INITIAL VISIT PAIN MANAGEMENT QUESTIONAIRE

Patient Full Name: _____Date of Birth:_____

Is this the name you fill medications under?(Circle one) Yes No

If no, what name is it filled under: _____

Where is your pain located:_____

How long have you been experiencing this pain: _____ days months years (*please circle one*)

When does your pain mostly occur? *(Example: sitting, standing, etc.)* _____

What makes your pain worse? _____

What makes your pain better? _____

Does your pain impact your sleep? (Circle One) Yes No

Besides medications what have you tried to help your pain?_____

What other medications (prescription or over-the-counter) have you tried? _____

_____

Have you ever had a Physiatry consult? (Circle One) Yes No

If yes, where? _____

Have you in the past or currently going to Physical Therapy (Circle One): Yes No

When:_____ Where: _____

Any other therapies you have tried (*acupuncture, SI Injections, hydrotherapy, etc.)*: _____

_____

Have you seen a "Pain Specialist", If so who/where: _____

Date pain medication therapy started (approximately): _____

Current Medication list (*what medication(s), dose, how often*):

_____

_____

_____

What is your pain level (1-10): today_____ without med_____ with med: _____

What is your activity level impairment (1-10): without med _____ with med: _____

Do you have any adverse effects from the opioid medication (check all that apply):

☐Nausea/vomiting	☐Confusion
☐Constipation	☐Falls
☐Dry Mouth	☐Increased sensitivity to pain
☐Itching	☐Depression
☐Sweating	☐Physical Dependence
☐Sleepiness/dizziness	☐Low Testosterone/libido/energy

Family History of (circle all that apply):

Alcohol Abuse	Illicit/Illegal Drug Abuse	Prescription Drug Abuse

Personal History of (circle all that apply):

Alcohol Abuse	Illicit/Illegal Drug Abuse	Prescription Drug Abuse
Substance Abuse	Overdose	Memory Problems
ADHD	OCD	Bipolar
Schizophrenia	Depression	Childhood/Preadolescent Sexual Abuse