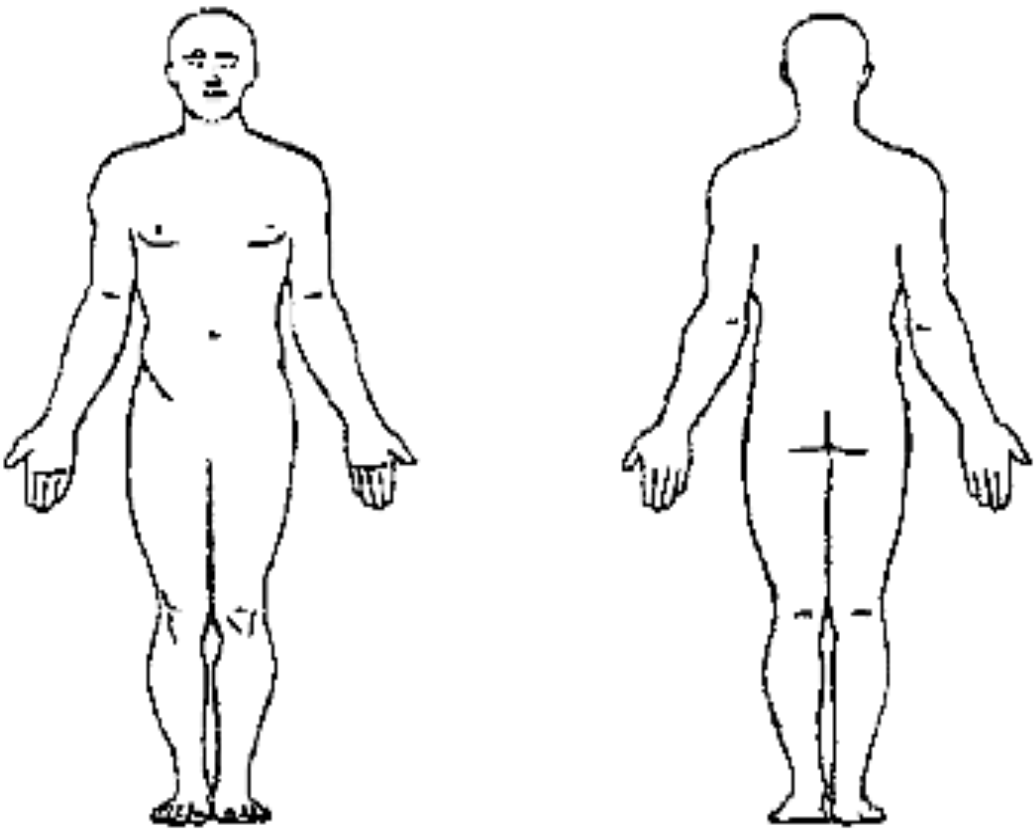
PAIN SOLUTIONS
NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DATE_____

Primary Doctor: _____Referring Doctor: _____

Please show the location of your pain by drawing on the figures below:



Pain History (PLEASE FILL IN THE BUBBLES)

1. **WHERE IS YOUR PAIN LOCATED?** O Low Back O Neck O Mid-back O Face O Head
   O Right arm O Left arm O Right leg O Left leg

2. **WHERE DOES THE PAIN RADIATE?** O Right leg O Left leg O Both legs O Right arm
   O Left arm O Both arms O Other _____

3. **THE PAIN FIRST STARTED:**
   O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10
   O days ago O weeks ago O months ago O years ago O other _____

   Was there an accident or injury that caused the pain? O **NO**
   O **YES** _____

4. **HOW WOULD YOU DESCRIBE YOUR PAIN?** (mark all that apply)
   O aching O throbbing O sharp O dull O nagging O shooting O burning
   O numb O tingling O stabbing O Other _____

5. **RATE YOUR PAIN AT IT'S <u>WORST</u> IN THE LAST 24 HOURS?**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

6. **RATE YOUR PAIN AT IT'S <u>BEST</u> IN THE LAST 24 HOURS?**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

7. **HOW SEVERE IS YOUR PAIN <u>ON AVERAGE</u>?**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

8. **HOW MUCH DOES THE PAIN INTERFERE WITH YOUR ACTIVITIES?**

0%	10	20	30	40	50	60	70	80	90	100%
No Interference										Completely Interferes

9. **HOW MUCH DOES THE PAIN INTERFERE WITH YOUR SLEEP?**

0%	10	20	30	40	50	60	70	80	90	100%
No Interference										Completely Interferes

