PAIN MANAGEMENT QUESTIONNAIRE

Patient Name: ______________________________________DOB: _______/ ______ /_______

Referring Physician: ____

Primary Care Physician: ____

Pharmacy: ____

Have you had any imaging of the area you are here to have evaluated: □ Yes □ No

If Yes, When: __________ / __________ / __________

Where: ____

Reason for appointment/Reason you were referred:

□ Back Pain □ Neck Pain □ Arm/Leg Pain □ Shingles

□ Abdominal Pain □ Cancer □ Headaches □ CRPS □ Other: __________

****Please fill out the rest of this form only for the pain associated with the area you marked above****

- Have you had this pain before: □ Yes □ No If Yes, How long? ______________________________
- Please describe how your pain began: ____
- Do you have weakness of your extremities: □ Yes □ No
  If Yes, Where: □ Left Leg □ Right Leg □ Left Arm □ Right Arm
- Do you have numbness (inability to feel): □ Yes □ No
  If Yes, Where: ____
- Do you have tingling: □ Yes □ No If Yes, Where: _______________________________________
- Do you have loss of control of your: □ Bowel □ Bladder
  If Yes,
  Have you experienced this for a long time: □ Yes □ No
  Does it only happen with coughing/sneezing: □ Yes □ No
  Is it difficult to go: □ Yes □ No
  Have you had any accidents: □ Yes □ No If Yes, How often: _________

- Does the pain interrupt your sleep: ☐ Yes ☐ No

- Have you had any un-purposeful ☐ Weight loss ☐ Weight gain
  If Yes, How much: _________ pounds When did this occur: ______________________________

- Do you wake up at night sweating or soaking wet: ☐ Yes ☐ No
  If Yes, How often: ______________ How long have you been experiencing: ______________
- Have you been seen by another pain clinic in the past: ☐ Yes ☐ No
  If Yes, When: __________ / __________ / __________ - __________ / __________ / __________
  Who/Where: ____

- Have you had any previous pain management injections: ☐ Yes ☐ No
  If Yes, What type: ____ Did it help: ☐ Yes ☐ No
  ____ Did it help: ☐ Yes ☐ No
  ____ Did it help: ☐ Yes ☐ No

- Have you had physical therapy: ☐ Yes ☐ No
  If Yes, When: __________ / __________ / __________ - __________ / __________ / __________
  Who/Where: ____
  Did you learn a home therapy program: ☐ Yes ☐ No

- Have you seen a chiropractor: ☐ Yes ☐ No
  If Yes, When: __________ / __________ / __________ - __________ / __________ / __________
  Who/Where: ____

- Have you seen a pain psychologist: ☐ Yes ☐ No
  If Yes, When: __________ / __________ / __________ - __________ / __________ / __________
  Who/Where: ____
  Did you learn: ☐ Biofeedback ☐ Coping skills ☐ Relaxation methods

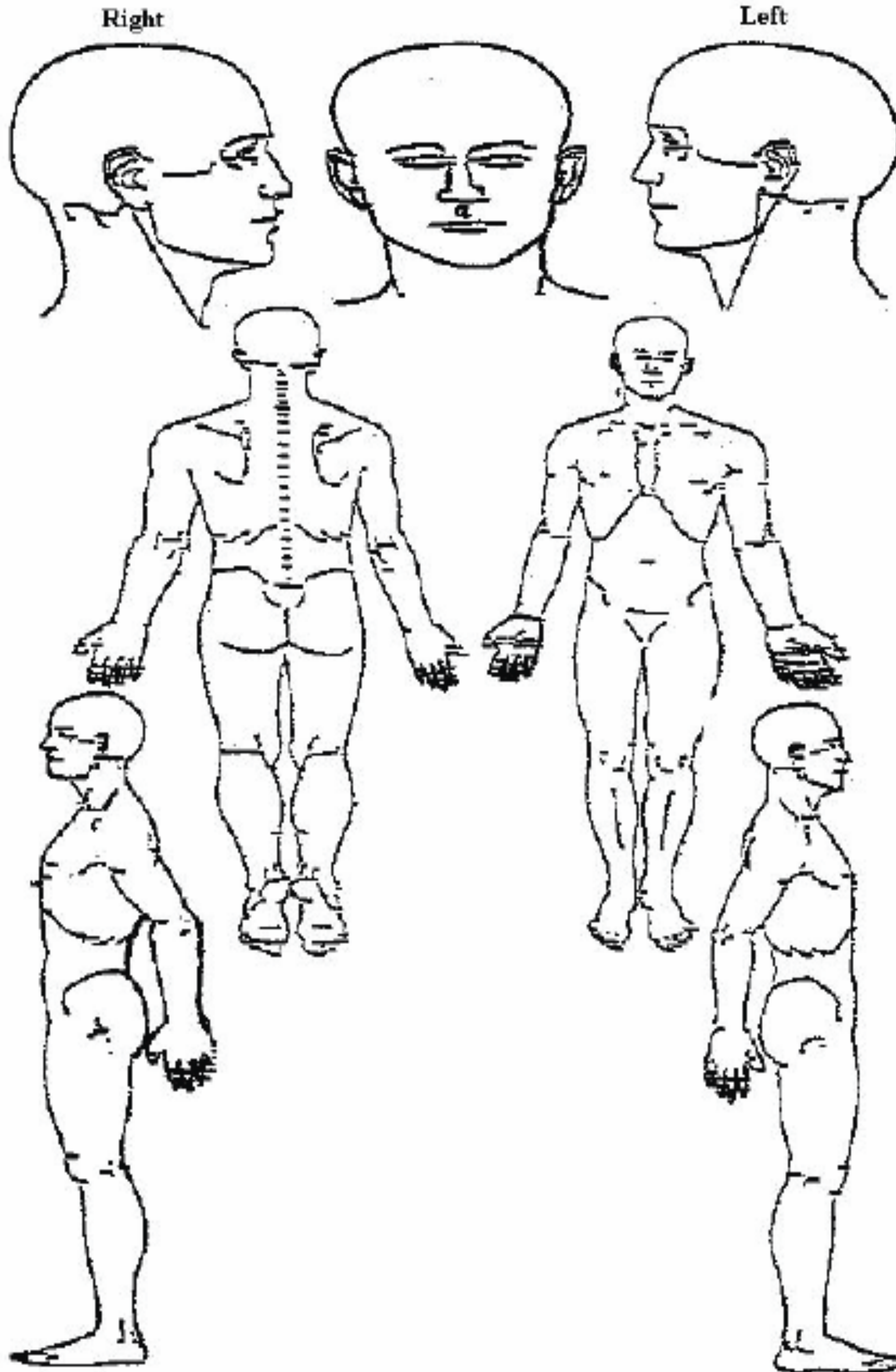
- Have you had acupuncture: ☐ Yes ☐ No
  If Yes, When: __________ / __________ / __________ Did it help: ☐ Yes ☐ No

