Pain & Rehabilitation Medicine

Patient Questionnaire

Name: _____

Date: _____, 20 _____

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Phone 301.656.0220 - Fax 301.654.0333 - www.painpoints.com

A multidisciplinary pain management center devoted to diagnosis, treatment, education and research

Introduction

We would like to welcome you to Pain & Rehabilitation Medicine. Thank you for selecting our team. We are committed to provide you with the best possible health care.

To help us assess your current health care needs, we would like you to complete the following forms. We know that we are asking you many questions, but we feel that it is important that you take the time to complete all pages. Many of our patients have seen several other health care providers, and continue to experience ongoing (medical) problems. Our comprehensive questionnaires really help us to determine the best diagnosis and treatment plan.

If you have any questions or need assistance, please feel free to ask us. We will be happy to help.

Robert D. Gerwin, MD
Medical Director

M. Glen Harper, MD
Neurologist

Breanna Roth, MSN, APRN-BC
Nurse Practitioner

Edward J. Kelty, PhD
Psychologist

Sometimes patients have similar names. To avoid confusion, we record your social security number. Of course, all information becomes part of your medical record and is strictly confidential.

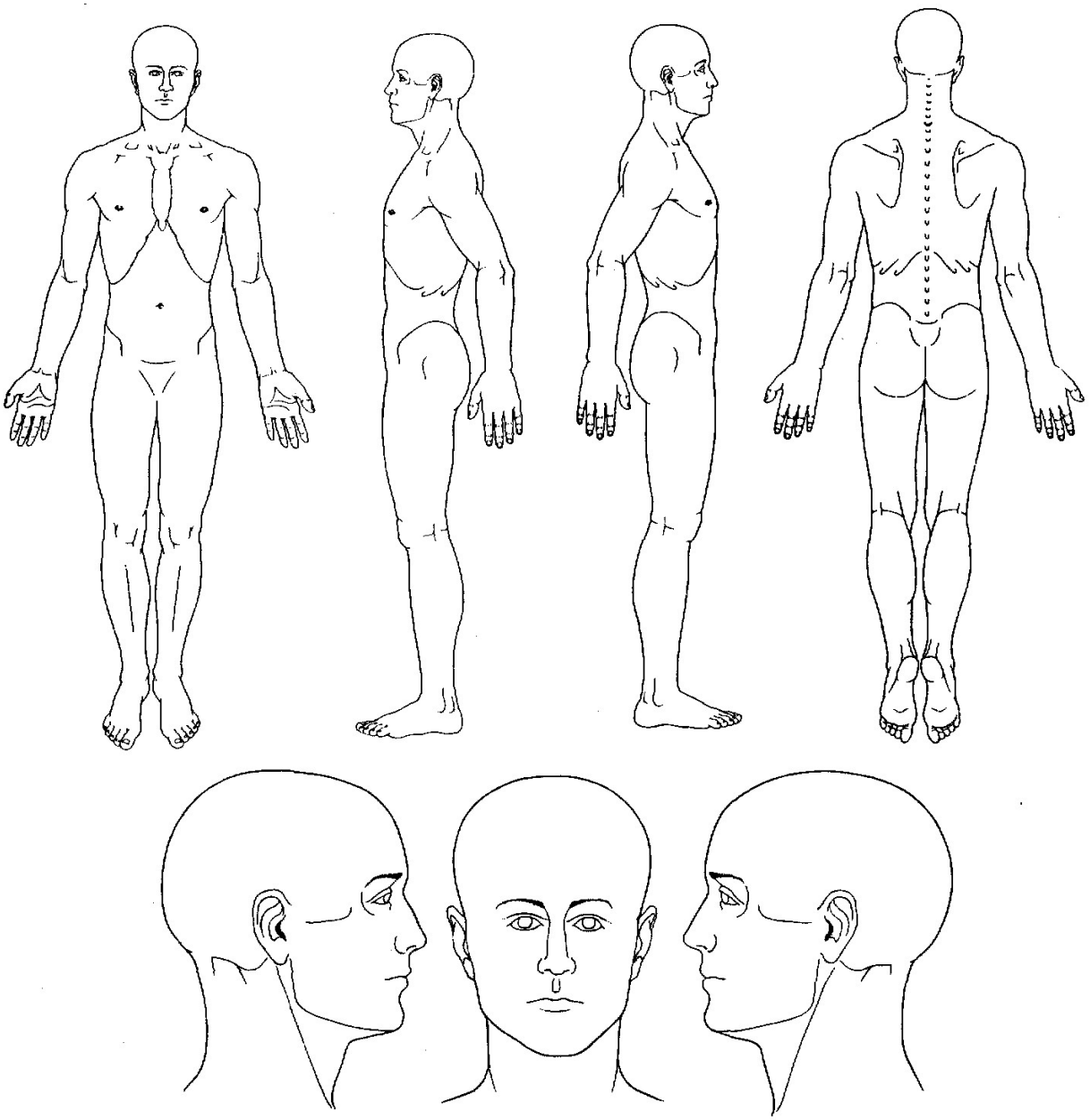
Your social security number is:

