CONSULTATION QUESTIONNAIRE

OREGON INTERVENTIONAL PAIN CONSULTANTS

Patient Name: _____ Date: _____

Please complete this form prior to your appointment. If this questionnaire is not completed prior to your appointment, you will be rescheduled to allow for a complete pain consultation

Date of Birth: _____ Sex: ( ) Male ( ) Female Pronouns: _____
Height: _____"_____ Current Weight (lbs): _____ Referring Provider: _____
Current Pharmacy Name: _____ Pharmacy City/Location: _____

1. What is the main reason for your referral to this practice? (*describe below*)

_____
_____
_____

2. When did your pain problems begin? (*Please provide the date of injury, year, or your age when pain began*)

_____
_____
_____

3. Under what circumstances did your pain begin? (*Check one*)

[ ] Accident at work
[ ] At work, but not an accident
[ ] Accident at home
[ ] Pain just began with no known cause
[ ] Motor Vehicle Accident
[ ] Following surgery
[ ] Following illness
[ ] Other (describe): _____

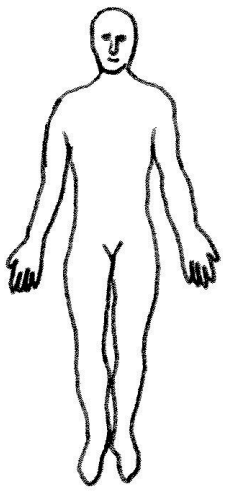
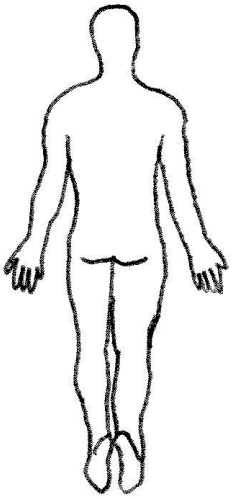
4. If you were injured, describe how: (*Check one and describe incident*)

[ ] Fall
[ ] Repetitive activity
[ ] Struck by falling or moving object
[ ] Lifting object
[ ] Pushing
[ ] Not injured
[ ] Other: _____

5. Diagnosis (*if known*): _____
_____

6. What do you feel is the cause of your pain? _____
_____
_____

7. Where is your pain? **Please place a <u>Descriptor Key</u> in the appropriate areas on the diagram below**

Right Left Left Right

Pain Description	Descriptor Key
Ache	> >
Numbness	. . . .
Pins & Needles	+ +
Burning	x x x x x x x x x x x x x x x x x x x x x x x x x x x x x x x x x x x x x
Stabbing	/ /

8. Location of Pain: (*<u>Check any terms that apply to your pain</u>*)

[ ] Superficial [ ] Deep [ ] Joints [ ] Nerves

[ ] Skin [ ] Muscular [ ] Bones [ ] Other: _____

9. Intensity of pain:

a) Please circle the number that describes your pain right **<u>NOW</u>**:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST PAIN

b) Please circle the number that describes your pain at its **<u>LEAST</u>**:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST PAIN

c) Please circle the number that describes your pain at its **<u>WORST</u>**:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST PAIN

d) Please circle the number that describes your pain on **<u>AVERAGE</u>**:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST PAIN

10. Is your pain ( ) constant or ( ) intermittent?

_____

_____

11. Is your pain worse at any particular time of day? ( ) No ( ) Yes- what time? (*describe below*)

_____

_____

12. What makes your pain *worse*? (*Check any terms that apply to your pain*)

[ ] Exercise	[ ] Climbing stairs	[ ] Work	[ ] Bending forward
[ ] Lifting	[ ] Driving	[ ] Sitting	[ ] Bending backward
[ ] Heat	[ ] Cold	[ ] Light touch	[ ] Stressful situations
[ ] Cough/sneeze	[ ] Walking	[ ] Standing	[ ] Sexual activity

[ ] Other: (describe) _____

13. What *relieves* the pain? (*Check any terms or action that decreases your pain*)

[ ] Lying down	[ ] Walking	[ ] Heat	[ ] Medications
[ ] Sitting	[ ] Exercise	[ ] Bath/shower	[ ] Other: (describe)
[ ] Standing	[ ] Ice	[ ] Physical therapy	_____

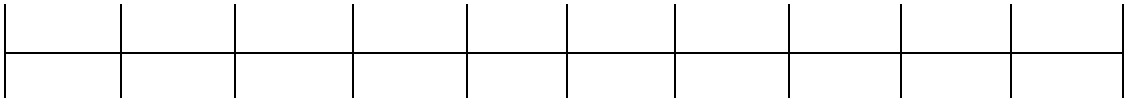
14. Have previous medications or therapies been helpful? Which ones?

