Questionnaires

Saint Luke's Health System

Pain Management Clinic
Patient Intake

Patient Information

Today's Date:_____

Your Name:_____ Date of Birth:_____ Age:_____

Referring Physician:_____ Primary Care Physician:_____

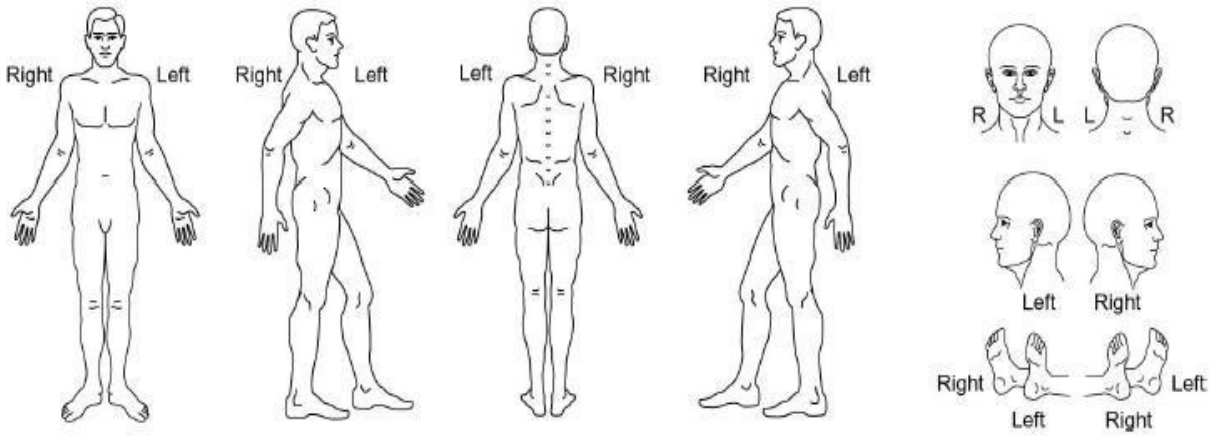
Pain History

Chief Complaint (reason for your visit today)?_____

Does this pain radiate? If so, where?_____

Please list any additional areas of pain:_____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately when did this pain begin?_____

What caused your current pain episode?_____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp
☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing
☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness

When is your pain at its worst?

☐ Mornings ☐ Daytime ☐ Evenings ☐ Middle of the night ☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right now:_____ The best it gets:_____ The worst it gets:_____

Things that make my pain better:_____

Things that cause an increase in pain:_____

Your goal for treatment of your pain: ☐ To be pain free ☐ Reduced pain ☐ Help living with pain

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Please mark all of the following treatments you have used for pain relief: ☑			
	No Change	**Worsened Pain**	**Helped Pain**
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐
Other:_____			

Mark all of the following tests that you have related to your current pain complaints:

☐ MRI of the:_____ Date:_____

☐ X-Ray of the:_____ Date:_____

☐ CT Scan of the:_____ Date:_____

☐ EMG/NCV study of the:_____ Date:_____

☐ I have not had ANY diagnostic test for my current pain complaint

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) _____ Date:_____

2) _____ Date:_____

3) _____ Date:_____

☐ I have **NEVER** had any surgical procedures performed

Family History

Any family medical history (Father, Mother, Grandparents, Siblings):

_____

_____

_____

_____

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Current Medications

Pharmacy Name:_____ **Phone Number:**_____

Are you currently taking any blood thinners or anti-coagulants? ☐ Yes ☐ No

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	Dose	Frequency
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

	Medication Name	Allergic Reaction
1)		
2)		
3)		

Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Social History

Alcohol Use:

☐ Social Use ☐ History of alcoholism ☐ Current alcoholism ☐ Never ☐ Daily use of alcohol

Tobacco Use:

☐ Current user: Packs per day?_____ ☐ Former user ☐ Never used

Recreational Drug Use:

☐ Current user: Use per week?_____ ☐ Former user ☐ Never used

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Past Medical History

Constitutional
- ☐ Fibromyalgia
- ☐ Inherited Illness

Eyes
- ☐ Cataracts

HENT
- ☐ Neck Lumps or Masses

Cardiovascular
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Heart Valve Problems
- ☐ Angina
- ☐ Stroke
- ☐ Peripheral Vascular Problems

Respiratory
- ☐ COPD
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Tuberculosis
- ☐ Lung Cancer

Gastrointestinal
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Liver Problems
- ☐ Jaundice
- ☐ Blood in Stools
- ☐ Colon Cancer

Genitourinary
- ☐ Kidney Stones
- ☐ Interstitial Cystitis
- ☐ Bladder Tumors
- ☐ Kidney Dialysis

Skin
- ☐ Eczema
- ☐ Skin Cancer
- ☐ Shingles

Nervous System
- ☐ Seizures
- ☐ Parkinson's
- ☐ Shingles
- ☐ Alzheimer's
- ☐ Paralysis
- ☐ Nerve Damage
- ☐ Multiple Sclerosis

Musculoskeletal
- ☐ Arthritis
- ☐ Muscle Disease

Cancer History

_____

_____

_____

Endocrine
- ☐ Diabetes
- ☐ Thyroid Gland Disease
- ☐ Adrenal Disease
- ☐ Pituitary Disease

Psychiatric
- ☐ Schizophrenia
- ☐ Depressive Disorder
- ☐ Bi-Polar Disorder
- ☐ Anxiety Disorder

Blood
- ☐ Anemia
- ☐ Leukemia
- ☐ Decreased Platelets
- ☐ Enlarged Lymph Notes

Review of Systems of Current Pain Issue

Constitutional
- ☐ Fatigue
- ☐ Chills
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Malaise

Eyes
- ☐ Double Vision
- ☐ Impaired Vision
- ☐ Eye Pain

HENT
- ☐ Headaches
- ☐ Vertigo
- ☐ Recent Head Injury
- ☐ Neck Stiffness/Tenderness
- ☐ Decrease Range of Motion

Skin
- ☐ Persistent Rash
- ☐ Persistent Itching
- ☐ Change in Pigmentation

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Passing Out
- ☐ Swelling in Ankles
- ☐ Fluid in Lungs
- ☐ Shortness of Breath

Respiratory
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Productive Cough
- ☐ Coughing up Blood

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Indigestion

Genitourinary
- ☐ Incontinence
- ☐ Difficulty Voiding
- ☐ Hesitancy
- ☐ Painful Urination

Nervous System
- ☐ Muscular Weakness
- ☐ Tingling or Numbness
- ☐ Loss of Balance
- ☐ Tingling in Feet
- ☐ Tremors

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Back pain/Spasms
- ☐ Leg Cramps
- ☐ Stiffness

Endocrine
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Increase Thirst
- ☐ Increased Urination
- ☐ Increased Fatigue

Psychiatric
- ☐ Stress
- ☐ Anxiety
- ☐ Depression
- ☐ Compulsive Behavior
- ☐ Excessive Anger

Blood
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Bleeding from Gums
- ☐ Prolonged Bleeding

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