_ _ _ _ _ _ _ _ _ _ _

Pain Assessment Form

Pain Diagram

At this time, where is your pain?
Please mark on the drawings the area where you feel pain (circle or mark with crosses)



Personal Pain Inventory

Name: _____ Date of Birth: ☐☐/☐☐/☐☐☐☐

Age: ☐☐☐ Height: ☐ft.☐☐ inches Weight: ☐☐☐ lbs. I am right ☐, left ☐handed.

Referred by Dr./Mr./Mrs./Ms.: _____

Address of referral source: _____

_____

Phone (referral source): ☐☐☐ - ☐☐☐ - ☐☐☐☐

☐ I request that a copy of the initial report will be sent to the above listed referral source

☐ I request that **no** reports will be sent to the above listed referral source.

In addition, I request a copy of my reports to be mailed to:

Name: _____ Name: _____

Address: _____ Address: _____

_____

Phone: ☐☐☐-☐☐☐-☐☐☐☐ Phone: ☐☐☐-☐☐☐-☐☐☐☐

Chief complaint: Please state your main problem(s): _____

_____

_____

How long has this been happening? _____ How often does this happen? _____

How long does it last?_____

What makes it better? _____

What makes it worse? _____

Motor vehicle accident? Yes ☐ No ☐. If yes, date of the accident: ☐☐/☐☐/☐☐☐☐

If yes, were you the driver ☐, front seat passenger ☐, or rear seat passenger ☐?

Did you wear a seat belt at the time of the accident? Yes ☐ No ☐. Did an airbag deploy? Yes ☐ No ☐

If due to an accident, please describe: _____

_____

Work related? Yes ☐ No ☐. If yes, please explain: _____

_____

Have you lost work time because of your illness or accident? Yes ☐ No ☐. If yes, please give dates:

From _____ to _____ .

Please list the medical doctors who have treated you:

☐ Primary family physician or internist: _____

☐ Gynecologist: _____

☐ Other(s): _____

Please list your present medication(s):

Name	How Often? (eg. once daily, twice daily)	Dosage	Name	How Often? (eg. once daily, twice daily)	Dosage

Please list previous medications you are no longer taking:

_____

_____

Allergies or drugs you cannot take: _____

_____

Surgeries:

Surgery	Date	Reason for surgery

Medical illnesses or other medical problems

Illness / Problem	Date of Onset	Illness / Problem	Date of Onset

Comments

_____

_____

_____

Please list any previous treatments you have received or are receiving and their outcomes:

Type of treatment (i.e., physical therapy, chiropractic, acupuncture, psychotherapy, etc.)	Name of provider	Start date (month/year)	End date (month/year)	Helpful? Yes	No
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Social History

Highest level of education completed:

- ☐ Elementary School
- ☐ Junior High School
- ☐ Graduated High School
- ☐ Some college
- ☐ Graduated college
- ☐ Received Master's degree
- ☐ Received advanced professional degree (i.e., Ph.D., M.D., J.D.)

