CONSULTATION QUESTIONNAIRE

OREGON INTERVENTIONAL PAIN CONSULTANTS

Patient Name: _____ Date: _____

Please complete this form prior to your appointment. If this questionnaire is not completed prior to your appointment, you may need to reschedule to allow for a complete pain consultation.

Age: _____ Date of Birth: _____ Sex: ( ) Male ( ) Female

Current Pharmacy Name: _____ City/Location: _____

1. What is the main reason for your referral to this practice?

_____

_____

_____

2. When did your pain problems begin? (Give the date of injury, year, or your age when pain began)

_____

_____

_____

3. Under what circumstances did your pain begin? (Check one)

[ ] Accident at work
[ ] At work, but not an accident
[ ] Accident at home
[ ] Pain just began with no known cause
[ ] Motor Vehicle Accident
[ ] Following surgery
[ ] Following illness
[ ] Other (describe):

4. If you were injured, describe how: (Check one and describe incident)

[ ] Fall
[ ] Lifting object
[ ] Pushing
[ ] Struck by falling or moving object
[ ] Repetitive activity
[ ] Not injured
[ ] Other:

5. Diagnosis (if known): _____

_____

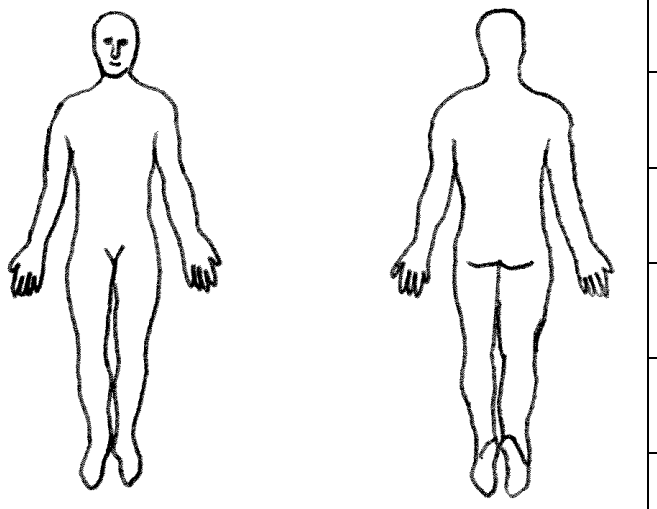
_____

6. What do you feel is the cause of your pain? _____

_____

_____

7. Where is your pain? (Shade in the painful areas on the diagram below)



Pain Description	Shade in Style
Ache	> > > > > > > > > > > > > > > > > > > >
Numbness	. . . .
Pins & Needles	+ + + + + + + + + + + + + + + + + + + +
Burning	x x x x x x x x x x x x x x x x x x x x
Stabbing	////////////// //////////////

8. Location of Pain: (Check any terms that apply to your pain)

- ▪ Superficial
- ▪ Deep
- ▪ Joints
- ▪ Nerves
- ▪ Skin
- ▪ Muscular
- ▪ Bones
- ▪ Other:

9. Intensity of pain:
   a. Please circle the number that describes your pain right **NOW**:

0 1 2 3 4 5 6 7 8 9 10

NONE MODERATE WORST POSSIBLE

   b. Please circle the number that describes your pain at its **LEAST**:

0 1 2 3 4 5 6 7 8 9 10

NONE MODERATE WORST POSSIBLE

   c. Please circle the number that describes your pain at its **WORST**:

0 1 2 3 4 5 6 7 8 9 10

NONE MODERATE WORST POSSIBLE

   d. Please circle the number that describes your pain on **AVERAGE**:

0 1 2 3 4 5 6 7 8 9 10

NONE MODERATE WORST POSSIBLE

10. Is your pain ( )constant ( )intermittent?

_____
_____
_____

11. Is your pain worse at any particular time of day? ( ) No ( ) Yes- when?

_____
_____
_____

12. What makes your pain worse? (Check any terms that apply to your pain)

- Exercise
- Climbing stairs
- Work
- Cold
- Other: (describe)
- Bending forward
- Lifting
- Driving
- Heat
- Bending backwards
- Sitting
- Cough/sneeze
- Light touch
- Walking
- Standing
- Sexual activity
- Stressful situations

13. What relieves the pain? (Check any terms or action that decreases your pain)

- Lying down
- Sitting
- Standing
- Walking
- Exercise
- Ice
- Heat
- Bath/shower
- Physical therapy
- Medications
- Other: (describe)

14. Have previous medications or therapies been helpful? Which ones?

Pain therapies tried:	Did it help?	How much? (%)
▪ Medications	( ) No ( ) Yes	_____
▪ Surgery	( ) No ( ) Yes	_____
▪ Nerve blocks (injections)	( ) No ( ) Yes	_____
▪ Exercise	( ) No ( ) Yes	_____
▪ Manipulations	( ) No ( ) Yes	_____
▪ Physical therapy	( ) No ( ) Yes	_____
▪ Trigger point therapy	( ) No ( ) Yes	_____
▪ Acupuncture	( ) No ( ) Yes	_____
▪ TENS (electric stimulation	( ) No ( ) Yes	_____
▪ Biofeedback/ relaxation	( ) No ( ) Yes	_____
▪ Yoga	( ) No ( ) Yes	_____
▪ Hypnosis	( ) No ( ) Yes	_____
▪ Group therapies	( ) No ( ) Yes	_____
▪ Psychology Counseling	( ) No ( ) Yes	_____
▪ Pain management program	( ) No ( ) Yes	_____
▪ Other:		

15. How much pain relief do your current pain medications provide? (%)

0 10 20 30 40 50 60 70 80 90 100

NONE COMPLETE

16. Do you have any numbness? ( ) No ( ) Yes- Where?

_____
_____
_____

17. Do you have any weakness? ( ) No ( ) Yes- Where?

_____
_____
_____

18. Is your pain associated with any swelling or color changes? ( ) No ( ) Yes- Describe

_____
_____
_____

19. Have there been changes in your ability to urinate? ( ) No ( ) Yes- How?

_____
_____
_____

20. Have there been changes in your ability to have bowel movements? ( ) No ( ) Yes- How?

_____
_____
_____

21. Have there been changes in your sexual function? ( ) No ( ) Yes- How?

_____
_____
_____

22. Does pain delay your getting to sleep? ( ) No ( ) Yes- How often?

_____
_____
_____

23. Does pain awaken you from sleep? ( ) No ( ) Yes- How often?

_____
_____
_____

24. How much total sleep do you average each night? _____ hours

_____
_____
_____

25. In the past 6 months, how many full days of work have you missed because of pain?

_____
_____
_____

26. Have you visited the emergency room for your pain? ( ) No ( ) Yes- number of times: _____

_____
_____
_____

27. Have you been hospitalized because of pain? ( ) No ( ) Yes- How often, when?

_____
_____
_____

28. How many physicians have you seen in effort to treat your pain? _____

_____
_____
_____

29. What medical tests have been done to evaluate your pain? (check and date)

Test:	Date:	Results (if known)
▪ X-Ray	_____	_____
▪ CT Scan	_____	_____
▪ Myelogram	_____	_____
▪ MRI	_____	_____
▪ Bone Scan	_____	_____
▪ EMG	_____	_____
▪ EKG	_____	_____
▪ Other:	_____	_____

_____
_____
_____

30. Do your medications cause you to have any side effects? ( ) No ( ) Yes-Explain:

_____
_____
_____

31. Please list any drug or food allergies:

_____

_____

_____

32. List all **prescription** medications that you are **currently** taking:

NAME OF MEDICATION	DOSE (mg) (#of pills)	HOW OFTEN? (# per day)	WHAT IS THIS MEDICATION FOR?

33. List all **over-the-counter** medications, supplements, or herbs that you are **currently** taking:

NAME OF MEDICATION	DOSE (mg) (#of pills)	HOW OFTEN? (# per day)	WHAT IS THIS MEDICATION FOR?

34. List all other pain medications that you have tried in the past:

NAME OF MEDICATION	MAXIMUM DOSE TAKEN AND # OF DOSES PER DAY	DURRATION OF USE	REASON FOR STOPPING OR SIDE EFFECTS

35. Past medical history and review of symptoms (check yes or no) [**X** Reviewed by physician's initials _____]

YES	NO	CIRCLE ANY CONDITIONS YOU HAVE EXPERIENCED	COMMENTS	**X**
		Problems with your: Eyes, Ears, Nose, Throat		
		Cardiovascular: Chest pain, Heart disease, Heart attack, Blood flow problems, Irregular rhythm, High blood pressure		
		Respiratory: Obstructive disease, Asthma, Chronic bronchitis, Shortness of Breath, Smoking		
		Gastrointestinal: Stomach ulcers, Hiatal hernia, Bowel problems, Bleeding, Gallbladder problems, Hepatitis/liver disease		
		Genitourinary: Kidney, Bladder, Prostate, Infections/bleeding		
		Musculoskeletal: Muscle or bone disorders, Joint/Arthritis (Where?), Trouble with Arms, Legs		
		Integumentary: Skin disorders, Breast diseases, Unusual lumps or bumps		
		Neurological: Stroke, Seizure, Epilepsy, Neuropathy, Nerve injury, Other:		
		Psychiatric: History of depression or other psychological conditions: Anxiety, Fear, Alcohol or other drug abuse		
		Endocrine: Diabetes (blood sugar), Thyroid		
		Hematologic:		

		Bleeding disorders, Easy bruising, Anemia		
		Allergic/Immunologic: Auto immune disorder i.e. Lupus, Immune Deficiency		
		Cancer (what type?)		
		Constitutional: Recurrent fevers, Weight change, Heat/Cold intolerance, Fatigue		
		Pregnancy, (Date of last period, type of birth control)		
		Other:		

36. Surgeries: ( ) None

YEAR	SURGERY	COMMENTS, POST SURGICAL COURSE
	Appendectomy	
	Biopsy (Result & Type)	
	Gall Bladder	
	Hernia	
	Hysterectomy	
	Prostate	
	Vasectomy	
	Other:	

37. List Major Injuries or Hospitalizations: ( ) None

YEAR	REASON FOR INJURY OR HOSPITALIZATION	COMMENTS OR HOSPITAL COURSE

38. Have you or any family members ever had any anesthesia or medication related complications?

( ) No ( ) Yes- Describe:

Social and Vocational History

39. Marital status:
    - Married
    - Never married
    - Live with spouse equivalent
    - Divorced/ Separate
    - Widowed

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

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

42. What exercise or recreational activities do you enjoy?

43. Have you been involved with any of the following items? (check Yes or No)

YES	NO	ITEM	COMMENTS (HOW MUCH AND HOW MANY YEARS)
		Smoke	
		Drink alcohol	
		Addictive street drugs	
		Disability	
		Litigation	

44. Highest grade or level of education completed: _____ grade or degree _____.

45. Are you currently employed? ( ) No ( ) Yes. If **No**, when did you last work? If **Yes**, place of employment:

46. What are your current and past occupations?

_____
_____
_____

47. Specifically, what do/did you do at work?

_____
_____
_____

48. On the scale from 0 to 10 do/did you find your job satisfying? (Place mark on the scale)

0 1 2 3 4 5 6 7 8 9 10

NOT SATISFYING VERY SATISFYING

49. On the scale from 0 to 10 do/did you find your job financially satisfying? (Place mark on the scale)

0 1 2 3 4 5 6 7 8 9 10

NOT SATISFYING VERY SATISFYING

50. Has your job changed because of your painful condition? ( ) No ( ) Yes- how?

_____
_____
_____

51. Are you under financial stress?

_____
_____
_____

52. Have there been any other stressful life experiences recently? ( ) No ( ) Yes- explain

_____
_____
_____

53. Have you ever been convicted for any crimes or felonies? ( ) No ( ) Yes- explain

_____
_____
_____

54. Do any close friends or family members have chronic (long term) pain problems? ( ) No ( ) Yes- describe

_____
_____
_____

55. Do any close friends or family members have chronic (long term) medical illness? ( ) No ( ) Yes- describe

56. Do you identify with any particular faith or religion? ( ) No ( ) Yes- which one?

57. On the scale from 0 to 10 how important is your faith to everyday life? (place a mark on the scale)

0 1 2 3 4 5 6 7 8 9 10

NOT IMPORTANT VERY IMPORTANT

58. Would you like to have spirituality somehow incorporated into your treatment plan? ( ) No ( ) Yes- how?

59. Have you been under the care of a mental health professional? ( ) No ( ) Yes- when, how often?

60. Circle the number that best describes how pain has interfered with the following:

a. General activity:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE COMPLETELY INTERFERES

b. Mood:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE COMPLETELY INTERFERES

c. Walking ability:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE COMPLETELY INTERFERES

d. Normal work (includes both work outside the home and housework):

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE COMPLETELY INTERFERES

e. Relations with other people:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE COMPLETELY INTERFERES

f. Enjoyment of life:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

g. Sexual activity:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

h. Sleep:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

Treatment Expectations

61. What types of treatment do you expect from your visits to the pain management center? Check all appropriate answers:
    - Consultation only (advice only to you and your primary care physician)
    - Counseling
    - Stress Management
    - Physical therapy
    - Drug treatment
    - Acupuncture
    - Surgery
    - Injections or nerve blocks
    - Electrical stimulation
    - Relaxation therapy
    - Biofeedback
    - Other (describe):
    - Don't know

62. What do you expect after your visits to our pain program? Check the one best answer:
    - A diagnosis (to help find the cause of pain)
    - A reduction in pain
    - Help in coping with the pain
    - A cure
    - No expectations
    - Do not know what to expect

63. What are your goals for treatment?

_____
_____
_____
_____
_____

_____ _____

Physician's Signature — Date Reviewed