Pain Management New Patient Questionnaire

Please answer the following questions so we may best serve you for this appointment.

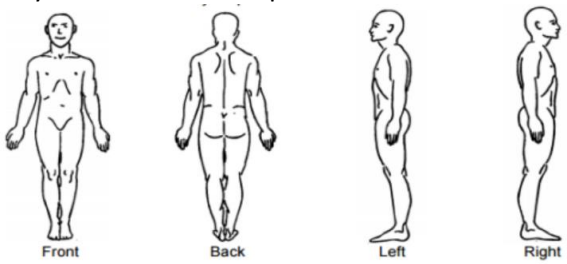
Name:	Phone:
Date of Birth:	Pharmacy:

1. You may have pain in multiple locations in your body. Please select only the area(s) below where you have your most significant pain: ☐ Neck Only ☐ Neck, Shoulder(s), and Arm(s) ☐ Back Only ☐ Back, Buttock, and Leg(s) ☐ Buttock Only ☐ Groin Only ☐ Side of the Hip Only ☐ Other If different from above, please list pain location(s):

_____

2. If you indicated multiple locations, which **one** location is the absolute worst? _____

2a. Please circle the area of the body that has the most pain:



2a. If you indicated **Neck, Shoulder and/or Arm**, please note what percentage of pain is in your: Neck_____% Shoulders/Arms_____% *(Total = 100%)*

2b. If you indicated **Back, Buttock and/or Leg**, please note what percentage of pain is in your: Back_____% Buttock/Legs_____% (*Total = 100%)*

3. How do you describe your pain? ☐ Aching ☐ Burning ☐ Dull ☐ Numbing ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Spasming ☐ Squeezing ☐ Pressing

4. What is the frequency of your pain? ☐ It comes and goes ☐ Is constant (sometimes mild and sometimes severe) ☐ Is constant (always severe)

5. The intesity of pain is generally assessed with a rate from 0 to 10. (0 = No pain at all and 10 = worst pain imaginable) How would you rate your pain? At its Best: _____ At its Worst: _____ On Average: _____

6. How long have you had this pain? _____

7. What do you feel caused your pain? ☐ It gradually came on its own ☐ Are related wear and tear ☐ Fell down ☐ Motor Vehicle Accident ☐ Exercise related injury ☐ Work related injury ☐ Other: _____

8. Have you experienced any of the following associated symptoms since your pain started? ☐ Arm Weakness If yes, which arm _____ ☐ Arm Numbness If yes, which arm _____ ☐ Leg Weakness If yes, which leg _____ ☐ Leg Numbness If yes, which leg _____ ☐ Incontinence Bladder ☐ Incontinence Bowel

9. Please indicate if the following activities make your pain worse, better, or no affect. (Select only those that apply.)

Activity	Better	Worse
Laying Down or Resting	☐	☐
Sitting	☐	☐
Standing	☐	☐
Walking	☐	☐
Lifting	☐	☐
Bending	☐	☐
Exercise	☐	☐
Sexual Activity	☐	☐
Other:	☐	☐

10. Is your pain causing or worsening any of the following? (Select all that apply) ☐ Depression ☐ Insomnia ☐ Unemployment ☐ Daily Routine

11. Have you tried any of the following treatments to address your pain? Select all that apply and note if it was a positive or negative experience addressing your pain.

Treatment	Dates Started and Completed	Did it Help?	If it helped, for how long? Days, Weeks, or Months
Physical Therapy		☐ Yes ☐ No	
Chiropractor		☐ Yes ☐ No	
Physician Directed Home Exercise		☐ Yes ☐ No	
Heat and/or Ice		☐ Yes ☐ No	
Injections at Pain Clinic		☐ Yes ☐ No	

MEDICATION: Please indicate any medications below that you are currently taking or have taken in the last 6 months

Medication	Medication	Medication
☐ Tylenol (Acetaminophen)	☐ Neurontin (Gabapentin)	☐ Tramadol
☐ Advil (Ibuprofen)	☐ Pregabalin (Lyrica)	☐ Morphine
☐ Aleve (Naprosyn)	☐ Trileptal (Oxcarbazepine)	☐ Norco (Hydrocodone)
☐ Mobic (Meloxicam)	☐ Baclofen	☐ Oxycodone (Percocet)
☐ Voltaren (Diclofenac, Flector Patch)	☐ Flexeril (Cyclobenzaprine)	☐ Dilaudid
☐ Celebrex (Celecoxib)	☐ Zanaflex (Tizanidine)	☐ Fentanyl Patch
☐ Relafen (Nabumetone)	☐ Robaxin (Methocarbamol)	☐ Subutex or Butrans (Buprenorphine)
☐ Lodine (Etodolac)	☐ Soma (Carisoprodol)	☐ Suboxone (Buprenorphine/Naloxone)
☐ Toradol	☐ Skelaxin (Metaxalone)	☐ Methadone
☐ Cybalta (Duloxetine)	☐ Codeine	☐ Zoloft (Sertraline)
☐ Effexor (Venlafaxine)	☐ Pamelor (Nortriptyline)	☐ Paxil (Paroxetine)
☐ Pristiq (Desvenlafaxine)	☐ Elavil (Amitriptyline)	
☐ Prozac (Fluoxetine)	☐ Lexapro (Escitalopram)	

12. Are you currently taking any blood thinner medications? ☐ Yes ☐ No

If yes, please list: _____

13. What war your functional goals after we treat you/ (example; golfing, gardening, playing with kids or grandkids, able to go shopping, etc.) _____

MEDICAL HISTORY:

If you have any of the following medical issues, please check the box. Select all that apply and provide approximate date.

Medical Issues	Approx. Date	Medical Issues	Approx. Date
☐ Arrhythmia		☐ High Blood Pressure	
☐ Anxiety		☐ HIV/AIDS	
☐ Back Pain		☐ Kidney Disease	
☐ Bleeding Disorder/Abnormal Bleeding		☐ Liver Disease	
☐ Cancer		☐ Seizures	
☐ Blood Clotting Disorder		☐ Depression	
☐ Congestive Heart Failure (CHF)		☐ Diabetes	
☐ COPD/Emphysema		☐ Other Please List.	

SURGICAL HISTORY:

If you have had any of the following surgeries, please check the box. Select all that apply and provide approximate date.

Surgery	Approximate Date	Surgery	Approximate Date
☐ Neck Spinal Surgery		☐ Hip Replacement	
☐ Back Spinal Surgery		☐ Foot Surgery	
☐ Spinal Cord Stimulator		☐ Shoulder Replacement	
☐ Pacemaker or Defibrillator		☐ Knee Replacement	
		☐ Rotator Cuff Repair	