Habits

How many cups of caffeinated coffee do you drink per day? ☐☐

How many caffeinated soft-drinks do you drink per day? ☐☐

How many glasses of alcoholic beverages do you drink per day? ☐☐

How many packs of cigarettes do you smoke per day? ☐☐

Do you now or have you ever used any other drugs, such as marijuana, cocaine, crack, acid, etc.? Yes ☐ No ☐. If yes, please explain: _____

_____

Have you ever been addicted to prescribed medications, alcohol, or recreational drugs? Yes ☐ No ☐. If yes, please explain: _____

Family History

Relative	Alive	Age	Health / Illness	Died	Age	Cause of death
Father						
Mother						
Brother						
Brother						
Sister						
Sister						
Child						
Child						

Work History

Are you presently working ☐, unemployed ☐, retired ☐, disabled ☐ ? If working, what is you present job?:

_____

How long have you worked at this job? _____

Do you enjoy your present job? Yes ☐ No ☐. If no, please explain: _____

_____

If you are retired, what did you do before retirement? _____

Does your present job involve mostly:

Sedentary work (sitting)? Yes ☐ No ☐. If yes, please explain: _____

Keyboard (computer) time? Yes ☐ No ☐. If yes, please explain: _____

Telephone time? Yes ☐ No ☐. If yes, please explain: _____

Hard manual work? Yes ☐ No ☐. If yes, please explain: _____

Much lifting? Yes ☐ No ☐. If yes, please explain: _____

All or much walking? Yes ☐ No ☐. If yes, please explain: _____

Much bending? Yes ☐ No ☐. If yes, please explain: _____

Review of Systems - Check all symptoms / diseases you have presently or have had in the past:

General	**Yes**	**No**		**Yes**	**No**
Easily fatigued	☐	☐	Lymph nodes, swollen glands	☐	☐
Trouble sleeping	☐	☐	Skin rash	☐	☐
Coldness	☐	☐	Easy bruising	☐	☐
Cold limbs (feet, hands)	☐	☐		☐	☐
For office use only					

Gastrointestinal	**Yes**	**No**		**Yes**	**No**
Bloating	☐	☐	Nausea/vomiting	☐	☐
Constipation	☐	☐	Ulcers	☐	☐
Diarrhea	☐	☐	Hepatitis	☐	☐
Irritable Bowel Syndrome	☐	☐	Cirrhosis	☐	☐
Colitis	☐	☐	Bleeding from bowel	☐	☐
For office use only					

Joints	Yes	No		Yes	No
Arthritis	☐	☐	Joint pain: shoulder	☐	☐
Osteoarthritis	☐	☐	Joint pain: elbow	☐	☐
Rheumatoid arthritis	☐	☐	Joint pain: wrist	☐	☐
Scoliosis	☐	☐	Joint pain: hip	☐	☐
Joint swelling	☐	☐	Joint pain: knee	☐	☐
Joint surgery	☐	☐	Joint pain: ankle	☐	☐
Date:					
Specify:					
For office use only					

Endocrine	Yes	No		Yes	No
Diabetes Mellitus	☐	☐	Estrogen	☐	☐
Thyroid disease	☐	☐	Pituitary failure	☐	☐
Thyroid surgery	☐	☐	Hypoglycemia (low blood sugar)	☐	☐
Hormone replacement	☐	☐		☐	☐
For office use only					

Hematology	Yes	No		Yes	No
Anemia	☐	☐	Lymphoma	☐	☐
Iron replacement	☐	☐	Leukemia	☐	☐
B12 Deficiency	☐	☐	Hodgkins Disease	☐	☐
Transfusion	☐	☐		☐	☐
For office use only					

Infectious Disease	Yes	No		Yes	No
Tuberculosis	☐	☐	Syphilis	☐	☐
AIDS	☐	☐	Gonorrhea	☐	☐
A positive HIV test	☐	☐	Lyme Disease	☐	☐
Have you been treated for any of these conditions?				☐	☐
If yes, with what drugs?					

