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 collision
   ○ Following illness
   ○ Other (*describe*) _____

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

   _____

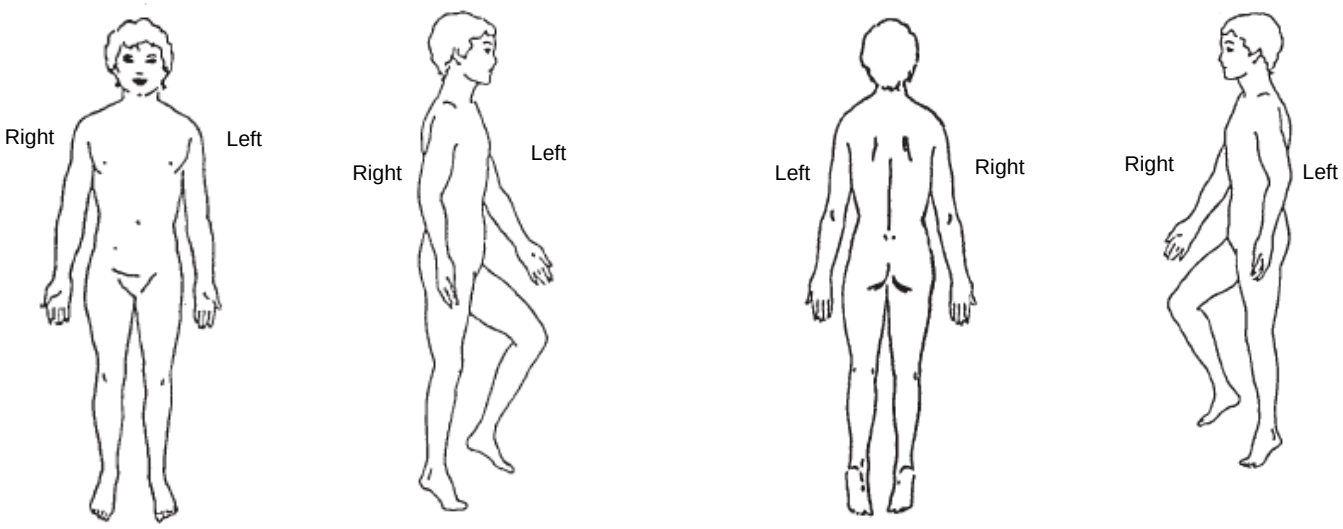
   _____

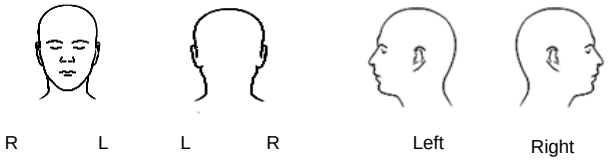
4. Is your pain ○ constant ○ intermittent ○ sharp ○ dull ○ achy
   ○ stinging ○ burning ○ throbbing ○ shooting

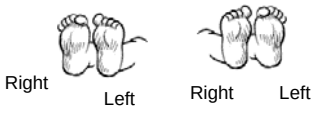
5. In general, when is your pain the worst?

   ○ Morning ○ Afternoon ○ Evening ○ No typical pattern

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







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:

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

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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*: (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

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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	○	○	○	○	○	
Drug Detoxification	○	○	○	○	○	
Surgery	○	○	○	○	○	
Epidural steroid injections	○	○	○	○	○	
Facet joint injections	○	○	○	○	○	
Trigger point injections	○	○	○	○	○	
Nerve (e.g., lumbar sympathetic, stellate ganglion, etc.) blocks	○	○	○	○	○	
Other injections (Specify: _____)	○	○	○	○	○	
Spinal cord stimulation	○	○	○	○	○	
Medication pump	○	○	○	○	○	
Radiation treatment	○	○	○	○	○	
Physical therapy	○	○	○	○	○	
Exercise	○	○	○	○	○	
Manipulations/ Mobilizations	○	○	○	○	○	
Traction Exercise/ Aerobic conditioning	○	○	○	○	○	
Passive (heat, ice, gentle massage, ultrasound)	○	○	○	○	○	
Aqua/water/pool therapy	○	○	○	○	○	
Trigger point therapy/ deep tissue massage/ acupressure	○	○	○	○	○	
Occupational therapy	○	○	○	○	○	
Acupuncture	○	○	○	○	○	
Chiropractic	○	○	○	○	○	
Orthotics (corrective shoe inserts)	○	○	○	○	○	
Prosthetics (e.g. braces, supports, etc)	○	○	○	○	○	
TENS or other electric stimulation	○	○	○	○	○	
Biofeedback / relaxation	○	○	○	○	○	
Yoga	○	○	○	○	○	
Hypnosis	○	○	○	○	○	
Group therapies	○	○	○	○	○	
Psychological counseling for pain	○	○	○	○	○	
Other:	○	○	○	○	○	

