CONFIDENTIAL
INNOVATIVE PAIN SOLUTIONS CENTERS
HEALTH QUESTIONNAIRE

Thank you for arranging to visit one of our physicians.

When you come for your first visit, **please bring this completed form** along with any medical records**, X-rays, CT** or **MRI** scans, medication bottles and other medical information related to the problem for which you are being seen.
Should you have any questions, please do not hesitate to contact us.

Thank you very much. We look forward to seeing you.

Please complete the attached questionnaire before your appointment. It is confidential and will be part of your medical record. It asks for information about your current problems and your past medical history. This form will give your doctor a better understanding of your problem, and will allow him or her to spend more time discussing treatment plans with you.

Innovative Pain Solutions Centers
6911 Laurel Bowie Road, Suite 212
Bowie, Maryland, 20715

201 Pine Bluff Road, Unit 1
Salisbury, Maryland 21801

Name:_____

Address:_____

City_____State_____ Zip_____

Telephone #: _____ (*day*) _____ (*evening*)

Date of Birth: _____ Sex: M F

Primary Care Physician: Name:_____

Address:_____

_____

Phone # _____ Fax # _____

List all other Physicians that your records should be sent to:

Name		Address	Phone #	Fax #
_____	____	_____	_____	_____
_____	____	_____	_____	_____

Name: _____
DOB: _____

Pain Related Information. Please answer all questions.

1) Describe the event(s) surrounding the onset of your pain. (I.e. date of injury, is it the same or getting worse?).

_____

_____

_____

_____

2) Duration of Pain: Years _____ Months _____

3) How many physicians have been involved in the treatment of your pain? (Please **circle**)

0-3 4-5 6-10 11-15 16-20

4) How many emergency room visits have you had in the last year for pain? (Please **circle**)

0 1 2 3 5 - 10

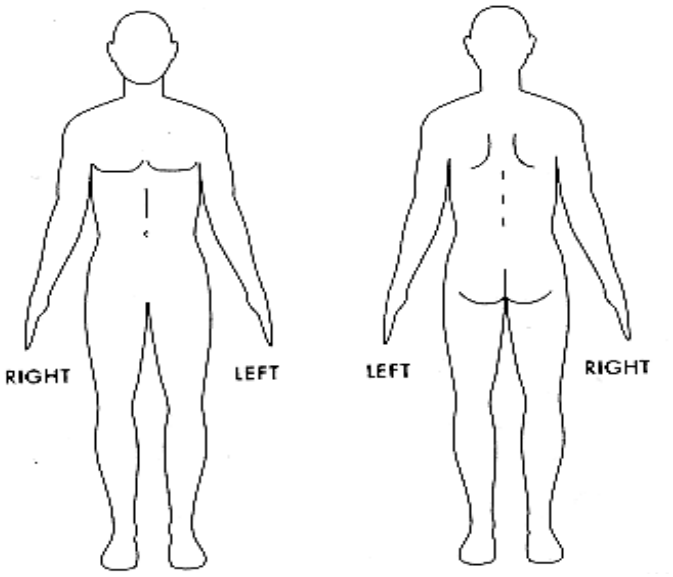
5) **Circle** all the things that make your pain ***worse***:

sitting standing rest heat cold walking exercise sex touch other

6) **Circle** all the things that make your pain ***better***:

sitting standing rest heat cold walking exercise sex touch other

7) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



8) I have some form of pain now that requires medication each and every day Yes No

9) Did you take pain medications in the last 7 days? Yes No

10) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, toothaches). Have you had pain other than these everyday kinds of pain during the last week? Yes No If YES, what kind?

11) Please rate your pain by **circling** the one number that best describes your pain at its **worst in the last week**.

0 1 2 3 4 5 6 7 8 9 10

No Pain as bad as pain you can imagine

Name: _____
DOB: _____

12) Please rate your pain by **circling** the one number that best describes your pain at **its <u>least</u> in the last week**.

0 1 2 3 4 5 6 7 8 9 10

No Pain as bad as pain you can imagine

13) Please rate your pain by **circling** the one number that best describes **your pain on the <u>average</u>**.

0 1 2 3 4 5 6 7 8 9 10

No Pain as bad as pain you can imagine

14) Please rate your pain by **circling** the one number that tells how much **pain you have <u>right now</u>**.

0 1 2 3 4 5 6 7 8 9 10

No Pain as bad as pain you can imagine

15) What kinds of things make your pain feel **better** (for example, heat, medicine, rest)?

