Folsom Pain Management

NEW PATIENT QUESTIONNAIRE

PATIENT NAME:____ DATE OF BIRTH:__________________

Thank you for taking the time to answer this questionnaire; it will help us in addressing your pain problems.

1. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor
2. Referring doctor: _______________________ Primary care doctor: _______________________
3. When did your pain problem begin? Month: _____________________ Year: ________________
4. How did your pain first start? (for example, car accident, fall, job function, sports injury, etc.):
   ____
   ____
5. Is your pain constant or intermittent? ☐ Constant ☐ Comes and goes
6. Are you involved in legal action or a disability claim related to your pain problem, or considering legal action in the future? ☐ Yes ☐ No
   If yes, please describe the current state of litigation: ____________________________________
   ____
   ____

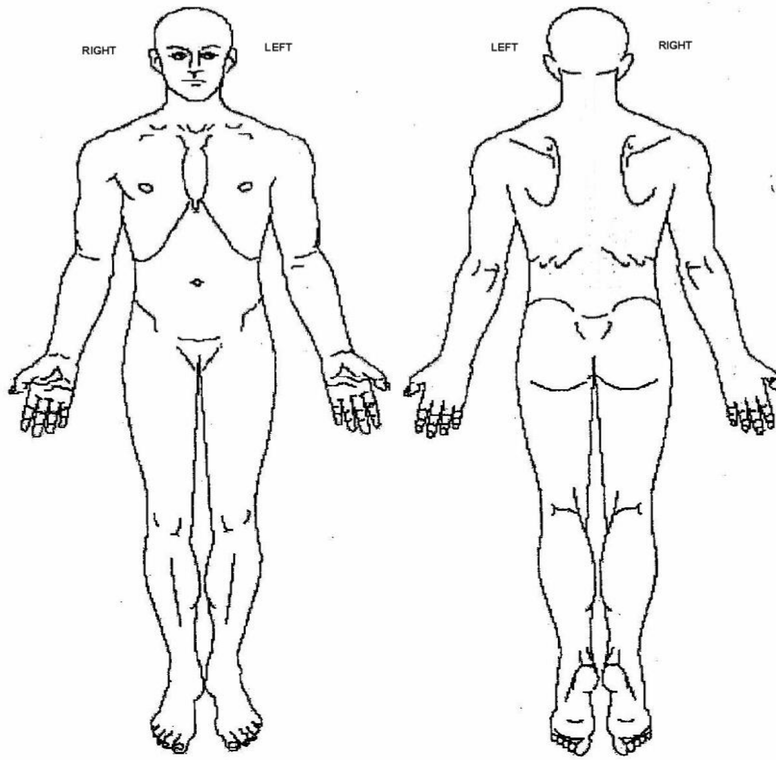
For the following, please **circle** an appropriate number, 0 being **Not able to** and 10 being **Very able to**.

7. Rate your ability to ***cope*** with your pain:
   0 1 2 3 4 5 6 7 8 9 10
8. Rate your ability to ***perform activities of daily living*** (hygiene, household chores, transportation, etc.):
   0 1 2 3 4 5 6 7 8 9 10
9. Rate your ability to ***function and interact*** with friends and family:
   0 1 2 3 4 5 6 7 8 9 10
10. Rate your ability to ***work in your usual occupation***:
    0 1 2 3 4 5 6 7 8 9 10

For the following, please **circle** an appropriate number, 0 being **No pain whatsoever** and 10 being **Worst pain imaginable**.

11. **Current** level of pain: 0 1 2 3 4 5 6 7 8 9 10
12. **Worst** pain you've experienced: 0 1 2 3 4 5 6 7 8 9 10
13. **Least** pain you've experienced: 0 1 2 3 4 5 6 7 8 9 10
14. **Average** level of pain (day to day): 0 1 2 3 4 5 6 7 8 9 10

15. Use the figures below to shade in and mark the areas where you have pain. If your pain moves around, put an “X” where it starts, and draw an arrow to where it spreads.



16. Please check all words that describe your pain:

☐ Aching ☐ Sharp ☐ Penetrating ☐ Throbbing ☐ Gnawing
☐ Tender ☐ Nagging ☐ Shooting ☐ Burning ☐ Tiring
☐ Stabbing ☐ Exhausting ☐ Miserable ☐ Unbearable ☐ Numbness/Tingling

If the above words do not describe your pain sufficiently, please do so here in your own words:
____
____
____
____

17. Please check all areas of your life that have been affected by your pain problem:

☐ Work ☐ Relationships ☐ Physical Activity ☐ Use of Alcohol
☐ Sleep ☐ Finances ☐ Emotions & Mood ☐ Use of recreational drugs
☐ Appetite ☐ Concentration ☐ Other

