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INITIAL COMPREHENSIVE PAIN QUESTIONNAIRE

Please complete this form before your first appointment at Orlando pain & Spine Center. Your careful answers will help us to understand your pain problem and design the best treatment program for you. You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case records without your written permission unless we are required to do so by law (e.g. Workmen's Compensation Claims).

Date _____

Name: _____
Last First Middle Initial

Address: _____
Street Address

City State Zip Code

Home Phone: _____ Work Phone: _____

Referring MD: _____

Other Physicians currently involved in my care:

Sex: Male Female Age: _____

Race: Asian – American African – American
White Hispanic Other

CHARACTERISTICS OF PAIN

What is the main problem for which you are seeking treatment?

How long have you had your current pain problem?

Years _____ Months _____

ONSET OF PAIN:

- Injury at work
- Injury, not at work
- Motor vehicle accident
- Illness, non-injury
- Treatment caused (e.g. radiation, surgery, etc.)
- Undetermined

If there was a precipitating event not mentioned, what was it? _____

SEVERITY OF PAIN: In general, over the past month, the intensity of my pain has been: _____

- Mild
- Moderate
- Moderate – Severe
- Severe

TIMING OF PAIN: How often do you have your pain (Please check one)?

- Constantly (100% of the time)
- Nearly constantly (60% to 95% of the time)
- Intermittently (30% to 60% of the time)
- Occasionally (Less than 30% of the time)

In General, during the past month, when has your pain been the worst?
(Please check one)

- Morning
- Afternoon
- Evening
- Night
- No typical pattern

PAIN / SYMPTON QUALITY: How would describe your pain

(Please check all that apply; if there is a dominant quality to your pain, please check the appropriate term):

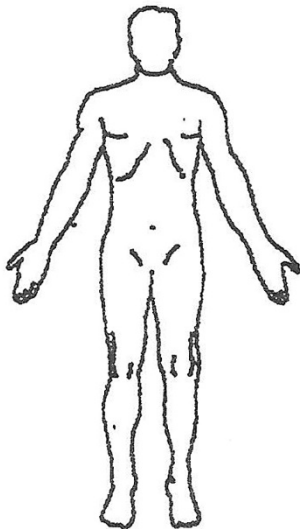
- | | | | |
|-----------------------------------|---|--|------------------------------------|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Sharp | <input type="checkbox"/> Cutting | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull / Aching | <input type="checkbox"/> Pressure – like | |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Other (Describe) _____ | | |

Associated with pain, I feel the following (Please check all appropriate terms):

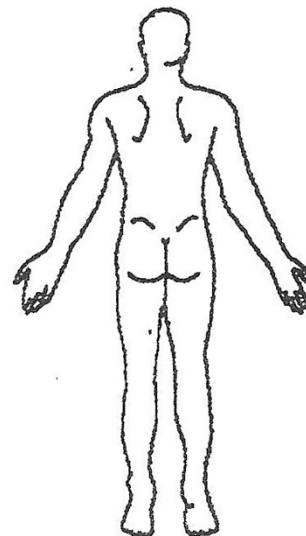
- | | | |
|--|-------------------------------|---|
| <input type="checkbox"/> Numbness I feel sensations in the | <input type="checkbox"/> same | <input type="checkbox"/> different areas than the pain. |
| <input type="checkbox"/> Pins and needles I feel sensations in the | <input type="checkbox"/> same | <input type="checkbox"/> different areas than the pain. |
| <input type="checkbox"/> Hair loss / skin changes / nail changes in extremities. | | |

I have had weakness in my: Upper extremities Yes Dropping objects? Yes
Lower extremities Yes Falling? Yes
Other (Please describe) _____

PAIN LOCATION: Please mark the locations of your pain on the diagrams with an "X". If whole areas are painful, please shade in the areas.



Front



Back

RELIEVING AND AGGRAVATING FACTORS:

How do the following affect your pain (Check one for each item)

	DECREASE	NO CHANGE	INCREASE
LYING DOWN			
STANDING			
WALKING			
EXERCISE			
RELAXATION			
COUGHING			
SNEEZING			
BOWEL MOVEMENTS			

I have ____ Had ____ - or – Not Had ____ a recent change in bowel or bladder habits.
Please describe recent changes _____

ACTIVITIES AND YOUR PAIN:

How many blocks can you walk? Less than a block Blocks (How many?)