16) What kinds of things make your pain **worse** (for example, walking, standing, and lifting)?

17) In the last week, how much <u>relief</u> have pain treatments or medications provided? Please **circle** the one percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No Complete Complete Relief

18) If you take pain medication, how many hours does it take before the pain returns? **Circle appropriate response**

Pain medication doesn't help at all
One hour
Two hours
Three hours
Four hours
Five to twelve hours
More than twelve hours
I do not take pain medication

19) *I believe my pain is due to:*

a) The effects of treatment (for example, medication, surgery, radiation, prosthetic device) Yes No

b) My primary disease (meaning the disease currently being treated and evaluated) Yes No

c) A medical condition unrelated to my primary disease (for example, arthritis) Yes No

Please describe condition:

20) For each of the following words, circle **Yes** or **No** if that adjective applies to your pain.

Aching	Yes	No	Exhausting	Yes	No
Throbbing	Yes	No	Tiring	Yes	No
Shooting	Yes	No	Penetrating	Yes	No
Stabbing	Yes	No	Nagging	Yes	No
Gnawing	Yes	No	Numb	Yes	No
Sharp	Yes	No	Miserable	Yes	No
Tender	Yes	No	Unbearable	Yes	No
Burning	Yes	No			

Name: _____
DOB: _____

21) **Circle** the one number that describes how, during the past week, pain has interfered with your:

a) *General Activity*

0 1 2 3 4 5 6 7 8 9 10

Does not interfere completely interferes

b) *Mood*

0 1 2 3 4 5 6 7 8 9 10

Does not interfere completely interferes

c) *Walking Ability*

0 1 2 3 4 5 6 7 8 9 10

Does not interfere completely interferes

d) *Normal Work* (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere completely interferes

e) *Relations with other people*

0 1 2 3 4 5 6 7 8 9 10

Does not interfere completely interferes

f) *Sleep*

0 1 2 3 4 5 6 7 8 9 10

Does not interfere completely interferes

g) *Enjoyment of life*

0 1 2 3 4 5 6 7 8 9 10

Does not interfere completely interferes

22) I prefer to take pain medicine: (**circle** appropriate response)

On a regular basis Only when necessary Do not take pain medicine

23) I take my pain medicine (in a 24 hour period):

Not every day 1 to 2 times per day 3 to 4 times per day 5 to 6 times per day More than 6 times per day

24) Do you feel you need a stronger type of pain medication?

Yes No Uncertain

25) Do you feel you need to take more of the pain medication than your doctor has prescribed?

Yes No Uncertain

26) Do you feel you need to receive further information about your pain medication?

Yes No

Name: _____
DOB: _____

27) Other methods I use to relieve my pain include: (Please check all that apply)

__ Warm compresses

__ Cold compresses

__ Relaxation techniques

__ Distraction

__Biofeedback

__Hypnosis

28) Check the nerve blocks, injections or procedures that have been performed.

		How many	Date Performed
___	Cervical (neck) Epidural Steroid Inj.	_____	_____
___	Lumbar Epidural Steroid Injection	_____	_____
___	Caudal Epidural Steroid Injection	_____	_____
___	Facet Joint Block	_____	_____
___	Facet Joint Denervation	_____	_____
___	Stellate Ganglion Block	_____	_____
___	Lumbar Sympathetic Block	_____	_____
___	Trigger point injection	_____	_____
___	Discogram	_____	_____
___	Occipital Nerve Block	_____	_____
___	Intercostal Nerve Block	_____	_____
___	Spinal cord stimulator	_____	_____
___	Intrathecal pump	_____	_____

Medical History: (including high blood pressure, diabetes, cancer, seizure disorder, stroke, etc)

Please List: _____

_____

Have you been hospitalized in the past? YES NO If yes, please explain:

Surgeries:

Have you had surgery in the past? YES NO

If yes, please list by date_____

_____

_____

Family's Medical History

Please list any major illnesses in your family. Including **cancer, stroke, high blood pressure, diabetes, chronic pain**, and others.

_____

_____

Medication Allergies

Drug	Reaction
_____	_____
_____	_____

Name: _____
DOB: _____

Are you allergic to iodine or contrast dye (for IVP, myelogram, etc.)? YES NO

If allergic, what happens? _____

Past Pain Medications: Have you ever taken any of the following pain-related medications? If so, please *check* and note any reason for discontinuing.