Head/Face/Neck	Yes	No		Yes	No
Change in vision	☐	☐	Loss of hearing	☐	☐
Loss of vision	☐	☐	Loss of smell	☐	☐
One eye	☐	☐	Trouble swallowing	☐	☐
Both eyes	☐	☐	Drooping eyelids	☐	☐
Double vision					

For office use only

Pulmonary	Yes	No		Yes	No
Shortness of breath	☐	☐	Coughing	☐	☐
Difficulty breathing with exercise	☐	☐	Now	☐	☐
Asthma	☐	☐	Chronic	☐	☐
Pulmonary embolism	☐	☐	Coughing blood	☐	☐

For office use only

Cardiac	Yes	No		Yes	No
Chest pain (Angina)	☐	☐	High blood pressure	☐	☐
At rest	☐	☐	Heart surgery	☐	☐
With activity	☐	☐	Heart attack	☐	☐
Irregular heartbeats (palpitations)	☐	☐		☐	☐

For office use only

Mental Health	Yes	No		Yes	No
Depression	☐	☐	Other psychiatric diagnosis	☐	☐
Panic attacks/Anxiety disorder	☐	☐		☐	☐
History of abuse	☐	☐		☐	☐

For office use only

Cancer	Yes	No
Have you had cancer?	☐	☐
If yes, please describe:		
For office use only		

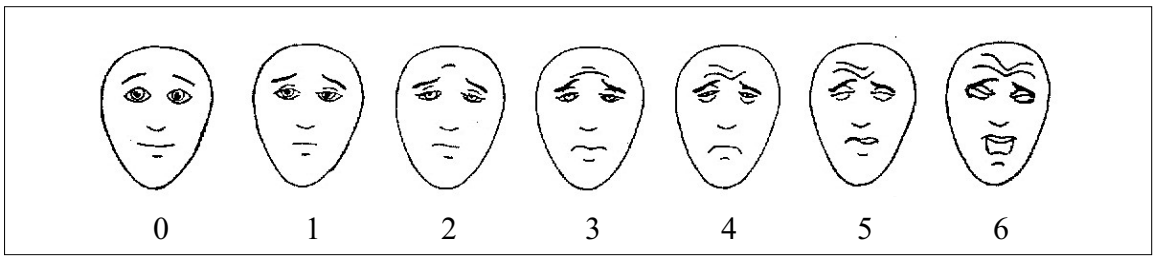
Genital/Urinary - for women			Yes	No
Menstrual period ☐ regular ☐ irregular		Post-menopausal	☐	☐
Periods are ☐ normal ☐ light ☐ heavy		Hysterectomy	☐	☐
Number of pregnancies:		Endometriosis	☐	☐
Number of births:		Breast Cancer	☐	☐
Number of miscarriages:		Breast fibrocystic disease	☐	☐
Number of abortions:		Breast biopsy	☐	☐
			☐	☐

