

PATIENT INFORMATION QUESTIONNAIRE

Name: _____ Date of Birth _____
Last First Middle

Sex: _____ (male, female, male-to-female, female-to-male) Preferred pronouns: _____

Referring Physician

Practice Name: _____
 Physicians Name: _____
 Address: _____
 Phone: _____

Primary Care Physician

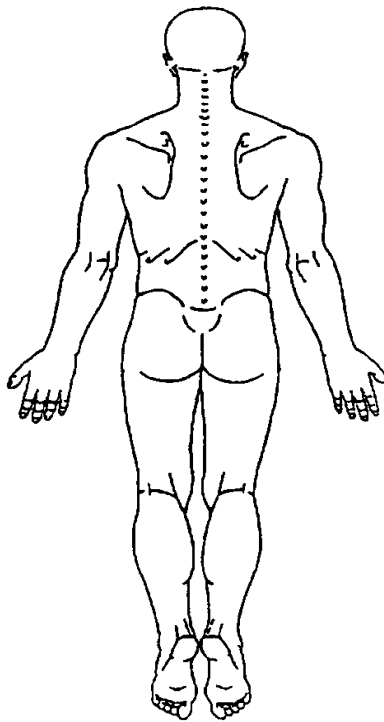
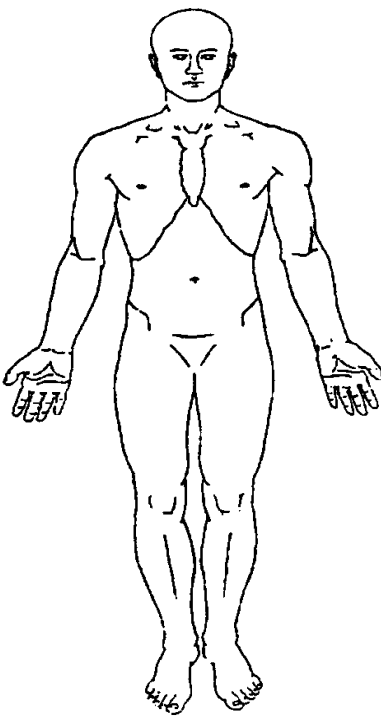
Practice Name: _____
 Physicians Name: _____
 Address: _____
 Phone: _____

Describe your most disabling/severe pain:

right left

left right

Approximately when did your pain begin?

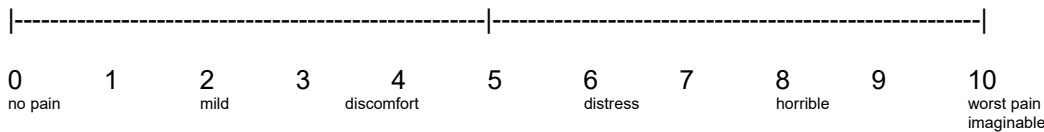


Describe the circumstances around the beginning of your pain (e.g. type of injury or trauma or surgery, etc):

Does the pain radiate anywhere? If so, where?

Please mark the area(s) on the diagram in which you are in pain.

Circle the number that best describes how severe your pain is currently?



Based on this scale what number (0-10) is your pain at its best? _____ and at its worst? _____

How long has this episode of pain been going on?

- < 1 week 1-4 wks 1-3 months
 3-6 months 6-12 months > 1 year

How often does the pain occur?

- Continuously Several times per day
 Intermittent Occasionally Less than daily

How has the pain intensity changed since it began? Increased Decreased No change

Select one or more items below to describe the nature of your pain:

Throbbing Shooting Sharp Cramping Hot/burning Aching Stabbing
Other: _____

Is the pain associated with any other symptoms (numbness/tingling/weakness/incontinence/etc.)?

How do the following factors affect your pain? (check one blank per number)

	Better	Worse	No effect		Better	Worse	No effect
1. Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Stairclimbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Lifting objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Other: _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Which of the following activities are affected by your pain?

Falling asleep Social Interaction Household Chores
 Staying asleep Sexual Activity Work/School Leisure

What goals do you wish to achieve with pain management?

Give the dates of the tests you have had to diagnose your pain:

X-rays _____ Myelogram _____
CT Scan _____ Nerve conduction/EMG _____
MRI _____ Other _____

List the name(s) of other specialists including previous pain clinics/specialists you have seen for you pain:

Name	Specialty	Dates seen
_____	_____	_____
_____	_____	_____
_____	_____	_____

Give the dates of treatments you have had for your pain

Acupuncture _____	Exercise _____	Physical Therapy _____
Biofeedback _____	Facet block _____	Psychotherapy _____
Brace _____	Hypnosis _____	Surgery _____
Chiropractor _____	Massage _____	TENS unit _____
Epidural _____	Nerve block _____	Trigger Point _____
Other _____		

Do you have any drug allergies?

