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
   - Following illness
   - Pain just began with no known cause
   - 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)

   [Diagram showing shaded areas on the human body]
1. Please rate your pain by filling in the circle that describes how much pain you have right now:
   - 0: No Pain
   - 10: 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: No Pain
   - 10: 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: No Pain
   - 10: Worst possible pain

4. Please rate your pain by filling in the circle that describes your pain on the average:
   - 0: No Pain
   - 10: 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:
   - None
   - 0%
   - 10%
   - 20%
   - 30%
   - 40%
   - 50%
   - 60%
   - 70%
   - 80%
   - 90%
   - 100%

6. Fill in the circle that describes how, during the past 24 hours, pain has interfered with your:
   - A. General Activity
   - B. Mood
   - C. Walking Ability
   - D. Normal Work (includes both work outside the home and housework)
   - E. Relations with other people
   - F. Enjoyment of life
   - G. Sexual activity
   - H. Sleep
   - Does not interfere
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Completely interferes
7. Please rank your main painful areas in order from worst to least painful. (*Fill in the bubbles*)

The worst is:

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

The next worst is:

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

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: *(describe)*

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: *(describe)*

**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__
NEW PATIENT QUESTIONNAIRE

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?

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

ONLINE 8/09 (supersedes 2/09)  OC-4531
14. What medical tests have been done to evaluate your pain? *(fill in bubble, date, and results)*

<table>
<thead>
<tr>
<th>Test</th>
<th>Date (approximate)</th>
<th>Result (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray</td>
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<tr>
<td>CT scan</td>
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<td>Myelogram</td>
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<td>MRI</td>
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<td>Bone scan</td>
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<td>EMG</td>
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<td>EKG</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

OTHER MEDICAL HISTORY

15. Current Medications

Please list all medications that you are taking now or attach your own medication list. Include over the counter, herbal, vitamin, and other supplemental medications.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often?</th>
<th>What is this for?</th>
<th>Prescribing Doctor</th>
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</thead>
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</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>YES TRIED</th>
<th>NAME OF MEDICATION</th>
<th>Maximum Dose</th>
<th>Length of Therapy</th>
<th>IF STOPPED, WHY?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Side Effects</td>
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<td></td>
<td>Not Effective</td>
</tr>
</tbody>
</table>

**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)
- Oxcarbazepine (Trileptal)
- Tiagabine (Gabitril)
- Topiramate (Topamax)
- Zonisamide (Zonegram)
- Pregabalin (Lyrica)
- Valproic acid (Depakote)
- Other

*Continued on next page*
## Patient Identification

<table>
<thead>
<tr>
<th>YES TRIED</th>
<th>NAME OF MEDICATION</th>
<th>Maximum Dose</th>
<th>Length of Therapy</th>
<th>IF STOPPED, WHY?</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>Side Effects</td>
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</tbody>
</table>

### 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

*Continued on next page*
## Patient Identification

<table>
<thead>
<tr>
<th>YES TRIED</th>
<th>NAME OF MEDICATION</th>
<th>Maximum Dose</th>
<th>Length of Therapy</th>
<th>IF STOPPED, WHY?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Side Effects</td>
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<td></td>
<td></td>
<td>Not Effective</td>
</tr>
</tbody>
</table>

### 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
19. Past Medical History and Review of Systems

**PLEASE CIRCLE ANY MEDICAL CONDITION OR SYMPTOMS**

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason/ Procedure or Surgery (in detail)</th>
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24. Do you have any medical devices implanted in your body? (Pacemaker, portacath, pump, rods, prosthesis, etc.)  ○ No  ○ Yes
**FAMILY HISTORY**

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mother</th>
<th>Father</th>
<th>Sister</th>
<th>Brother</th>
<th>Maternal Grandmother</th>
<th>Maternal Grandfather</th>
<th>Paternal Grandmother</th>
<th>Paternal Grandfather</th>
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</thead>
<tbody>
<tr>
<td>Alcohol/Drug</td>
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<td>Genitourinary (GU)</td>
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<tr>
<td>Heart</td>
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<td>○</td>
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<tr>
<td>Hypertension</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Lipids</td>
<td>○</td>
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<td>○</td>
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<tr>
<td>Psychiatry</td>
<td>○</td>
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<td>○</td>
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<tr>
<td>Stroke</td>
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<td>○</td>
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<tr>
<td>Thyroid</td>
<td>○</td>
<td>○</td>
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<td>○</td>
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<tr>
<td>Non-contributory</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>○</td>
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<td>○</td>
</tr>
<tr>
<td>Additional Family History</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
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.

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

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?

<table>
<thead>
<tr>
<th>Current Use</th>
<th>Past Use</th>
<th>Item</th>
<th>Comments (how much and how many years?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td>○</td>
<td>Marijuana use</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If yes, do you have a medical marijuana card?</td>
<td></td>
</tr>
<tr>
<td>○</td>
<td>○</td>
<td>Cocaine</td>
<td></td>
</tr>
<tr>
<td>○</td>
<td>○</td>
<td>Methamphetamine</td>
<td></td>
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<tr>
<td>○</td>
<td>○</td>
<td>Heroin</td>
<td></td>
</tr>
<tr>
<td>○</td>
<td>○</td>
<td>Other illicit/street drug use</td>
<td></td>
</tr>
</tbody>
</table>
NEW PATIENT QUESTIONNAIRE

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
   ○ Cohabitating, 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
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 ________________________________
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:________________________________________________