AULTMAN

Center for Pain Management
Questionnaire

Name:_____ Birth Date:___/___/____ Age:____ ❑Male ❑Female

Primary Care Physician/Family Physician Name:_____

PLEASE FILL OUT THE FRONT AND BACK OF EACH PAGE AND RETURN TO AULTMAN CENTER FOR PAIN MANAGEMENT. IF THE QUESTIONNAIRE IS NOT ENTIRELY COMPLETED OR DOES NOT HAVE YOUR SIGNATURE, DATE AND TIME, IT WILL NOT BE REVIEWED, AND YOU WILL NOT BE SCHEDULED FOR AN APPOINTMENT.

1. Main reason for your visit:_____

2. Is your pain related to an injury? ❑ YES ❑ NO Date of injury: _____

   Description of injury_____

3. Is the pain related to a work injury? ❑ YES ❑ NO Date of injury _____

   Description of injury_____

4. Do you have a lawyer regarding this injury? ❑ YES ❑ NO

   Name of lawyer:_____

5. What do you think caused your pain?_____

   When did your pain begin? DATE_____

6. Where is your pain located? PLEASE BE SPECIFIC:_____

7. Rate your pain on a scale from 0-10 with 0 being no pain and 10 being the worst pain imaginable.

   Today 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

   Best Day 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

   Worst Day 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

8. Is your pain: ❑ CONSTANT ❑ COMES AND GOES

9. Does your pain ever wake you up at night? ❑ YES ❑ NO

If YES, how often: ❑ Everyday ❑ Occasionally ❑ Frequently but not every day

10. How many hours do you sleep at night? _____Hours

11. Have you ever taken medication to help you sleep? ❑ YES ❑ NO

If YES, what medication? NAME_____, _____MG, DIRECTIONS_____

12. Check which of the following activities change the nature of your pain:

Movement	Increase pain	Decrease pain	No change in pain
When I first get out of bed			
Getting up out of a chair			
Sitting			
Standing			
Leaning forward			
Walking			
Lying on my side			
Lying on my back			
Driving			
Coughing / Sneezing			
Stooping			
Lifting			
Bending Backward			
Twisting			
Socializing			
Alcohol			
Medication			
Relaxation			
Morning			
Night time			
Other			

13. What makes your pain better? _____

_____

_____

_____

14. What makes your pain worse? _____

_____

_____

_____

PREVIOUS EVALUATION AND TREATMENT FOR YOUR CURRENT PROBLEM

1. Have you seen any other doctors, pain management clinics, emergency rooms or therapists for your **current** problem? Please list below:

Name	Address	Date of First Visit	Date of Last Visit
1.			
2.			
3.			
4.			

2. Please check **ANY** of the following **TESTS** you had done for your **current condition**?

Test	Yes	No
Regular X-Rays		
Myelogram		
MRI		
CT Scan		
Bone Scan		
Discograms		
EMG/Nerve Conduction		
Blood Tests		

3. Please check which of the following have been used to treat your **current condition**. Also indicate whether the treatment was helpful or not.

Treatment	Yes	No	Helpful	Not Helpful	Worse
Physical Therapy					
Traction					
Chiropractic Adjustment					
Acupuncture					
Epidural Injections					
Other Injections					
TENS Unit					
Medicines					
Pain/Stress Management					
Counseling for stress/depression/anger					
Surgery					
Spinal Cord Stimulator **Trial Date:_____** **Implanted Date:_____ Type:_____**					
Intrathecal Pain Pump **Trial Date:_____** **Implanted Date:_____ Type:_____**					

ALLERGIES

1. Do you have allergies to any of the following?

Allergy	Yes	No	If yes, please list	Reaction
Medications				
X-Ray Contrast Dye				
Iodine / Shellfish				
Latex				
Foods				

MEDICATIONS

1. Do you take a blood thinner? Yes_____ No_____

   If yes, please circle the medication(s) you are taking:

   Fragmin – Aspirin – Coumadin (Warfarin, Jantoven) – Lovenox – Heparin – Arixtra – Plavix

   Ticlid – Effient – Pradaxa – Eliquis – Xarelto – Brilinta - Other_____

2. List all of your current medications, dosage and how many times per day you take them:
   Include ALL prescribed, over-the-counter, vitamins and herbal medications, supplements.