If you checked *other*, please give any details here: _____________________________________
____
____

18. What influences your pain? Please check the column that applies for each activity…

Activity	Relieves	Worsens	Makes No Difference	Comments
Exercise				
Walking				
Massage				
Sitting				
Standing				
Touch				
Heat Pack / Pad				
Ice Pack				
Temperature (hot)				
Temperature (cold)				
Weather				
Bright Lights				
Eating				
Alcohol				
Emotional Stress				
Urination				
Defecation (bowel movements)				
Noise				
People				
Music				
Sleeping				
Sexual Activity				
Menstrual Cycle				
Medicines				
Rolling in Bed / Sleep Position				
Moving from Sitting to Standing				
Stairs				
Other (explain)				

19. What treatments have you had for your pain? Please check the column that applies for each treatment…

Treatment	Helpful	Not Helpful	Comments
Surgery			
Nerve Block(s)			
Epidural Steroids			
Back Injections			
Acupuncture			
Trigger Point Injection(s)			
TENS Unit			
Heat/Ice Treatments			
Biofeedback			
Hypnosis			
Counseling			
Physical Therapy			
Traction			
Chiropractic Treatment			
Occupational Therapy			
Medication Regimen			
Other (explain)			

20. Current medications you are taking (prescription, over-the-counter, or homeopathic):

Medication	Dosage (amount / how often)	Ordering Doctor	Comments (Effectiveness / Side Effects)

21. Past medications you have taken specifically for pain: ________________________________
____
____
____

Examples of pain medications include:

Opioids: Fentanyl (Actiq, Duragesic), Demerol, Hydrocodone (Vicodin, Lortab, Norco), Tramadol, Morphine, Oxymorphone, Methadone, Oxycodone, Hydromorphone, Tapentadol, Propoxyphene (Darvocet), Buprenorphine (Suboxone, Subutex), Codeine

Anti---Inflammatories / Tylenol: Diclofenac, Oxaprozin, Meloxicam, Nabumetone, Aspirin, Indomethacin, Ibuprofen, Acetaminophen, Celecoxib, Etodolac, Naproxen, Flector patch

Muscle Relaxants: Baclofen, Methocarbamol (Robaxin), Carisoprodol (Soma), Cyclobenzaprine (Flexeril), Metaxalone (Skelaxin), Tizanidine (Zanaflex)

Antidepressants: Cymbalta, Nortriptyline, Remeron, Wellbutrin, Effexor, Paxil, Serzone, Zoloft, Amitriptyline, Pristiq, Imipramine (Tofranil), Lexapro, Fluoxetine (Prozac), Trazodone

Sleep Aids: Zolpidem (Ambien), Lunesta, Rozerem, Xyrem, Restoril, Sonata

Other: Axert, Hydroxyzine, Lyrica (Pregablin), Tegretol, Zonegran, Buspar, Imitrex, Maxalt, Topamax, Frova, Keppra, Gabapentin (Neurontin), Vistaril, Gabitril, Lidoderm Patch, Relpax, Zomig.

22. All known drug / medication allergies: ____
____

23. All past surgeries: ____
____

24. All current medical issues (for instance, diabetes, heart disease, hepatitis): ________________
____

25. Any family history of (check all that apply):

☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Substance Abuse ☐ Chronic Pain

26. Diagnostic tests you've taken (with approximate date on which it was done):

Test Type	For Body Part	Date Done	Location
X-Ray			
MRI			
CT Scan			
EMG / Nerve Conduction			
Myelogram			

27. Do you smoke? ☐ No ☐ Yes, ________ packs per day

28. Do you drink alcohol? ☐ No ☐ Yes, the amount/frequency being ________________________

29. Do you exercise regularly? ☐ No ☐ Yes, the type/frequency being ______________________

30. Do you take recreational / illicit drugs? ☐ No ☐ Yes, the last time being _________________

31. Please circle any of the following known health issues you contend with:

General:	Weight change	Fever	Fatigue		
Head:	Visual	Hearing	Headaches	Dizziness / Lightheadedness	
Lungs:	Asthma	Bronchitis	COPD	SOB	
Heart:	High Blood Pressure	Heart Attack	Chest Pain	On Blood Thinner	
GI:	Reflux	Hiatal Hernia	Constipation	Liver Disease	Diarrhea
GU:	Kidney Disease	Prostate Disease	GYN Disease		
Endocrine:	Diabetes	Thyroid Disease			
Muscular:	Arthritis	Fibromyalgia	Osteoporosis	Back Pain	Neck Pain
Neuro:	Stroke	Seizures	Headaches		
Psych:	Depression	Substance Abuse	Anxiety	Other	