Medication	**Last dose** Amount	**Stopped due to:** Side Effect (please describe)	**Didn't Work**	**Stopped Working**
ACETAMINOPHEN (TYLENOL)	_____	_____	☐	☐
IBUPROFEN (MOTRIN, ADVIL)	_____	_____	☐	☐
TORADOL (KETOROLAC)	_____	_____	☐	☐
CELEBREX	_____	_____	☐	☐
ULTRAM (TRAMADOL)	_____	_____	☐	☐
CODEINE (Tylenol #3)	_____	_____	☐	☐
DEMEROL	_____	_____	☐	☐
DILAUDID	_____	_____	☐	☐
FENTANYL PATCH	_____	_____	☐	☐
KADIAN	_____	_____	☐	☐
HYDROCODONE (VICODIN)	_____	_____	☐	☐
METHADONE (DOLOPHINE)	_____	_____	☐	☐
MORPHINE (MS CONTIN)	_____	_____	☐	☐
OXYCONTIN	_____	_____	☐	☐
OXYCODONE (PERCOCET)	_____	_____	☐	☐
AMITRIPTYLINE (ELAVIL)	_____	_____	☐	☐
IMIPRAMINE	_____	_____	☐	☐
DESIPRAMINE	_____	_____	☐	☐
DOXEPIN (SINEQUAN)	_____	_____	☐	☐
NORTRIPTYLINE (PAMELOR)	_____	_____	☐	☐
CYMBALTA	_____	_____	☐	☐
EFFEXOR	_____	_____	☐	☐
PROZAC/PAXIL	_____	_____	☐	☐
TRAZADONE (DESYREL)	_____	_____	☐	☐
WELLBUTRIN	_____	_____	☐	☐
LIDODERM PATCH	_____	_____	☐	☐
BUTORPHANOL (STADOL	_____	_____	☐	☐
PENTAZOCINE HCI (TALWIN)	_____	_____	☐	☐
PROPOXYPHENE (DARVOCET)	_____	_____	☐	☐
NEURONTIN	_____	_____	☐	☐
DEPOKOTE	_____	_____	☐	☐
TEGRETOL	_____	_____	☐	☐
TOPAMAX	_____	_____	☐	☐
LAMICTAL	_____	_____	☐	☐
DEXTROMETHORPHAN	_____	_____	☐	☐
VALIUM	_____	_____	☐	☐
XANAX	_____	_____	☐	☐
SKELAXIN	_____	_____	☐	☐
ZANAFLEX	_____	_____	☐	☐
SOMA	_____	_____	☐	☐

Review of Systems: Please review the list below. If you have currently, or have had a *problem* in any of these areas, please circle **"yes"** and explain in the space below. If not, please circle **"no"**.

General/ENT

Skin	NO	YES _____
Head	NO	YES _____
Eyes	NO	YES _____
Ears	NO	YES _____
Nose/Sinus	NO	YES _____

Lungs and Chest

Asthma	NO	YES _____
Emphysema	NO	YES _____
Lung Cancer	NO	YES _____
Pneumonia	NO	YES _____

Heart and Blood Vessels

Heart attack	NO	YES _____
Angina (chest pain)	NO	YES _____
High blood pressure	NO	YES _____
Irregular heartbeat	NO	YES _____
Poor circulation in legs	NO	YES _____
Blood clot in legs	NO	YES _____
Blood clot in lungs	NO	YES _____
Sores that won't heal	NO	YES _____
Swellings in legs	NO	YES _____

Urinary/Genital

Kidney stones	NO	YES _____
Painful urination	NO	YES _____
Urinary dribbling	NO	YES _____
Difficult urinating	NO	YES _____
Urinary infections	NO	YES _____
Sexually transmitted diseases	NO	YES _____
Incontinence	NO	YES _____

Bones/Joints

Broken bones	NO	YES _____
Arthritis	NO	YES _____
Amputations	NO	YES _____

Nerves/Brain

Sensation loss	NO	YES _____
Fainting	NO	YES _____
Seizures	NO	YES _____
Stroke	NO	YES _____
Spinal cord injury	NO	YES _____

