McKinney Spine & Pain Center.

Initial Evaluation

PAIN MANAGEMENT QUESTIONNAIRE

Please complete this form before your first appointment at **McKinney Spine & Pain Center.** Your careful answers will help us to understand your pain problem and design the best treatment program for you. You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your medical record without your written permission unless we are required to do so by law (e.g., Workmans' Compensation Claims).

Referring Physician _____

Primary Care Physician (if not the same) _____

Patient Information

_____ Age:_____Sex: M____F_____

Last Name First Name

About Your Pain

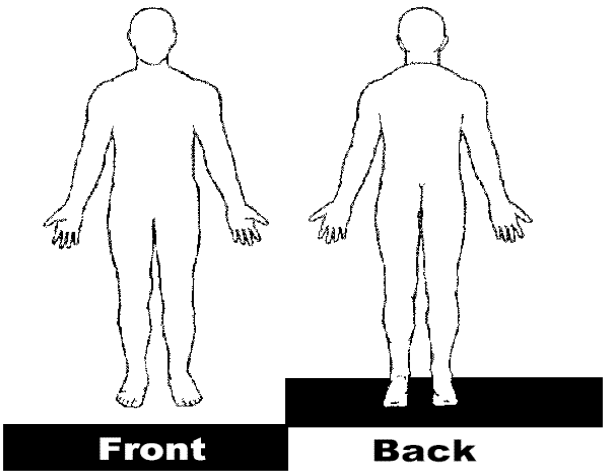
What is the main problem for which you are seeking treatment at Pain Institute of Central California, Inc.?

_____

_____

_____

PAIN LOCATION



Please mark the location(s) of your pain on the diagrams above with an "X"
If whole areas are painful, please shade in the painful area(s).

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Onset of Pain and Duration
Briefly describe when and how your pain problem began.

_____
_____
_____
_____

Timing of Pain
How often do you have your pain? (Please check one)

- ☐ Constantly (100% of the time)
- ☐ Frequently (75% of the time)
- ☐ Intermittently (50% of the time)
- ☐ Occasionally (25% of the time)

Pain Quality
How would you describe the pain? (Choose as many adjectives as are applicable)

☐ burning	☐ sharp	☐ cutting	☐ throbbing	☐ cramping
☐ numbness	☐ dull, aching	☐ pressure	☐ pins & needles	
☐ shooting	☐ electric-like	☐ other_____		

Pain Intensity

Circle your current pain intensity with "0" representing no pain and "10" the most severe pain imaginable.

0 1 2 3 4 5 6 7 8 9 10

Circle your average pain score over the last 7 days.

0 1 2 3 4 5 6 7 8 9 10

Circle your best pain score over the last 7 days.

0 1 2 3 4 5 6 7 8 9 10

Circle your worst pain score over the last 7 days.

0 1 2 3 4 5 6 7 8 9 10

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Relieving and Aggravating Factors
How do the following affect your pain? (Please check one for each item)

	Decrease	Increase	No Change
Lying down	_____	_____	_____
Standing	_____	_____	_____
Sitting	_____	_____	_____
Walking	_____	_____	_____
Exercise (if applicable)	_____	_____	_____
Medications	_____	_____	_____
Relaxation	_____	_____	_____
Thinking about something else	_____	_____	_____
Coughing/Sneezing	_____	_____	_____
Urination	_____	_____	_____
Bowel Movements	_____	_____	_____

Functional Limitations
Place a check mark next to the activities that you avoid because of pain.

_____Going to work
_____Performing household chores
_____Doing yard work or shopping
_____Socializing with friends
_____Participating in recreation
_____Having sexual relations
_____Physical exercise
_____Driving
_____Caring for self

How many feet, blocks or miles can you walk before having to stop because of pain?
_____feet _____blocks(s) _____mile(s)

How many minutes or hours can you sit before having to get up and move about because of pain?
_____minutes _____hours

How many minutes or hours can you stand before you have to sit down because of pain?
_____minutes _____hours

How often during the day do you lie down because of pain?
_____Never _____seldom _____sometimes _____often _____constantly

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Medications
Please list your current medications with dosages

Name of medication	Dose	How often per day

Please list any previous pain medications that you stopped taking and the reason for stopping

Name of medication	Dose	How often per day

Allergies
Are you allergic to any iodine dye contrast agents? Yes___ No___ (if yes, please explain)
Also, please indicate the names of any medication(s) that you are allergic to (and what happened to you when you took it/them)

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Pain Treatments
Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability

Treatment	**Date (approx)**	**Excellent Relief**	**Moderate Relief**	**No Relief**
Medications	_____	_____	_____	_____
Hospital bed rest	_____	_____	_____	_____
Traction	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Hypnosis	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Nerve block/injections	_____	_____	_____	_____
TENS	_____	_____	_____	_____
Physical Therapy	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Heat Treatment	_____	_____	_____	_____
Biofeedback	_____	_____	_____	_____
Psychotherapy	_____	_____	_____	_____
Chiropractic	_____	_____	_____	_____
Other	_____	_____	_____	_____