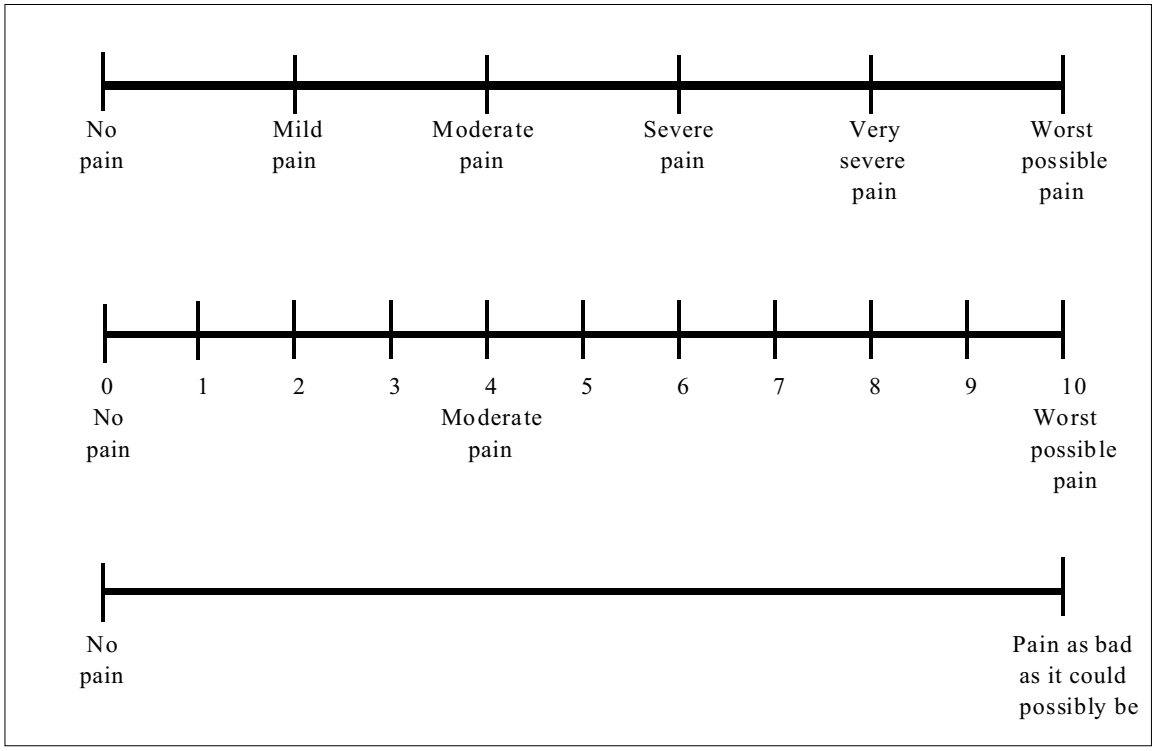
Genital/Urinary - for men	Yes	No		Yes	No
Impotence	☐	☐	Prostate cancer	☐	☐
Prostate enlargement	☐	☐	Prostate surgery	☐	☐
For office use only					

Neurologic	Yes	No		Yes	No
Aneurysm	☐	☐	General weakness	☐	☐
Stroke	☐	☐	Weakness in arms	☐	☐
TIA (“mini-stroke”)	☐	☐	Weakness in legs	☐	☐
Seizure	☐	☐	Loss of feeling in one side	☐	☐
Parkinson’s	☐	☐	Loss of feeling in legs	☐	☐
Head injury	☐	☐	Loss of balance	☐	☐
Brain injury	☐	☐	Dizziness	☐	☐
Meningitis	☐	☐	Tremor (shaking)	☐	☐
Headaches	☐	☐	Attention deficit	☐	☐
A change in memory	☐	☐	Learning disabilities	☐	☐
For office use only					

Pain Rating Scales

Please use **just one of the scales below** to indicate the average level of pain that you experienced over the last 24 hours, taking into account the greatest and least amount of pain that you felt. Please mark just one face, or description, or number, or place on the line. Regard the right end of the scales as the worst pain can be. There is no greater pain than the right end of the scale. In other words, there is no score of "15" on a scale from 0 to 10. You may use any one of the four scales presented.





Note: Sometimes the clinicians may ask you to use these pain rating scales differently. For example, we may ask you to mark your current pain level, or your pain level before and after a treatment session. Please mark just one spot on only one of the pain scales each time.

Clinician use only: This pain rating was used to mark:

☐	Current pain level	☐	Pain after treatment
☐	Pain before treatment	☐	Pain during the past week
☐	_____	☐	_____

SHORT-FORM MCGILL PAIN QUESTIONNAIRE

1. Pain Rating Index (PRI):
The words below describe average pain. Place a check mark (✓) in the column that represents the degree to which you feel that type of pain. Please consider all of your pain.