Does leg pain disappear at rest? Yes No

How many minutes or hours can you sit? _____ Minutes _____ Hours.

How often during the day do you lie down because of pain?

Never Seldom Sometimes Often Constantly

To assist walking, I use Cane Walker Wheelchair No Assistance Device

Are you **NOT** able to perform any of the following activities of daily living?

Check all that apply.

Going to work Performing household chores Doing yard work or shopping.

Socializing with friends Participating in recreational activities Exercising

PAIN TREATMENTS:

Please check your response to all treatments you have tried.

TREATMENT	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
Surgery			
Standing			
Traction			
Nerve Block Injection			
Physical Therapy			
Exercise			
Tens			
Heat Treatment			
Ice Treatment			
Psychotherapy			
Acupuncture			
Hypnosis			
Biofeedback			
Chiropractic Manipulation			

PRIOR PAIN MEDICATIONS:

Please check all medications you have used in the past for treatment of pain. These are listed by class of medications.

OPIOIDS

NSAIDs / TYLENOL

MUSCLE RELAXANTS

- Hydrocodone (Vicodin)
- Propoxyphene (Darvocet)
- Codeine
- Fentanyl (Duragesic)
- Dilaudid
- Morphine / MSContin
- Demerol
- Levodromoran
- Methadone
- Oxycodone (Percocet)
- Oxycontin
- Stadol
- Talvein
- Tramadol
- Nucynta

- Tylenol
- Aspirin
- Motrin
- Naproxen
- Daypro
- Salsalate /
- Feidene
- Indocin
- Lodine
- Orudis
- Reiafen
- Celebrex
- Vicox
- Toradol

- Some
- Parafon Forte
- Flexeril
- Baclofen
- Zanaflex
- Robaxin
- Sketamin
- Valium (Diazepam)

ANTIDPRESSANTS

- Elavil
- Parnelor (Nortriptyline)
- Desipramine
- Imipramine (Tofranil)
- Zoloft

- Paxil
- Prozac
- Serzone

OTHER

- Neurontin
- Tegretol
- Difantin
- Depakote
- Klonopin

- Xanax
- Ativan
- Mexilitine
- Imitrex
- Ergotamine

PAST MEDICAL HISTORY:

Have you had any of the following health problems (Please check all that apply)?

- Hypertension
 - Heart Attack
 - Emphysema
 - Stroke
 - Depression
 - HIV
 - Arthritis – Specify Location _____
 - Cancer – Specify Type _____
 - Other – Specify _____
- Coronary Artery Disease
 - Diabetes
 - Kidney Disease
 - Seizure or epilepsy
 - Anodety
 - Hepatitis C
- Angina or Chest Pain
 - Astima or Wheezing
 - Liver Disease
 - Bleeding Problems
 - Thyroid Disease

PAST SURGICAL HISTORY:

DATE (APPROXIMATE)	TYPE OF OPERATION

CURRENT MEDICATIONS FOR PAIN:

NAME	DOSE	FREQUENCY

MY PAIN MEDICATIONS PROVIDE RELIEF:

- None of the time Some of the time Most of the time
 All the time

SIDE EFFECTS FROM THESE MEDICATIONS INCLUDE:

- Itching Nausea Vomiting Constipation
 Sedation Stomach Upset
 Other (Please Specify) _____

CURRENT MEDICATIONS (Other Than Analgesics):

NAME	DOSE	FREQUENCY

ALLERGIES:

Please indicate the name of any medications to which you are allergic:

What type of reaction did you have _____

Are you allergic to contrast dye used for X – rays Yes No

REVIEW OF SYSTEMS:

Please check all items you feel are applicable to you:

- | | | |
|---|--|---|
| <input type="checkbox"/> Recent significant gain of weight _____ pounds over _____ weeks/months/years | | |
| <input type="checkbox"/> Recent significant loss of weight _____ pounds over _____ weeks/months/years | | |
| <input type="checkbox"/> Fever | | |
| <input type="checkbox"/> Dizziness | | |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> Double or blurry vision | <input type="checkbox"/> Seizures | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Easy or excessive bruising | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Easy or excessive bleeding | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Skin ulceration | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Difficulty imitating urine stream | <input type="checkbox"/> Adrenal disease | |
| <input type="checkbox"/> Genital pain | <input type="checkbox"/> Hypothyroidism | |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hyperthyroidism | |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Joint stiffness | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Decreased range of motion | |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pain in extremity (Specify) _____ | |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Swelling (Specify) _____ | |