Pain therapies tried (***check below if tried***):	Did it help?	How much? (%)
[ ] Medications	[ ] Yes [ ] No	_____
[ ] Surgery	[ ] Yes [ ] No	_____
[ ] Nerve blocks (injections)	[ ] Yes [ ] No	_____
[ ] Exercise	[ ] Yes [ ] No	_____
[ ] Manipulations	[ ] Yes [ ] No	_____
[ ] Physical therapy	[ ] Yes [ ] No	_____
[ ] Trigger point therapy	[ ] Yes [ ] No	_____
[ ] Acupuncture	[ ] Yes [ ] No	_____
[ ] TENS (electric stimulation)	[ ] Yes [ ] No	_____
[ ] Biofeedback/ relaxation	[ ] Yes [ ] No	_____
[ ] Yoga	[ ] Yes [ ] No	_____
[ ] Hypnosis	[ ] Yes [ ] No	_____
[ ] Group therapies	[ ] Yes [ ] No	_____
[ ] Psychology counseling	[ ] Yes [ ] No	_____
[ ] Pain management program	[ ] Yes [ ] No	_____

[ ] Other: (describe) _____

15. How much pain relief do your current pain medications provide? (*circle*)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



16. Do you have any numbness? ( ) No ( ) Yes- Where? (*describe below*)

_____
_____
_____

17. Do you have any weakness? ( ) No ( ) Yes- Where? (*describe below*)

_____
_____
_____

18. Is your pain associated with any swelling or color changes? ( ) No ( ) Yes- Where? (*describe below*)

_____
_____
_____

19. Have there been changes in your ability to urinate? ( ) No ( ) Yes- How? (*describe below*)

_____
_____
_____

20. Have there been changes in your ability to have bowel movements? ( ) No ( ) Yes- How? (*describe below*)

_____
_____
_____

21. Have there been changes in your sexual function due to your pain? ( ) No ( ) Yes- How? (*describe below*)

_____
_____
_____

22. Does pain delay your getting to sleep? ( ) No ( ) Yes- How often? (*describe below*)

_____
_____
_____

23. Does pain awaken you from sleep? ( ) No ( ) Yes- How often? (*describe below*)

_____
_____
_____

24. How much total sleep do you average each night? _____ hours

_____
_____
_____

25. In the past 6 months, how many full days of work have you missed because of pain? ( ) Not Applicable

_____

_____

_____

26. Have you visited the emergency room or been hospitalized for your pain? ( ) No ( ) Yes- number of times:_____

_____

_____

_____

27. How many physicians have you seen in effort to treat your pain? _____

_____

_____

_____

28. What medical tests have been done to evaluate your pain? (*please check test type and provide date*)

Test:	Date:	Results (if known):
[ ] Xray	_____	_____
[ ] CT Scan	_____	_____
[ ] Myelogram	_____	_____
[ ] MRI	_____	_____
[ ] Bone Scan	_____	_____
[ ] EMG	_____	_____
[ ] EKG	_____	_____
[ ] Other:	_____	_____

_____

_____

_____

_____

30. Do your medications cause you to have any side effects? ( ) No ( ) Yes- *Describe below*:

_____

_____

_____

31. Please list any drug or food allergies: ( ) No known allergies

_____

_____

_____

32. List all **prescription** medications that you are **currently** taking:

NAME OF MEDICATION	DOSE (mg) (Strength of pills)	HOW OFTEN? (# of pills per day)	WHAT IS THIS MEDICATION FOR?

33. List all **over-the-counter** medications, supplements, or herbs that you are **currently** taking:

NAME OF MEDICATION	DOSE (mg) (Strength of pills)	HOW OFTEN? (# of pills per day)	WHAT IS THIS MEDICATION FOR?

34. List all other pain medications that you have tried in the past:

NAME OF MEDICATION	MAXIMUM DOSE (MG) AND # OF DOSES PER DAY	DURATION OF USE	REASON FOR STOPPING OR SIDE EFFECTS

35. Past medical history and review of symptoms (*please check Yes or No & circle any conditions you have experienced*)

YES	NO	**CIRCLE ANY CONDITIONS YOU HAVE EXPERIENCED**	DESCRIBE / OTHER COMMENTS:
		Problems with your: Eyes, Ears, Nose, Throat	
		Cardiovascular: Chest pain, Heart disease, Heart attack, Blood flow problems, Irregular rhythm, High blood pressure	
		Respiratory: Obstructive disease, Asthma, Chronic bronchitis, Shortness of Breath, COPD, Sleep apnea, Smoking	
		Gastrointestinal: Stomach ulcers, Hernia, Bowel problems, Bleeding, Gallbladder problems, Hepatitis/liver disease	
		Genitourinary: Kidney problems, Bladder problems, Prostate problems, Infections/bleeding	
		Musculoskeletal: Muscle or bone disorders, Joint/Arthritis (Where?), Trouble with Arms, Legs or Joints, Muscle cramps	
		Integumentary: Skin disorders, Breast diseases, Unusual lumps or bumps, Itching, Rash, Jaundice, Changes in hair/nails	
		Neurological: Stroke, Seizure, Epilepsy, Neuropathy, Nerve injury, Fainting (syncope), Tremors, Tingling, Paralysis	
		Psychiatric: History of depression or other psychological conditions such as: PTSD, Anxiety, Fear, Alcohol or drug abuse, etc	
		Endocrine: Diabetes (blood sugar), Thyroid problems	