14. What medical tests have been done to evaluate your pain? *(fill in bubble, date, and results)*

	Test	Date (approximate)	Result (if known)
○	X-ray		
○	CT scan		
○	Myelogram		
○	MRI		
○	Bone scan		
○	EMG		
○	EKG		
○	Other		

OTHER MEDICAL HISTORY

15. Current Medications

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

Medication	**Dose** Mg or # of pills	**How often?** # times per day	**What is this for?**	**Prescribing Doctor**

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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/Opioids				
	Buprenorphine (Subutex, Suboxone)				
	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)				
	Oxymorphone (Opana)				
	Propoxyphene (Darvon)				
	Tapentadol (Nucynta)				
	Tramadol (Ultram,Ultram ER, Ultracet, Ryzotl				
	Other				
	Anti-Seizure Medicines				
	Carbamazepine (Tegretol)				
	Gabapentin (Neurontin)				
	Lacosamide (Vimpat)				
	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				
	Amitriptyline (Elavil)				
	Bupropion (Wellbutrin)				
	Citalopram (Celexa)				
	Desipramine (Norpramin)				
	Desvenlafaxine (Pristiq)				
	Duloxetine (Cymbalta)				
	Escitalopram (Lexapro)				
	Fluoxetine (Prozac)				
	Fluvoxamine (Luvox)				
	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)				
	Resperidone (Risperdal)				
	Other				

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YES TRIED	NAME OF MEDICATION	Maximum Dose	Length of Therapy	IF STOPPED, WHY?	
				Side Effects	Not Effective
	Sleep				
	Melatonin				
	Eszopiclone (Lunesta)				
	Ramelton (Rozerem)				
	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)				
	Ketamine				
	Pramipexole (Mirapex)				
	Pyridostigmine (Mestinon)				
	Lidocaine patch (Lidoderm)				
	Other				

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19. Review of Systems: PLEASE CHECK ALL THAT APPLY

Constitutional:
- ☐ fever
- ☐ chills
- ☐ weight loss
- ☐ malaise/fatigue
- ☐ diaphoresis
- ☐ weakness
- ☐ None of the above

Eyes:
- ☐ blurred
- ☐ double vision
- ☐ photophobia
- ☐ eye pain
- ☐ eye discharge
- ☐ eye redness
- ☐ None of the above

Gastrointestinal:
- ☐ heartburn
- ☐ nausea
- ☐ vomiting
- ☐ abdominal pain
- ☐ diarrhea
- ☐ constipation
- ☐ blood in stool
- ☐ melena
- ☐ None of the above

Endo/Heme/Aller:
- ☐ easy bruise/bleed
- ☐ Env allergies
- ☐ polydipsia
- ☐ diabetes
- ☐ thyroid disorder
- ☐ clotting disorders
- ☐ None of the above

Skin:
- ☐ rash
- ☐ itching
- ☐ nail changes
- ☐ skin disorders
- ☐ None of the above

Cardiovasular:
- ☐ chest pain
- ☐ palpitations
- ☐ orthopnea
- ☐ claudication
- ☐ leg swelling
- ☐ high blood pressure
- ☐ PND – difficulty breathing at night
- ☐ None of the above

Genitourinary:
- ☐ dysuria
- ☐ urgency
- ☐ frequency
- ☐ hematuria
- ☐ flank pain
- ☐ urinary Incontinenece
- ☐ None of the above

Neurological:
- ☐ dizziness
- ☐ tingling
- ☐ tremor
- ☐ sensory change
- ☐ speech change
- ☐ focal weakness
- ☐ seizures
- ☐ loss of consciousness
- ☐ None of the above

HENT:
- ☐ headaches
- ☐ hearing loss
- ☐ tinnitus
- ☐ ear pain
- ☐ ear discharge
- ☐ nose bleeds
- ☐ congestion
- ☐ stridor
- ☐ sore throat
- ☐ None of the above

Respiratory:
- ☐ cough
- ☐ hemoptysis
- ☐ sputum production
- ☐ shortness of breath
- ☐ wheezing
- ☐ asthma
- ☐ sleep apnea
- ☐ None of the above

Musculoskeletal:
- ☐ myalgias
- ☐ neck pain
- ☐ back pain
- ☐ joint pain
- ☐ falls
- ☐ fracture
- ☐ herniated disc
- ☐ None of the above

Psychiatric:
- ☐ depression
- ☐ suicidal ideas
- ☐ substance abuse
- ☐ hallucinations
- ☐ nervous/anxious
- ☐ insomnia
- ☐ memory loss
- ☐ None of the above

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. Do you have any medical devices implanted in your body?