- Have you used a TENS unit (electrical stimulation of the skin): ☐ Yes ☐ No
  If Yes, When: __________ / __________ / __________ Did it help: ☐ Yes ☐ No

Pain Location

On the figures below, using the symbols lsited below, please mark the areas of your body where you feel:

Numbness = = = =	Stabbing / / / /	Burning x x x x
Pin & Needles o o o o	Aching ((((	Area where it hurts the most √



MEDICATIONS

Please list **ALL** medications, including herbal and over-the-counter:

Drug	Dose	Prescribing Provider

ALLERGIES

Drug/Item	Reaction

PREVIOUS SURGERIES

Please be as specific as possible:

Surgery	Date	Location/Physician

Revised 5/20/19

MEDICAL HISTORY

Please be as specific as possible:

Condition	Management	Treatment Outcome

FAMILY HISTORY

- Is your mother living: □ Yes □ No
  If Yes, Age: ________________ If No, Age at death: ________________
  List all medical problems: ____
- Is your father living: □ Yes □ No
  If Yes, Age: ________________ If No, Age at death: ________________
  List all medical problems: ____
- Siblings:
  □ Brother □ Sister Living: □ Yes □ No
  If Yes, Age: ________________ If No, Age at death: ________________
  List all medical problems: ____
  □ Brother □ Sister Living: □ Yes □ No
  If Yes, Age: ________________ If No, Age at death: ________________
  List all medical problems: ____
  □ Brother □ Sister Living: □ Yes □ No
  If Yes, Age: ________________ If No, Age at death: ________________
  List all medical problems: ____

SOCIAL

- Have you had any recent social changes (marriage, divorce, employment, etc.): □ Yes □ No
  If Yes, describe: ____
- Are you married: □ Yes □ No
  If Yes, How Long: ________________ Name of spouse: ____
- Is your spouse deceased: □ Yes □ No If Yes, When: __________ / __________ / __________

- Have you been divorced: ☐ Yes ☐ No If Yes, How many times: _______________
- Are you currently employed: ☐ Yes ☐ No If Yes, How long: _______________
  Occupation: ___________________________________
- Are you receiving disability: ☐ Yes ☐ No
- Is this pain being treated by a workers compensation claim: ☐ Yes ☐ No
- Have you taken any legal action in regards to your pain: ☐ Yes ☐ No
- Have you ever been abused: ☐ Yes ☐ No If Yes, ☐ Physical ☐ Sexual ☐ Emotional

HABITS

- Do you smoke: ☐ Yes ☐ No ☐ Quit When: __________ / __________ / __________
  If Yes, Packs per day: _______________ Years: _______________
- Do you smoke a pipe: ☐ Yes ☐ No ☐ Quit When: __________ / __________ / __________
  If Yes, How much: _______________ Years: _______________
- Do you chew tobacco: ☐ Yes ☐ No ☐ Quit When: __________ / __________ / __________
  If Yes, How much: _______________ Years: _______________
- Do you drink alcohol: ☐ Yes ☐ No ☐ Quit When: __________ / __________ / __________
  If Yes, How much: _______________ Years: _______________
- Do you use illegal drugs: ☐ Yes ☐ No ☐ Quit When: __________ / __________ / __________
  If Yes, How much: _______________ Years: _______________
  What types: ____

1. Has the patient had 2 or more falls within the last 12 months? ◯ Yes ◯ No

2. Has the patient had any falls with injury within the last 12 months? ◯ Yes ◯ No

Is the Pain Chronic?	Average Pain Rating Over Last Week	Rate How Pain has Interfered with Enjoyment of Life	Rate How Pain has Interfered with General Activity
◯ Yes ◯ No	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Previous COVID Vaccine

◯ Yes ◯ Refused
◯ No ◯ Unable to obtain

Select Yes if patient is fully vaccinated. (2 doses of 2 dose series or 1 dose of 1 dose series)

Select No if patient is not vaccinated or partially vaccinated

Influenza vaccine already given this season?

- ○ Yes
- ○ No

Influenza vaccine indicated?

- ○ Yes
- ○ Refused
- ○ Contraindicated
- ○ Yes but vaccine unavailable

Reason Patient Refused

- ☐ Does not want it
- ☐ Previous negative experience
- ☐ Referred to another site/department
- ☐ Referral to Allergy Department - BC Only
- ☐ Will talk to physician first
- ☐ Other:

Advance Directive

- ○ Yes
- ○ No
- ○ N/A - Patient less than 18 yrs