****BRING ALL MEDICATIONS WITH YOU TO YOUR FIRST VISIT****

Medication	Dosage (mg)	How often per day

PAST MEDICAL HISTORY

1. Please list all past **surgeries**:_____

_____

_____

2. Please list any other **medical conditions** (not listed below):_____

_____

FAMILY HISTORY

1. Have you or an immediate family member ever had any of the following medical conditions?

Medical Condition	Self	Family	Medical Condition	Self	Family
Arthritis			**Heart Disease**		
Bipolar			**Intestinal Problems**		
Bleeding Tendencies			**Kidney Problems**		
Breathing Problems			**Malignant Hyperthermia**		
Circulation Problems			**Schizophrenia**		
Clotting Disorder			**Stomach Problems**		
COPD			**Stroke**		
Depression/Anxiety			**Substance Abuse**		
Diabetes			• **alcohol**		
Difficulty with Anesthesia			• **medications**		
Emphysema			**Thyroid Disorder**		
Fibromyalgia			**Ulcers**		

SOCIAL HISTORY

1. Are you: (check one) ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widow/Widower

2. Significant other/spouse name:_____

3. How much schooling have you completed? (check one that applies to you)

   ❑ Less than high school ❑ High School ❑ 1-3 years of College ❑ College Graduate

   ❑ Bachelors ❑ Advanced Degree

4. Who lives in your home with you, and how are they related? _____

_____

5. Do you use any of the following currently or in the past?

Substance	Currently Yes	Past Yes	Never	Type	Amount per Day
Alcohol					
Tobacco					
Marijuana					
Cocaine					
Heroin					
CBD Oil					
Medical Marijuana					
Prescription Meds					

6. Have you EVER been told you have a problem with alcohol or drug abuse? ❑ YES ❑ NO

If YES, please check the abused substance: ❑ Alcohol ❑ Drug (Name/Type)_____

7. Have you ever participated in rehabilitation for substance abuse? ❑ YES ❑ NO

If YES, please list the date(s) and location(s)_____

_____

8. Have you ever been convicted or charged with a drug or alcohol offense? ❑ YES ❑ NO

If YES, please list_____

Family History of Substance Abuse (Mother, Father, Grandparents, Siblings)			**Personal (Your) History of Substance Abuse**		
Alcohol	❑ **Yes**	❑ **No**	Alcohol	❑ **Yes**	❑ **No**
Illegal Drugs	❑ **Yes**	❑ **No**	Illegal Drugs	❑ **Yes**	❑ **No**
Prescription Drugs	❑ **Yes**	❑ **No**	Prescription Drugs	❑ **Yes**	❑ **No**
			Present Age		
			History of Preadolescent Sexual Abuse	❑ **Yes**	❑ **No**
			Psychologic Disease		
			Diagnosed ADHD, ADD, OCD	❑ **Yes**	❑ **No**

9. Are you or have you ever been enrolled in MAT – medically assisted treatment for drug overuse? ❑ YES ❑ NO

Have you ever taken: ❑ Suboxone ❑ Subutex ❑ Vivitrol

10. Please fill in the blanks:

Current occupation:_____ Current employer: _____

If retired former occupation: _____ Former employer:_____

Are you working now? ❑ YES ❑ NO If NO: Date of last day worked:_____

Are you currently receiving disability benefits? ❑ YES ❑ NO

If you are disabled, on what basis was disability granted? _____

Describe your work:_____

How many hours of your working day do you spend:

Activity	Hours
Sitting	
Driving	
Standing	
Lifting	
Weight -	
Walking	

On a scale from 1-10 with 1 being least, rate how much you like your job?

Not Like 1 – 2 -3 – 4 – 5 – 6 – 7 – 8 – 9 - 10 Love

Do you feel your pain prevents you from working? ❑ YES ❑ NO

SYSTEMS REVIEW

Please check the appropriate boxes

System	Yes	No
CONSTITUTIONAL		
Fever		
Weight loss		
Weight gain		
EYES		
Vision loss		
Blurred vision		
ENT		
Hearing loss		
Hoarseness		
Throat pain		
Difficulty swallowing		
SKIN		
Rash		
Sores		
Itching		
RESPIRATORY		
Cough		
Shortness of breath		
CARDIOVASCULAR		
Chest pain		
Heart racing		
Palpitations		
GASTROINTESTINAL		
Nausea		
Vomiting		
Diarrhea		
Constipation		
URINARY		
Incontinence (loss of bladder control)		
Urgency (immediate need to urinate)		
Nocturia (having to urinate at night)		

System	Yes	No
MUSCULOSKELETAL		
Joint pain		
Joint swelling		
NEUROLOGICAL		
Memory loss		
Speech difficulty		
Walking difficulty		
Balance difficulty		
Loss of consciousness		
Weakness		
Right Arm Leg		
Left Arm Leg		
Paralysis		
Right Arm Leg		
Left Arm Leg		
Sensory disturbance		
Right Arm Leg		
Left Arm Leg		
PSYCHIATRIC		
Depression		
Anxiety		
Bipolar		
Schizophrenia		
ENDOCRINE		
High blood sugar		
Low blood sugar		
HEMATOLOGIC		
Low blood count		
Easy bleeding		
Blood clots		
SLEEP		
Snoring		
Insomnia		
Day time sleepiness		
Fatigue		

This questionnaire will become part of The Aultman Center for Pain Management Medical Record. Any false information or omissions may lead to termination of treatment from Pain Management. Complications and side effects due to falsifications or omissions are the responsibility of the patient.

I verify that the above information is accurate and complete.

Date Time Patient Signature