A	None	Mild	Moderate	Severe
Throbbing	0	1	2	3
Shooting	0	1	2	3
Stabbing	0	1	2	3
Sharp	0	1	2	3
Cramping	0	1	2	3
Gnawing	0	1	2	3
Hot-Burning	0	1	2	3
Aching	0	1	2	3
Heavy	0	1	2	3
Tender	0	1	2	3
Splitting	0	1	2	3
B				
Tiring-Exhausting	0	1	2	3
Sickening	0	1	2	3
Fearful	0	1	2	3
Punishing-Cruel	0	1	2	3

2. Present Pain Intensity (PPI) – Visual Analog Scale (VAS). Circle the number below for all of your pain:

No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

3. Evaluate the overall intensity of total pain experience. Place a check mark (✓) in the appropriate column:

0	No pain	
1	Mild pain	
2	Discomforting	
3	Distressing	
4	Horrible	
5	Excruciating	

Pain Outcomes Questionnaire – Short Form
Michael E. Clark, Ph.D. and Ronald J. Gironda, Ph.D.
James A. Haley Veterans Affairs Hospital, Tampa, Florida

1.) Enter today's date: ____ / ____ / ____ (MM/DD/YY)

2.) On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst possible pain, how would you rate your pain on the **AVERAGE** during the **LAST WEEK**?

0 1 2 3 4 5 6 7 8 9 10
no pain at all worst possible pain

3.) Does your pain interfere with your ability to walk?

0 1 2 3 4 5 6 7 8 9 10
not at all all the time

4.) Does your pain interfere with your ability to carry/handle everyday objects such as a bag of groceries or books?

0 1 2 3 4 5 6 7 8 9 10
not at all all the time

5.) Does your pain interfere with your ability to climb stairs?

0 1 2 3 4 5 6 7 8 9 10
not at all all the time

6.) Does your pain require you to use a cane, walker, wheelchair or other devices?

0 1 2 3 4 5 6 7 8 9 10
not at all all the time

7.) Does your pain interfere with your ability to bathe yourself?

0 1 2 3 4 5 6 7 8 9 10
not at all all the time

8.) Does your pain interfere with your ability to dress yourself?

0 1 2 3 4 5 6 7 8 9 10
not at all all the time

9.) Does your pain interfere with your ability to use the bathroom?

0 1 2 3 4 5 6 7 8 9 10
not at all all the time

10.) Does your pain interfere with your ability to manage your personal grooming (for example, combing your hair, brushing your teeth, etc.)?

0 1 2 3 4 5 6 7 8 9 10
not at all all the time

11.) Does your pain affect your self-esteem or self-worth?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

12.) How would you rate your physical activity?

0 1 2 3 4 5 6 7 8 9 10
significant limitation in basic activities — can perform vigorous activities without limitation

13.) How would you rate your overall energy?

0 1 2 3 4 5 6 7 8 9 10
totally worn out — most energy ever

14.) How would you rate your strength and endurance **TODAY**?

0 1 2 3 4 5 6 7 8 9 10
very poor strength and endurance — very high strength and endurance

15.) How would you rate your feelings of depression **TODAY**?

0 1 2 3 4 5 6 7 8 9 10
not depressed at all — extremely depressed

16.) How would you rate your feelings of anxiety **TODAY**?

0 1 2 3 4 5 6 7 8 9 10
not anxious at all — extremely anxious

17.) How much do you worry about re-injuring yourself if you are more active?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

18.) How safe do you think it is for you to exercise?