Infusion pump	○ No	○ Yes
Spinal cord stimulator	○ No	○ Yes
Rods	○ No	○ Yes
Prosthesis	○ No	○ Yes
Pacemaker	○ No	○ Yes
Portacath	○ No	○ Yes

Other: _____

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24. List all prior hospitalizations and/or surgeries

Neurological/Orthopedic:	Dates (approximate)	Level(s)	Side(left or right)
☐ Craniotomy/brain surgery			
☐ Cervical fusion			
☐ Cervical laminectomy			
☐ Lumbar fusion			
☐ Lumbar laminectomy			
☐ Surgical treatment of fracture			
☐ Hip replacement			
☐ Knee arthroscopy			
☐ Knee replacement			

Abdominal:	Dates (approximate)	Location?
☐ Hernia repair		
☐ Abdominal wall defect repair		
☐ Gastric bypass		
☐ Colectomy		
☐ Colostomy		
☐ Lysis of adhesions		

Genitourinary:	Dates (approximate)
☐ Nephrectomy	
☐ Hysterectomy	
☐ Cesarean section	
☐ TURP/Transurethral Resection of Prostate	
☐ Prostatectomy	

Vascular/Lung:	Dates (approximate)
☐ Femoral bypass	
☐ Abdominal aortic aneurysm repair	
☐ Heart valve surgery	
☐ Coronary artery bypass graft	
☐ Thoracotomy/lung surgery	

OTHER SURGICAL HISTORY:

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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	○	○	○	○	○	○	○	○
Allergies	○	○	○	○	○	○	○	○
Anesthesia	○	○	○	○	○	○	○	○
Arthritis	○	○	○	○	○	○	○	○
Asthma	○	○	○	○	○	○	○	○
Blood Disease	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○
Genetic	○	○	○	○	○	○	○	○
GI	○	○	○	○	○	○	○	○
Genitourinary (GU)	○	○	○	○	○	○	○	○
Headaches	○	○	○	○	○	○	○	○
Heart	○	○	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○	○	○
Lipids	○	○	○	○	○	○	○	○
Psychiatry	○	○	○	○	○	○	○	○
Stroke	○	○	○	○	○	○	○	○
Thyroid	○	○	○	○	○	○	○	○
Non-contributory	○	○	○	○	○	○	○	○
Additional Family History	○	○	○	○	○	○	○	○

OTHER MEDICAL HISTORY: _____

_____

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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	Never Used	Item	Comments (how much and how many years?
			Marijuana use	_____
○	○	○	If yes, do you have a medical marijuana Card?	○ No ○ Yes
○	○	○	Cocaine	_____
○	○	○	Methamphetamine	_____
○	○	○	Heroin	_____
○	○	○	Other illicit/street drug use	_____

30. Do you smoke? ○ No ○ Yes If yes, how many packs a day? _____ for how long? _____
If no, have you ever smoked? ○ No ○ Yes If Yes: When did you quit? _____
How many packs per day did you smoke?_____

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31. No Yes

○	○	Have you felt you ought to cut down on your drinking or drug use?
○	○	Have people annoyed you by criticizing your drinking or drug use?
○	○	Have you felt bad or guilty about your drinking or drug use?
○	○	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?
○	○	Do you drink alcohol to decrease or relieve pain?

SOCIAL AND WORK

32. Marital Status
○ Married ○ Divorced ○ Separated
○ Cohabitating, not married ○ Widowed ○ Never married, not cohabitating

33. Partner Status
○ Same sex partner ○ Opposite sex partner ○ No partner

34. 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.)

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

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

_____

_____

37. Employment: ○ No ○ Yes *(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

38. Describe your current (or most recent) occupation and duties

_____

When did you last work? _____

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

_____

40. 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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41. 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

42. 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

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

_____

_____

44. Please mark the statements that apply to you:

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* _____

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

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

_____

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

GOALS AND EXPECTATIONS

47. 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

48. 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: _____