Name: _____
DOB: _____

Multiple sclerosis NO YES _____

Headache/Migraine NO YES _____

Coordination loss NO YES _____

Weakness/Paralysis NO YES _____

Disc problems NO YES _____

Blood

Anemia ("low blood") NO YES _____

Abnormal clotting NO YES _____

Easy bruising/bleeding NO YES _____

Transfusions NO YES _____

Stomach/Esophagus/Intestines

Heartburn NO YES _____

Nausea/Vomiting NO YES _____

Constipation NO YES _____

Diarrhea NO YES _____

Hemorrhoids NO YES _____

Gallstones NO YES _____

Changes in stool NO YES _____

Hernia NO YES _____

Ulcers NO YES _____

Polyps NO YES _____

Psychology/Psychiatry

Depression NO YES _____

Anxiety NO YES _____

Panic attacks NO YES _____

Suicidal thoughts NO YES _____

Sleep disturbance NO YES _____

Irritability NO YES _____

Mood swings NO YES _____

Counseling NO YES _____

Endocrine

Heat/Cold Intolerance NO YES _____

Weight Loss/Gain NO YES _____

Change in Appetite NO YES _____

Change in Sexual Desire NO YES _____

<u>Male</u>

Erectile Dysfunction NO YES _____

<u>Female</u>

Abnormal Vaginal Bleeding, Discharge, or Pain NO YES _____

Name: _____
DOB: _____

Breast Lumps, Discharge NO YES _____

Change in Menstrual Cycle NO YES _____

WORK:

Do you work? Yes No

If yes, what do you do? _____How many hours per day_____

If no, how long have you been out of work? _____ *What was your occupation?* _____

If you do not work, how do you spend your day? _____

Have you ever been in the military? Yes No

Are you able to do household chores? Yes No (explain)_____

INCOME:

Are you on *Disability*? Yes No

Are you involved with *Worker's Compensation*? Yes No

Is there any *litigation* pending against an employer or individual involved in an accident or injury? Yes No

Are you *applying* for disability or worker's compensation? If so, which one? _____

HOUSEHOLD:

What are your hobbies?_____

Circle your present marital status? Single Married Separated Divorce Widowed

If you have children, how many and how old?_____

DAILY ACTIVITIES:

What exercises do you participate in? _____

Circle the number between 0 and 10 which represents your activity level.

(inactive) 0 1 2 3 4 5 6 7 8 9 10 (Very active)

SPIRITUALITY:

Do you have a religious affiliation? YES _____ NO

Circle the number between 0 and 10 which represents your involvement in religious activities (i.e. church, synagogue, mosque)

(no involvement) 0 1 2 3 4 5 6 7 8 9 10 (Actively involved)

EDUCATION:

Have you completed? (circle) Grade School High School Junior College College

Trade School Graduate School Professional School

SOCIAL:

Circle the number between 0 and 10 which represents your involvement in social activities

(no involvement) 0 1 2 3 4 5 6 7 8 9 10 (Actively involved)

Is this a change since the onset of your pain? YES NO

Do you smoke? YES NO If yes, how many packs per day? _____ How many years? _____

Do you use alcohol? YES NO About how often? _____

Name: _____
DOB: _____

Was there ever a time in your life when you may have had an alcohol problem? YES NO

Did you or do you use *street drugs*? If yes, which ones _____ NO

Have you ever been *addicted* to prescription drugs YES NO

Does anybody in your family have a history of drug misuse/abuse/addiction? YES NO

Have you ever been in a **treatment program** for *alcohol* or *drug abuse*?

If Yes, please explain_____

Current Opioid Therapy, if applicable (for example, percocet, oxycontin, duragesic patch):

What percent relief do your opioids (*narcotics*) provide? _____%

Do you you have any side effects from your opioids? (*circle those that apply*) no side effects, constipation, itching, dry mouth, nausea, erectile problems, menstrual change, vomiting, dizziness, sleepiness, lightheadedness, problems urinating, appetite change, tooth decay.

Are you any more functional from using opioids? *(circle*) No Yes If so, how?

_____

Are your opioids kept in a secure place? (*circle*) No Yes Where?_____

Do you feel that your mood has improved from opioid therapy? (*circle)* No Yes If so, how?

_____

Has your quality of life improved? *(circle)* No Yes If so, how?_____

Name of pharmacy listed on opioid bottle? _____

EXPECTATIONS:

What are you hoping to gain from your visit with Severn Anesthesia and nterventional Pain Medicine?

_____

_____

_____

Circle the percentage of pain relief you would feel would make your treatment worthwhile.

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

THANK YOU FOR COMPLETING THIS FORM.