Previous Diagnostic Studies
Please indicate approximate date and results, if known:
MRI_____
CT_____
X-RAYS_____
EMG_____
OTHER_____

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ROS (Review of Systems/Symptoms)
Please circle any of the following signs or symptoms that you feel are applicable to you now

Fever or chills	yes
Unplanned weight loss	yes
Double or blurred vision	yes
Hearing loss	yes
Difficulty swallowing	yes
Bleeding gums	yes
Low platelet count	yes
Heat or cold intolerance (circle which one)	yes
Thyroid problems	yes
Skin rash	yes
Shortness of breath	yes
Wheezing	yes
Palpitations	yes
Chest pain	yes
Constipation	yes
Abdominal pain	yes
Nausea/vomiting	yes
Diarrhea	yes
Sexual dysfunction	yes
Urinary retention (difficulty urinating)	yes
Back pain	yes
Joint pain (knee, elbow, etc.)	yes
Muscle pain	yes
Loss of consciousness or blackouts	yes
Memory loss	yes
Muscle weakness	yes
Seizures	yes
Trouble walking	yes
Dizziness	yes
Drowsiness or excessive fatigue	yes
Difficulty falling or remaining asleep	yes
Loss of interest in hobbies or activities	yes
Feelings of guilt	yes
Feeling depressed	yes

Other Pain Problems
Do you have other pain problems not already mentioned? What are they?

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Past Medical History
Have you had any of the following health problems? (please check all that apply)

_____High blood pressure	_____Diabetes	_____Kidney disease
_____Angina	_____Stroke	_____Liver disease
_____Heart attack	_____Cancer	_____Arthritis
_____Asthma	_____seizures/epilepsy	_____Bleeding problems
_____Chronic cough	_____Psychological problems	_____other_____

Please explain any medical conditions check above

_____
_____
_____
_____

All Surgeries
Approximate date and type of operation

_____
_____
_____
_____
_____

Psychological History
Education

Your highest educational level achieved

_____Graduate or professional training (obtained degree)
_____College graduate (obtained degree)
_____Partial college training
_____High school graduate
_____GED or trade-technical school graduate
_____Partial high school (10^{th} grade through partial 12^{th})
_____Partial junior high school (7^{th} grade through 9^{th} grade)
_____Elementary school (6^{th} grade or less)

Legal Issues
Please indicate any of the following claims you have filed related to your pain problem
_____Workman's Compensation
_____Personal injury/liability (unrelated to work)

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_____Social Security Disability Insurance (SSDI)
_____Other insurance (please explain)_____
_____None

Psychological Treatment
Have you ever had Psychiatric, Psychological or Social work evaluations or treatments for any problems, including current pain?

_____Yes _____No If yes, when?_____

Have you ever considered suicide? _____Yes _____No

Substance Abuse
Are you suffering from or do you have a history of:

Alcoholism _____Yes _____No
Heroin abuse _____Yes _____No
Cocaine or amphetamine abuse _____Yes _____No

Have you ever been in a detoxification program for drug use? _____Yes _____No
Alcoholics Anonymous _____Yes _____No
Narcotics Anonymous _____Yes _____No

Do you or did you ever smoke cigarettes or use tobacco? _____Yes _____No
How many years have you or did you smoke?_____
How many packs per day do you or did you smoke?_____
Have you quit using tobacco and if so, how long?_____

Employment

Current employment status (please check all that apply)

_____Full time_____Part time_____Temporarily disabled _____Permanently disabled
_____Unemployed _____Homemaker _____Retired_____Student

_____Your employment status **HAS** been affected by the present pain condition

_____Your employment status **HAS NOT** been affected by the present pain condition

If unemployed, how long have you been off work? (if employed, do not answer)
_____Months _____Years

Your current or former occupation(s)_____

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Family Life
Living arrangements:

"I currently am":

_____Living alone
_____Living with friends
_____Living with children
_____Living with spouse/partner
_____Living with spouse/partner and children

Family History

Do you have members of your family who have had migraine headaches? _____Yes___No
Do you have members of your family who have had back pain? _____Yes___No
Do you have members of your family who have committed suicide? _____Yes___No
Do you have members of your family who have had psychiatric illness? _____Yes___No

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I hereby authorize the release of the reports of my evaluations and treatments, including psychological, from PAIN INSTITUTE OF CENTRAL CA, INC. to my physicians and to the other relevant person(s) listed below:

Signature_____
Date_____
Printed Name_____

Physicians, Providers, Attorney, Case Manager, Other	Address	Phone/Fax