CENTER FOR SPINE, JOINT & NEUROMUSCULAR REHAB
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CONSULT FOR PAIN MANAGEMENT QUESTIONNAIRE

Name: _____ DOB: ___-___-___ Age: ____ Dominant Hand: Right Left

CHIEF COMPLAINT (*ONE **(1)** MAIN AREA OF PAIN YOU WOULD LIKE TO FOCUS ON TODAY?*)

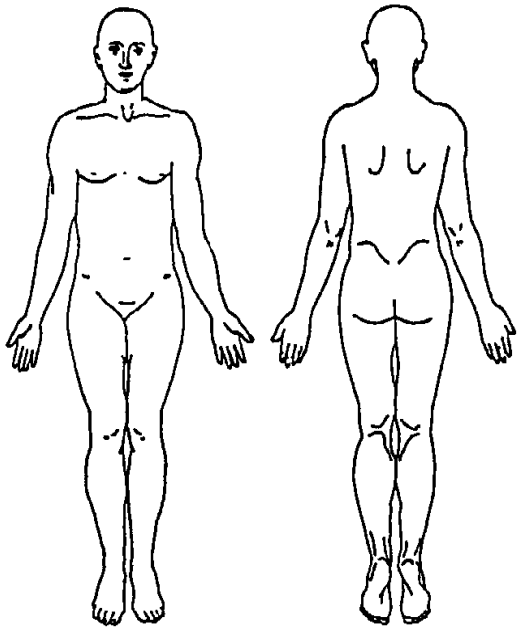
- neck pain shoulder pain arm pain back pain hip pain leg pain ankle/foot pain all over muscle/joint pain
  other reason(s):_____

HISTORY OF PRESENT INJURY

- When did this problem originally start? _____
- Was there an inciting event to your symptoms (Please mark only one):
  fall work injury auto accident (have an attorney?) normal aging sports injury
  Other_____
- Who have you sought treatment from? (*list all doctors/specialists*):_____
  Surgeon Rheumatologist Neurologist Physical Therapist Chiropractor PCP/Walk-in Clinic
  Other_____
- Have you been to a pain management clinic before? (*please list*):_____
  - Do you have a discharge letter from them? (Yes/No): _____
- Since the problem started, has the pain: improved worsened remained the same

What is your MAX pain level without treatment? ***(circle below)***

Shade on the body diagram where you are having pain:



IS YOUR PAIN: (please choose only one)
Constant Occasional
How often does your pain spike during the day?_____

DESCRIBE YOUR PAIN:
Aching/Throbbing Dull *or* Sharp Shooting *or* Pinpoint
Burning Tingling Numbness
Radiating (where to?)_____

WHAT HELPS EASE YOUR PAIN:
Sitting Standing Walking Bending Lying Down Changing positions
Heat Ice Rest Other_____
Helpful Medications (list): _____

WHAT WORSENS YOUR PAIN:
Sitting Standing Walking Bending Lying Down Driving Coughing
Stairs Pushing Pulling Twisting Other_____

FOR LOW BACK PAIN ONLY - ANY PERSONAL HISTORY OF: *(Please circle any that apply)*
cancer, unexplained weight loss, HIV infection, other chronic infections, fracture of the spine, organ transplant, chronic steroid use, medications from Rheumatologist, loss of control of bladder or bowel, numbness in the groin area, major weakness in the legs

Do you feel that you may need Pain Medication at today's visit? Yes No Maybe

TESTS PERFORMED FOR THIS SPECIFIC PAIN: *(date and where performed and who ordered)*

X-rays: _____ MRI: _____ Bone Density: _____
EMG: _____ CAT scan: _____ Lab Work: _____
CAT scan: _____ Functional Capacity Exam:_____ Other: _____

ALL TREATMENT TRIED FOR THIS SPECIFIC PAIN:

□ No Treatments □ Weight Loss Efforts □ Physical Therapy □ Chiropractic Care □ Surgery
□ Back Brace □ TENS Unit □ Trigger Points □ Joint Injections □ Botox/Myobloc
□ Supartz/Orthovisc Knee Injections □ Epidural Steroid Injection (ESI) □ Nerve Blocks
□ Facet Block Injections □ Radio Frequency Ablation □ Spinal Cord Stimulator
□ Other:_____

THE ABOVE LIST OF TREATMENTS TRIED WERE HELPFUL:

□ None □ Weight Loss Efforts □ Physical Therapy □ Chiropractic Care □ Surgery
□ Back Brace □ TENS Unit □ Trigger Points □ Joint Injections □ Botox/Myobloc
□ Supartz/Orthovisc Knee Injections □ Epidural Steroid Injection (ESI) □ Nerve Blocks
□ Facet Block Injections □ Radio Frequency Ablation □ Spinal Cord Stimulator
□ Other:_____

ALL NON-OPIATE MEDICATIONS EVER TRIED FOR PAIN:

□ None □ OTC Pain Meds □ Toradol □ Celebrex □ Mobic □ etodolac (Lodine) □ baclofen
□ naproxen (Naprosyn/Aleve) □ carisoprodal (Soma) □ methocarbamol (Robaxin) □ tizanidine (Zanaflex) □ Skelaxin
□ cyclobenzaprine (Flexeril/Amrix) □ Savella □ Lyrica □ gabapentin (Neurontin) □ Cymbalta
□ Lidoderm Patches □ tramadol (Ultram/Ultracet) □ Others:_____

THE ABOVE LIST OF MEDICATIONS TRIED WERE HELPFUL:

□ None □ OTC Pain Meds □ Toradol □ Celebrex □ Mobic □ etodolac (Lodine) □ baclofen
□ naproxen (Naprosyn/Aleve) □ carisoprodal (Soma) □ methocarbamol (Robaxin) □ tizanidine (Zanaflex) □ Skelaxin
□ cyclobenzaprine (Flexeril/Amrix) □ Savella □ Lyrica □ gabapentin (Neurontin) □ Cymbalta
□ Lidoderm Patches □ tramadol (Ultram/Ultracet) □ Others:_____

ALL OPIATE MEDICATIONS EVER TRIED FOR PAIN:

□ None □ hydrocodone (Lortab/Norco) □ oxycodone (Percocet/Endocet/Roxicodone/OxyContin)
□ morphine (MS Contin/Kadian/Avinza) □ hydromorphone (Dilaudid) □ propoxyphene (Darvocet)
□ Butrans patch □ fentanyl patches (Duragesic) □ methadone □Opana/Opana ER
□ Others:_____

THE ABOVE LIST OF MEDICATIONS TRIED WERE HELPFUL:

□ None □ hydrocodone (Lortab/Norco) □ oxycodone (Percocet/Endocet/Roxicodone/OxyContin)
□ morphine (MS Contin/Kadian/Avinza) □ hydromorphone (Dilaudid) □ propoxyphene (Darvocet)
□ Butrans patch □ fentanyl patches (Duragesic) □ methadone □Opana/Opana ER
□ Others:_____

PAST MEDICAL HISTORY: *Have you ever had any of the following conditions? (Check all that apply)*

□ High Blood pressure □ Seizures □ Anemia (low blood count) □ Asthma □ Arthritis
□ Diabetes □ Stroke(s) □ Lung disease-COPD □ HIV □ Osteoarthritis
□ Heart Disease □ Kidney disease □ Peripheral vascular disease □ Ulcers □ Rheumatoid Arthritis
□ Thyroid disease □ Hepatitis (B/C?) □ Bleeding problems □ Depression / Anxiety
□ Cancer: _____ □ Other:_____ _____

PAST SURGICAL HISTORY: (*surgeon and date*)_____
_____
_

FAMILY MEDICAL HISTORY: (*please list):*_____

SOCIAL HISTORY:

Height: _____ Weight:_____*(taken in office)*
Do You Exercise? yes/no; How often? _____ What type?_____
Tobacco use: *Current Everyday Smoker? *Current Sometime Smoker? *Former Smoker? *Never Smoker?
Alcohol use: *Beer *Wine *Other: _____How often? _____
Illicit drug use: yes/no (If yes, what): _____How often? _____How long? _____
Prescription drug abuse: yes/no_____
High risk HIV Behavior: yes/no _____
Domestic Violence or Abuse: yes/no_____
Marriage Status: S M W D
Children: yes/no (If yes, how many?) _____
Education Level: *less than high school *high school *trade *undergraduate (college) *grad school (masters or beyond)
Support: *family *friend's *lives alone *church *none
Employment status: *full-time with work restrictions *full-time without work restrictions *part-time with work restrictions *part-time without work restrictions *retired *applying for disability *disabled *workers compensation (working/not working for how long? _____)
Type of labor: *sedentary (<10 pound lifting) *light duty (10 pound frequent or 10-20 pound occasional lifting) *moderate duty (25 pound frequent or 25-50 pound occasional lifting) *heavy duty (50 pound frequent or 50-100 pound repetitive lifting)
Duration of employment with current company:_____
Job satisfaction: *happy *satisfied *neutral *dissatisfied *disgruntled
Psychosocial stress: *abuse (physical, mental, sexual) *financial strain *relationship strain *none

ALL FEMALES (age 18-45):

Any chance you may be pregnant? Yes No Not Sure
Date of LMP (last menstrual period)? Date: (___/____/_____) □ I Don't Know
I no longer have menstrual cycles anymore due to? Hysterectomy Menopause Other: _____
Form of birth control? Pill Patch Shot IUD Condom Tubal Ligation Abstinence None Other: _____
If you are not using birth control, do you have access to obtaining contraception?
□ Yes
□ No -- **Would you like a handout for local OB/GYN or Planned Parenthood Services?**
Yes No
If you are pregnant, do we have a letter from your OB/GYN on file regarding medication management? Yes No

CURRENT MEDICATIONS: (*If more, please list on separate sheet)*

Medication:	Dosage:	Frequency: (how often)	Prescribing Physician:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATION ALLERGIES: □YES □NO

□ Latex □ Iodine □ IVP Contrast □ Steroids □ Others:_____

REVIEW OF SYSTEMS: *(Please circle any that apply to how you are feeling currently **at this time, at this visit**)*

General: fevers, chills, sweats, anorexia, fatigue, malaise, weight loss.
Eyes: blurring, double vision, irritation, discharge, vision loss, eye pain, photophobia.
Ears/Nose/Throat: ear discharge, decreased hearing, congestion, nosebleeds, sore throat, difficulty swallowing.
Breast: swelling, masses, nipple discharge, pain, skin changes.
Cardiovascular: chest pain, palpitations, fainting, difficulty breathing on exertion or lying down, peripheral edema.
Respiratory: cough, difficulty breathing, excessive sputum, bloody sputum, wheezing.
Gastrointestinal: nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, jaundice.
Genitourinary: urinary frequency, incontinence, discharge, bleeding, pelvic pain, genital sores, decreased libido.
Musculoskeletal: back or neck pain, leg or arm pain, joint pain or swelling, muscle cramps or weakness.
Skin: rash, itching, dryness, suspicious lesions.
Neurologic: paralysis, weakness, abnormal sensations, seizures, fainting, tremors, dizziness, numbness, tingling.
Psychiatric: depression, anxiety, memory loss, mental disturbance, suicidal ideation, hallucinations, paranoia.
Endocrine: cold intolerance, heat intolerance, increased thirst, increased hunger, increased urination, weight change.
Hematologic: abnormal bruising, bleeding, enlarged lymph nodes.
Allergic/Immunologic: hay fever, persistent infections, HIV exposure.

The above information is complete and accurate to the best of my knowledge.

_____ ____-____-____
Patient signature Date