



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*)

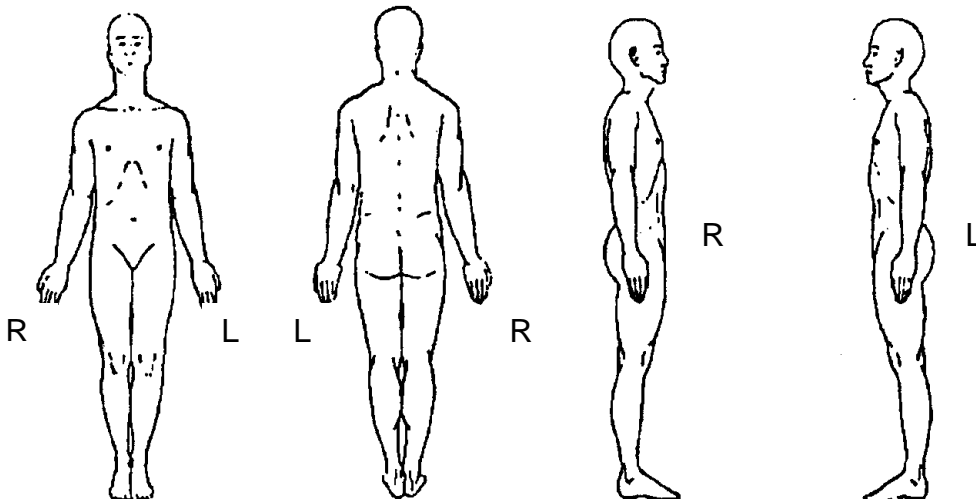
- Accident at work
- Accident at home
- Following surgery
- Pain just began with no known cause
- At work, but not an accident
- Motor vehicle collision
- Following illness
- Other (*describe*) _____

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*)





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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
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

B. Mood	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

C. Walking Ability	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

E. Relations with other people	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

F. Enjoyment of life	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

G. Sexual activity	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

H. Sleep	Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<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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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, stellate 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/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 (Zonegran)				
	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)				
	Risperidone (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

Eyes:

- blurred
- double vision
- photophobia
- eye pain
- eye discharge
- eye redness

Gastrointestinal:

- heartburn
- nausea
- vomiting
- abdominal pain
- diarrhea
- constipation
- blood in stool
- melena

Endo/Heme/Aller:

- easy bruise/bleed
- Env allergies
- polydipsia
- diabetes
- thyroid disorder
- clotting disorders

Skin:

- rash
- itching
- nail changes
- skin disorders

Cardiovascular:

- chest pain
- palpitations
- orthopnea
- claudication
- leg swelling
- high blood pressure
- PND – difficulty breathing at night

Genitourinary:

- dysuria
- urgency
- frequency
- hematuria
- flank pain
- urinary incontinence

Neurological:

- dizziness
- tingling
- tremor
- sensory change
- speech change
- focal weakness
- seizures
- loss of consciousness

HENT:

- headaches
- hearing loss
- tinnitus
- ear pain
- ear discharge
- nose bleeds
- congestion
- stridor
- sore throat

Respiratory:

- cough
- hemoptysis
- sputum production
- shortness of breath
- wheezing
- asthma
- sleep apnea

Musculoskeletal:

- myalgias
- neck pain
- back pain
- joint pain
- falls
- fracture
- herniated disc

Psychiatric:

- depression
- suicidal ideas
- substance abuse
- hallucinations
- nervous/anxious
- insomnia
- memory loss



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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

Neurosurgical/Orthopedic:

- | | | |
|---|---|---|
| <input type="checkbox"/> Craniotomy/brain surgery | <input type="checkbox"/> Cervical fusion | <input type="checkbox"/> Cervical laminectomy |
| <input type="checkbox"/> Lumbar fusion | <input type="checkbox"/> Lumbar laminectomy | <input type="checkbox"/> Surgical treatment of fracture |
| <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Knee arthroscopy | <input type="checkbox"/> Knee replacement |

Abdominal:

- | | | |
|--|---|---|
| <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Abdominal wall defect repair | <input type="checkbox"/> Gastric bypass |
| <input type="checkbox"/> Colectomy | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Lysis of adhesions |

Genitourinary:

- | | | |
|---|--|---|
| <input type="checkbox"/> Nephrectomy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Cesarean section |
| <input type="checkbox"/> TURP/Transurethral Resection of Prostate | <input type="checkbox"/> Prostatectomy | |

Vascular/Lung:

- | | | |
|---|---|---|
| <input type="checkbox"/> Femoral bypass | <input type="checkbox"/> Abdominal aortic aneurysm repair | <input type="checkbox"/> Heart valve surgery |
| <input type="checkbox"/> Coronary artery bypass graft | <input type="checkbox"/> Coronary stent placement | <input type="checkbox"/> Thoracotomy/lung surgery |

OTHER SURGICAL HISTORY: _____

24. 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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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"/>
Headaches	<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"/>

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?)
<input type="radio"/>	<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"/>	<input type="radio"/>	Cocaine	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Methamphetamine	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heroin	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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 Works Cited

There are no sources in the current document.

32. Marital Status

- Married Divorced Separated
- Cohabiting, 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 your 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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NEW PATIENT QUESTIONNAIRE

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



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NEW PATIENT QUESTIONNAIRE

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: _____
