuits ongoing, pending, planned, or under consideration?

No Yes - *explain* _____

44. Are you under financial stress? No Yes- how? _____

45. Have there been any other stressful life experiences recently? No Yes- explain



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GOALS AND EXPECTATIONS

46. What do you expect from our pain program? *(select the one best answer)*

- A diagnosis (to help find the cause of pain)
- Help in coping with the pain
- A reduction in pain
- A cure
- No expectations
- Do not know what to expect

47. What types of treatment do you expect from your visits to the Comprehensive Pain Center?

(select all appropriate answers)

- Consultation only *(advice only to you and your primary care physician)*
- Counseling
- Stress Management
- Physical Therapy
- Drug treatment
- Acupuncture
- Surgery
- Relaxation therapy
- Biofeedback
- Injections or nerve blocks
- Electrical stimulation such as TENS unit
- Spinal cord stimulator
- Implanted medication pump
- Don't know
- Other (describe) _____

Form completed by: _____

Thank you for taking the time to complete this questionnaire. We will review it with you at your first visit.

Provider Comments/Signature: _____