YES	NO	**<u>CIRCLE</u> ANY CONDITIONS YOU HAVE EXPERIENCED**	DESCRIBE / OTHER COMMENTS:
		Hematologic: Anemia, Easy bruising , Bleeding disorders	
		Allergic/Immunologic: Auto immune disorder i.e. Lupus, Immune Deficiency	
		Cancer: (what type?)	
		Constitutional: Recurrent fevers, Weight changes, Heat/Cold intolerance, Fatigue, Chills, Night sweats	
		Pregnancy, (Date of last period, type of birth control)	
		Other:	

36. Surgeries: ( ) None

YEAR	SURGERY	COMMENTS, POST SURGICAL COURSE
	Appendectomy	
	Biopsy (Result & Type)	
	Gall Bladder	
	Hernia	
	Prostate	
	Hysterectomy	
	Vasectomy	
	Other:	

37. List Major Injuries or Hospitalizations: ( ) None

YEAR	REASON FOR INJURY OR HOSPITALIZATION	COMMENTS OR HOSPITAL COURSE

38. Have you or any family members ever had any anesthesia or medication related complications?

( ) No ( ) Yes- *describe below*:

_____

_____

_____

Social and Vocational History

39. Marital status (*circle*) :

- Married
- Never married
- Live with spouse equivalent
- Divorced/ Separated
- Widowed

40. How many people live in your household? (*including yourself*)

_____
_____
_____

41. Do you have children? ( ) No ( ) Yes (*names, ages and health status*)

_____
_____
_____

42. What recreational activities do you enjoy? (*describe below*)

_____
_____
_____

43. What exercise do you enjoy? How often? (*describe below*)

_____
_____
_____

44. Are you or have you been involved with any of the following items? (*check Yes or No*)

YES	NO	ITEM	COMMENTS (HOW MUCH, HOW OFTEN AND HOW MANY YEARS)
		Smoking/ Vaping Nicotine	
		Drink alcohol	
		Addictive street drugs	
		Disability	
		Litigation	
		THC/ CBD	

45. Highest grade or level of education completed: _____ grade or degree _____

_____
_____
_____

46. Are you currently employed? ( ) No ( ) Yes. If **No**, *when did you last work?* If **Yes**, *place of employment*:

_____
_____
_____

47. What are your current and past occupations? What do/did you do at work? (*describe below*)

_____
_____
_____

48. Has your job changed because of your painful condition? ( ) No ( ) Yes- how? ( ) Not applicable

_____
_____
_____

49. Are your basic needs such as access to food, water, safe housing, and medical care being met?

_____
_____
_____

50. Are you under financial stress? ( ) No ( ) Yes- *describe below*

_____
_____
_____

51. Have there been any other stressful life experiences recently? ( ) No ( ) Yes- *describe below*

_____
_____
_____

52. Do any close friends or family members have chronic medical and/or pain problems? ( ) No ( ) Yes- *describe*

_____
_____
_____

53. Do you identify with any particular faith or religion? ( ) No ( ) Yes- *which one*?

_____
_____
_____

54. Have you ever been convicted of any crimes or felonies? ( ) No ( ) Yes- *describe below*

_____
_____
_____

55. Have you been under the care of a mental health professional? ( ) No ( ) Yes- *when, how often?*

_____
_____
_____

56. Over the last 2 weeks, how often have you been bothered by any of the following problems? ***(circle below)***

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE USE *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off **any** problems above, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people? ***(circle)***

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

57. Circle the number that best describes how pain has interfered with the following:

a. General activity:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

b. Mood

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

c. Walking ability:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

d. Normal work (includes both work outside the home and housework):

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

e. Relations with other people:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

f. Enjoyment of life:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

g. Sexual activity:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

h. Sleep:

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

Treatment Expectations

61. What types of treatment do you expect from your visits to the pain management center? (*Check all appropriate answers)*

[ ] Consultation only (advice only to you and your primary care physician)

[ ] Counseling	[ ] Injections or nerve blocks	[ ] Stress Management
[ ] Electrical stimulation	[ ] Physical therapy	[ ] Relaxation therapy
[ ] Drug treatment	[ ] Biofeedback	[ ] Acupuncture
[ ] Surgery	[ ] Don't know	[ ] Other (describe):

_____

62. What do you expect after your visits to our pain program? (*Check the one best answer*)

[ ] A diagnosis (to help find the cause of pain)	[ ] A cure
[ ] A reduction in pain	[ ] No expectations
[ ] Help in coping with the pain	[ ] Do not know what to expect

63. What are your goals for treatment? (*describe below*)

_____

_____

_____