No known drug allergies **Yes** (please list drug and reaction):

List all medications you are currently taking:

Medication	Dose	Frequency	Medication	Dose	Frequency
1. _____			9. _____		
2. _____			10. _____		
3. _____			11. _____		
4. _____			12. _____		
5. _____			13. _____		
6. _____			14. _____		
7. _____			15. _____		
8. _____			16. _____		

Past pain medications tried with dosage and duration of treatment:

Past Surgical History

Surgery	Year	Surgery	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Please check any of the conditions below that run in your family:

- Arthritis
 Stroke
 Depression
 Diabetes
 Heart disease
 Lupus
 Cancer -type: _____
 Other: _____

Past Medical History

Review of Systems

Constitutional

- Obesity
 Weight Gain
 Chills
 Fever
 Weight loss
 Night Sweats
 Fatigue

Musculoskeletal

- Osteoarthritis
 Rheumatoid arthritis
 Fibromyalgia
 Numbness
 Weakness

Neurological

- Headache
 Seizures
 Confusion
 Light sensitivity
 Migraines
 Stroke
 Dizziness
 Loss of consciousness

Psychiatric

- Depression
 Substance use
 Anxiety
 Suicidal thoughts
 Difficulty Sleeping
 disorder

Cardiovascular

- Angina
 Heart Stent
 Chest Pain
 Palpitations
 Heart Attack
 Pacemaker

Respiratory

- Asthma
 Emphysema
 Shortness of breath

Gastrointestinal

- Reflux Hepatitis Abdominal Pain Diarrhea
 Incontinence Ulcers Bloating Heartburn
 Irritable bowel syndrome Constipation Nausea

Genitourinary

- Impotence Kidney stones Decreased libido Urinary frequency
 Urinary Incontinence Urinary tract infection Prostate problems Urinary hesitancy

Integumentary

- Herpes Zoster Skin Cancer Rash Swelling

Endocrine, Hematologic, Allergy/Immunologic, HEENT

- Cancer: _____ HIV Bruise easily Visual changes
 Diabetes Thyroid problems Ringing in ears

Rheumatologic

- Lupus Polymyalgia Rheumatica Other: _____

Social History

Please list everyone with whom you live:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which of the following describes your marital status?

- Single Married
 Separated Divorced
 Widow(er) Other: _____

What is your employment status? (Current or former profession: _____)

- Full time Part time On disability Retired Workman's Comp Unemployed

How much education have you completed? Grade-yrs____; high school; college; other: _____

Do you have pending settlement for disability, workman's comp or a legal matter? Y N

Do you use or have used at any time any of the following?

- Alcohol Tobacco products Recreational Drugs (including narcotics)
 Yes No Yes No Yes No
 Present Past Present Past Present Past

Please list: _____



Services and Treatment Policy

We are pleased that your physician has requested a consultation for you at the Rex Hospital Pain Management Center. Our goal is to provide you with a proper diagnosis and plan for the most effective treatment of your pain.

We expect that you may have had previous attempts to treat your pain prior to your consultation with us. In some instances, the use of pain medications on a long-term basis is appropriate. However, the Rex Hospital Pain Management Center is not obligated to prescribe narcotic drugs or provide any treatment procedures during your consultation with us. We firmly believe it is in your best interest to have a complete evaluation to determine the most effective method to reduce pain and restore function. Continuing a therapy that does not achieve those goals would defeat the purpose of the evaluation. Additionally, please do not terminate care with another physician because you have an appointment in the Rex Hospital Pain Management Center. Based on the outcome of your evaluation, we may make recommendations to your current physicians without arranging further follow-up in the Rex Hospital Pain Management Center.

Unfortunately, many conditions, which cause chronic pain also, cause disability. The process of disability evaluation and filing of claims is quite extensive. At the current time, the Rex Hospital Pain Management Center does not perform disability evaluations. Your referring physician should be able to assist you in coordinating disability evaluations when appropriate.

Appointment Policy

If you are unable to make your scheduled appointment, you must call to cancel the appointment no later than 24 hours before the scheduled time. Repeated “no shows” and cancellations of your scheduled appointments may result in your being discharged from care at the Rex Hospital Pain Management Center. You will be referred back to your primary care physician or to another chronic pain management facility.

My signature below confirms that I have read and agree to abide by the above policies.

Patient Signature _____

Date _____