0 1 2 3 4 5 6 7 8 9 10
not safe at all — extremely safe

19.) Do you have problems concentrating on things **TODAY**?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

20.) How often do you feel tense?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

Tampa Scale for Kinesiophobia

Please circle the most appropriate answer for each of the following statements.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I'm afraid I might injure myself if I exercise.	1	2	3	4
2. If I were to try to overcome it, my pain would increase.	1	2	3	4
3. My body is telling me I have something dangerously wrong.	1	2	3	4
4. My pain would probably be relieved if I were to exercise.	1	2	3	4
5. People aren't taking my medical condition seriously enough.	1	2	3	4
6. My accident (or my condition) has put my body at risk for the rest of my life.	1	2	3	4
7. Pain always means I have injured my body.	1	2	3	4
8. Just because something aggravates my pain does not mean it is dangerous.	1	2	3	4
9. I am afraid that I might injure myself accidentally.	1	2	3	4
10. Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening.	1	2	3	4
11. I would have this much pain if there weren't something potentially dangerous going on in my body.	1	2	3	4
12. Although my condition is painful, I would be better off if I were physically active.	1	2	3	4
13. Pain lets me know when to stop exercising so that I don't injure myself.	1	2	3	4
14. It's really not safe for a person with a condition like mine to be physically active.	1	2	3	4
15. I can't do all the things normal people do because it's too easy for me to get injured.	1	2	3	4
16. Even though something is causing me a lot of pain, I don't think it's actually dangerous.	1	2	3	4
17. No one should have to exercise when he/she is in pain.	1	2	3	4

Pain Stages of Change Questionnaire

Precontemplation	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. I have tried everything that people have recommended to manage my pain and nothing helps.	1	2	3	4	5
2. My pain is a medical problem and I should be dealing with physicians about it.	1	2	3	4	5
3. Everybody I speak with tells me that I have to learn to live with my pain, but I don't see why I should have to.	1	2	3	4	5
4. I still think despite what doctors tell me, there must be some surgical procedure or medication that would get rid of my pain.	1	2	3	4	5
5. The best thing I can do is find a doctor who can figure out how to get rid of my pain once and for all.	1	2	3	4	5
6. Why can't someone just do something to take away my pain?	1	2	3	4	5
7. All of this talk about how to cope better is a waste of my time.	1	2	3	4	5
Contemplation					
1. I have been thinking that the way I cope with my pain could improve.	1	2	3	4	5
2. I have recently realized that there is no medical cure for my pain condition, so I want to learn some ways to cope with it.	1	2	3	4	5

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
3. Even if my pain doesn't go away, I am ready to start changing how I deal with it.	1	2	3	4	5
4. I realize now that it's time for me to come up with a better plan to cope with my pain problem.	1	2	3	4	5
5. I am beginning to wonder if I need to get some help to cope with my pain problem.	1	2	3	4	5
6. I have recently figured out that it's up to me to deal better with my pain.	1	2	3	4	5
7. I have recently come to the conclusion that it's time for me to change how I cope with my pain.	1	2	3	4	5
8. I'm starting to wonder whether it's up to me to manage my pain rather than relying on physicians.	1	2	3	4	5
9. I have been thinking that doctors can only help so much in managing my pain and that the rest is up to me.	1	2	3	4	5
10. I have been wondering if there is something I could do to manage my pain better.	1	2	3	4	5
Action					
1. I am developing new ways to cope with my pain.	1	2	3	4	5
2. I have started to come up with strategies to help myself control my pain.	1	2	3	4	5
3. I'm getting help learning some strategies for coping better with my pain.	1	2	3	4	5
4. I am learning to help myself control my pain without doctors.	1	2	3	4	5

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
5. I am testing out some coping skills to manage my pain better.	1	2	3	4	5
6. I am learning ways to control my pain other than with medications or surgery.	1	2	3	4	5
Maintenance					
1. I have learned some good ways to keep my pain problem from interfering with my life.	1	2	3	4	5
2. When my pain flares up, I find myself automatically using coping strategies that have worked in the past, such as relaxation exercise or mental distraction.	1	2	3	4	5
3. I am using some strategies that help me better deal with my pain problem on a day-to-day basis.	1	2	3	4	5
4. I use what I have learned to help keep my pain under control.	1	2	3	4	5
5. I am currently using some suggestions people have made about how to live with my pain problem.	1	2	3	4	5
6. I have incorporated strategies for dealing with my pain into my everyday life.	1	2	3	4	5
7. I have made a lot of progress in coping with my pain.	1	2	3	4	5