10. **THE PAIN IS:** O constant O intermittent O worse in am O worse in afternoon
    O worse in evening O worse at night

11. **WHAT MAKES THE PAIN WORSE?** O standing O walking O sitting
    O lifting O bending over O other_____

12. **WHAT MAKES THE PAIN BETTER?** O standing O walking O bending

O lifting O sitting O lying down O ice O heat O medications
O other_____

13. **IN ADDITION TO THE PAIN, DO YOU HAVE?** O Numbness O Weakness
O In the right arm O In the left arm O In both arms O In the right leg O In the left leg
O In both legs O New bladder incontinence O New bowel incontinence O None of these

14. **IS YOUR PAIN:** O getting better O getting worse O staying about the same

15. **WHAT TESTS HAVE YOU HAD FOR YOUR PAIN? (Please list date of last exam)**

O X-rays _____ O MRI Scan_____ O CT Scan_____
O EMG_____ O Other _____

16. **WHAT MEDICATIONS HAVE YOU TRIED FOR YOUR PAIN? (Check ALL that apply)**

Anti-Inflammatory:	O Ibuprofen (Advil, Motrin)	O Naproxen	O Celebrex	O Aspirin	
	O Relafen	O Meloxicam (Mobic)	O Indomethicin		
Narcotic:	O Morphine	O Avinza	O MSIR	O MS Contin	O Kadian
	O Dilaudid	O Oxycodone	O Oxycontin	O Percocet	O Percodan
	O Darvocet	O Darvon	O Hydrocodone	O Vicodin	O Lortab
	O Lorcet	O Norco	O Fentanyl	O Duragesic	O Actiq
	O Fentora	O Codeine	O Tramadol	O Ultram	O Stadol
Antidepressants	O Duloxetine (Cymbalta)		O Fluoxetine (Prozac)	O Escitalopram (Lexapro)	
	O Trazodone (Deseryl)		O Venflaxine (Effexor)	O Sertraline (Zoloft)	
	O Amitriptyline (Elavil)		O Nortriptyline (Pamelor)	O Desipramine (Norpramine)	
	O Buproprion (Wellbutrin)		O Citalopram (Celexa)	O Paroxetine (Paxil)	
	O Nefazodone (Serzone)				
Anti-Seizure	O Gabapentin (Neurontin)		O Pregabalin (Lyrica)	O Zonisamide (Zonegram)	
	O Carbamazepine (Tegretol)		O Lamotrigine (Lamictal)	O Oxycarbazepine (Trileptal)	
	O Tiagabine (Gabatril)		O Topiramate (Topamax)		
Muscle Relaxants/	O Baclofen (Lioresal)		O Tizanidine (Zanaflex)	O Metaxolone (Skelaxin)	
Anti-Anxiety	O Cyclobenzaprine (Flexeril)		O Methocarbamol (Robaxin)	O Carisoprodol (Soma)	
	O Diazepam (Valium)		O Clonazepam (Klonopin)	O Alprazolam (Xanax)	
Sleeping Aids	O Zolpidem (Ambien)		O Eszopiclone (Lunesta)	O Zalepion (Sonata)	
	O Trazodone (Deseryl)		O Amitriptyline (Elavil)	O Temazepam (Restoril)	
	O Triazolam (Halcion)		O Tylenol – PM		
Other Pain Meds	O Lidoderm Patch	O Flector Patch	O Topical Gel	O Mirapex	

17. **WHAT TREATMENTS HAVE YOU HAD FOR YOUR PAIN?**

O Physical therapy O Water Therapy O Traction O Exercise O Yoga O Psychology
O Acupuncture O Chiropractic O Massage O TENS O Biofeedback O Hypnosis
O Rolfing O Trigger Point Injections O Facet Injections O Epidural Injections
O Nerve Blocks O Spinal Pump O Spinal Cord Stimulator
O Other _____

Past Medical History (Please Fill in "yes" or "no" to all questions)

CARDIOVASCULAR

Cardiac Arrythmia	O Yes	O No
Heart Attack	O Yes	O No
Coronary Artery Disease	O Yes	O No
Atrial fibrillation	O Yes	O No
Mitral Valve Prolapse	O Yes	O No
Congestive Heart Failure	O Yes	O No
High Blood Pressure	O Yes	O No
High Cholesterol	O Yes	O No
DVT (blood clot)	O Yes	O No

RESPIRATORY

Asthma	O Yes	O No
COPD - Emphysema	O Yes	O No
Sleep apnea	O Yes	O No

NEUROLOGY

TMJ	O Yes	O No
Seizures	O Yes	O No
Trigeminal Neuralgia	O Yes	O No
Headache - Migraines	O Yes	O No
Headache - Tension	O Yes	O No
Headache - Cluster	O Yes	O No
Post-herpetic Neuralgia	O Yes	O No
Multiple Sclerosis	O Yes	O No
Myasthenia Gravis	O Yes	O No
Stroke	O Yes	O No

PSYCH

Anxiety/depression	O Yes	O No
Bipolar Disorder	O Yes	O No
Schizophrenia	O Yes	O No
Dementia	O Yes	O No

GASTOINTESTINAL

Irritable bowel syndrome	O Yes	O No
Peptic ulcer disease	O Yes	O No
Indigestion/acid reflux	O Yes	O No
Hiatus hernia	O Yes	O No
Hepatitis B	O Yes	O No
Hepatitis C	O Yes	O No
Ulcerative Colitis	O Yes	O No

OTHER

Kidney stones	O Yes	O No
Kidney Failure	O Yes	O No
Kidney Disease	O Yes	O No
Hypothyroidism	O Yes	O No
Lupus	O Yes	O No
Cancer	O Yes	O No
What kind?_____		
Osteoporosis	O Yes	O No
Fibromyalgia	O Yes	O No
Arthritis - Rheumatoid	O Yes	O No
Osteoarthritis	O Yes	O No
RSD	O Yes	O No
Anemia	O Yes	O No
Diabetes(insulin)	O Yes	O No
Diabetes(no insulin)	O Yes	O No

Social History

Do you drink Alcohol?	O No O Yes	O Occasionally O daily O weekly
Do you smoke?	O No O Yes	O <1ppd O 1ppd O 2ppd O 3ppd
Do you exercise?	O No O Yes	
Do you work?	O No O Yes	O Full-time O Part-time O Unemployed due to pair
		O Homemaker O Retired Occupation_____
Do you use Illegal Drugs?	O No O Yes	O Used in the past
		Drug(s) Used _____

OTHER SYMPTOMS (Please indicate other symptoms you may have)

CONSTITUTIONAL

Fever	O Yes O No
Fatigue	O Yes O No
Insomnia	O Yes O No
Weight loss	O Yes O No
Weight gain	O Yes O No
Loss of Appetite	O Yes O No

GI

Blood in stool	O Yes O No
Diarrhea	O Yes O No
Vomiting	O Yes O No
Constipation	O Yes O No
Nausea	O Yes O No
Difficulty swallowing	O Yes O No
Abdominal pain	O Yes O No
Heartburn	O Yes O No

CARDIOVASCULAR

Dizziness	O Yes O No
Chest pain	O Yes O No
Palpitations	O Yes O No
Leg swelling	O Yes O No
Shortness of breath	O Yes O No

ENT

Cough	O Yes O No

HEMATOLOGY

Abnormal bruising	O Yes O No
Abnormal bleeding	O Yes O No

NEUROLOGY

Seizures	O Yes O No
Headache	O Yes O No
Memory loss	O Yes O No
Numbness	O Yes O No
Where?_____	

URINARY

Urinary retention	O Yes O No
Incontinence	O Yes O No

RESPIRATORY

Wheezing	O Yes O No

MUSCULOSKELETAL

Joint pain	O Yes O No
Joint stiffness	O Yes O No
Back pain	O Yes O No
Muscle weakness	O Yes O No

PSYCH

Depression	O Yes O No
Sleep disturbances	O Yes O No
Suicidal ideation	O Yes O No
Anxiety	O Yes O No

CURRENT MEDICATIONS (Include dosage and # tablets per day)

Have you had any surgeries? _____
_____
_____

Are you taking any of the following blood thinners? ___ **Coumadin** ___ **Plavix**

Do you have any <u>allergies to medications?</u> ___ **Latex** ___ **Iodine**

__**Other Medications?** _____

What are your goals for your pain treatment?
_____
_____

Are there any specific treatments that you would like for your pain?

Medications: _____
Physical Therapy: _____
Exercise: _____
Psychologist referral: _____
Surgery referral _____
Injections: _____

Other pain therapies: (Please circle)

acupuncture chiropractic massage TENS

DRX9000 Pool exercise biofeedback Other _____

Do you have a driver with you today? __ **yes** __ **no**

THIS IS THE END OF THE QUESTIONNAIRE. THANK YOU!