SOCIAL HISTORY:

EDUCATION: Your highest education level achieved:

- Graduate or professional training
- College graduate
- Partial college training
- High school graduate
- GED or trade – technical school graduate
- Partial high school (10th grade thru partial 12th)
- Partial junior high school (7th grade through 9th grade)
- Elementary school

EMPLOYMENT: Your current or most recent occupation:

- Semi-skilled or unskilled (e.g. Waitress, assembler)
- Skilled trade or clerical (e.g. Carpenter, electrician, truck driver, secretary)
- Business executive or managerial
- Professional (e.g. Lawyer, teacher, nurse, physician, psychologist)
- Homemaker
- Other: (Please specify) _____

LEGAL ISSUES: Please indicate any of the following claims you have filed related to your pain problem:

- Worker's compensation
- Personal Injury / Liability
- Social Security Disability Insurance (SSDI)
- Other Insurance

SLEEP DISTURBANCE:

- | | | |
|---|------------------------------|-----------------------------|
| <input type="checkbox"/> Do you have difficulty falling asleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Do you have difficulty remaining asleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Are you ever awakened by pain? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you use any sleep – aids, please specify _____

FAMILY LIFE: Please specify living

- | | |
|--|--|
| <input type="checkbox"/> Living alone | |
| <input type="checkbox"/> Living with spouse / partner | <input type="checkbox"/> Living with friends |
| <input type="checkbox"/> Living with spouse / partner and children | <input type="checkbox"/> Living with other |
| <input type="checkbox"/> Living with children | |

PSYCHOLOGICAL TREATMENT:

Have you ever had psychological, or social work evaluation or treatment for any problems, including your current pain? Yes No

For what diagnosis were you treated? _____
When? _____

Please list your current or last therapist's _____

- | | | | |
|-----------------------------------|------------------------------|-----------------------------|-------------|
| Have you ever considered suicide? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| Have you ever planned suicide? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| Have you ever attempted suicide? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |

SUBSTANCE ABUSE:

Have you ever been a smoker? Yes – current Yes – In past No – never

If you smoke, how many packs per day? _____ Packs per day

For how many years did you smoke? _____ Years

How long ago did you quit? _____ Years

Do you have a history of alcoholism Yes No Current Problem?

Have you abused prescription analgesics? Yes No Current Problem?

Cocaine or intravenous substance abuse? Yes No Current Problem?

How many years has it been since you abused alcohol or drugs _____ years.

If you have a history of alcoholism, have you ever been enrolled in Alcoholics Anonymous? Yes No When _____

If you have a history of substance abuse, have you ever been in a detoxification program? Yes No When _____

FAMILY HISTORY: Please specify any medical or psychiatric conditions common in your family and who suffers with these ailments:

Condition: _____ Specific family member(s) _____

Condition: _____ Specific family member(s) _____

Condition: _____ Specific family member(s) _____

Condition: _____ Specific family member(s) _____

PHYSICAL EXAMINATION:

How much do you weigh? _____ Pounds
How tall are you? _____ Feet _____ Inches
Blood Pressure _____
Heart Rate _____
Respiratory Rate _____
Temp _____
Pain VAS _____

PHYSICAL EXAMINATION:

HEENT: Head: Atraumatic Nomo cephalic Other: _____
Pupils: Equal, Round
 Reactive and able accommodate Other: _____
Neck: Supple without masses Other: _____
Thyroid: Not Enlarged Enlarged
 Mass detected Other: _____
HEART: Regular Rate & Rhythm S1, S2 present Other: _____
LUNGS: Clear to auscultation bilaterally Wheeze Other: _____
ABDOMEN: Soft, non- tender, non-distended with normal active bowel sounds
 Other: _____
NEURO: Gait: Normal Antalgic
Higher intelligence: Intact CN II-XII Other: _____
Motor Intact Other: _____
Sensory Intact to touch and pinprick Other: _____
Reflexes Normal Reduced Hyper Specify _____

Diagnostic Testing:

Diagnosis:

Recommendations / Treatment Plan: