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INITIAL COMPREHESSIVE PAIN QUESTIONAIRE

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: _____Cell Phone: _____
Email Address: Pharmacy:

Referring Physician: _____
PCP and 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):

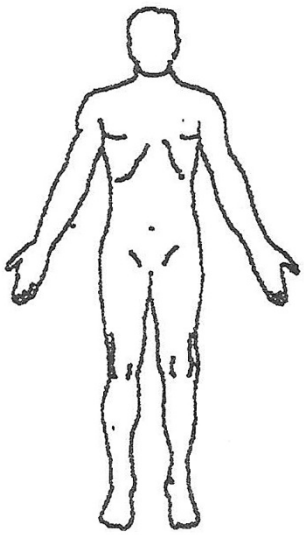
☐ Burning ☐ Sharp ☐ Cutting ☐ Throbbing
☐ Cramping ☐ Dull / Aching ☐ Pressure – like
☐ Shooting ☐ Other (Describe) _____

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

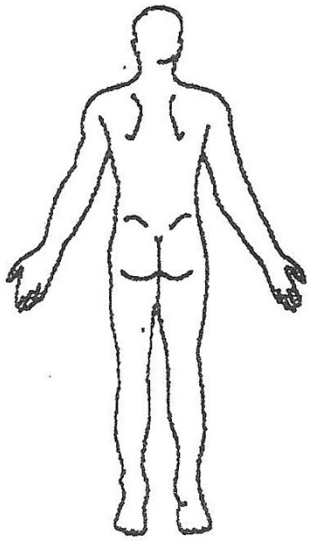
☐ Numbness I feel sensations in the ☐ same ☐ different areas than the pain.
☐ Pins and needles I feel sensations in the ☐ same ☐ different areas than the pain.
☐ Hair loss / skin changes / nail changes in extremities.

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 and "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 DOWWN			
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.

☐

OPIODS

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

NSAIDs / TYLENOL

☐ Tylenol
☐ Aspirin
☐ Motrin
☐ Naproxen
☐ Daypro
☐ Salsalate /
☐ Feidene
☐ Indocin
☐ Lodine
☐ Orudis
☐ Reiafen
☐ Celebrex
☐ Vicoxx
☐ Toradol

MUSCLE RELAOCANTS

☐ Some
☐ Parafon Forte
☐ Flexeril
☐ Baciofen
☐ Zanaflex
☐ Robaxin
☐ Skelaxin
☐ Valium (Diazepam)

ANTIDPRESSANTS

- ☐ Elavil
- ☐ Pamelor (Nortriptyline)
- ☐ Desipramine
- ☐ Imipramine (Totranil)
- ☐ Imitrex
- ☐ Paxil
- ☐ Prozac
- ☐ Serzone

OTHER

- ☐ Neurontin
- ☐ Tegretol
- ☐ Difantin
- ☐ Depakote
- ☐ Klonopin
- ☐ Xanax
- ☐ Ativan
- ☐ Mexilitine
- ☐ Zoloft
- ☐ 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
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Seizure or epilepsy
- ☐ Anxiety
- ☐ Hepatitis C
- ☐ Angina or Chest Pain
- ☐ Asthma or Wheezing
- ☐ Liver Disease
- ☐ Bleeding Problems
- ☐ Thyroid Disease
- ☐ Arthritis – Specify Location_____
- ☐ Cancer – Specify Type _____

Other – Specify _____

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:

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

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 ISSUUES: 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:

- ☐ Do you have difficulty falling asleep? ☐ Yes ☐ No
- ☐ Do you have difficulty remaining asleep? ☐ Yes ☐ No
- ☐ Are you ever awakened by pain? ☐ Yes ☐ No

If you use any sleep – aids, please specify_____

FAMILY LIFE: Please specify living

- ☐ Living alone
- ☐ Living with spouse / partner
- ☐ Living with spouse / partner and children
- ☐ Living with children
- ☐ Living with friends
- ☐ Living with other

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? ☐ Yes ☐ No When? _____

Have you ever planned suicide? ☐ Yes ☐ No When? _____

Have you ever attempted suicide? ☐ Yes ☐ 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 aliments:

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: Galt: ☐ 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: