



SUMMIT

Pain Management

INITIAL PATIENT QUESTIONNAIRE

Last name: _____ First name: _____

AKA/Maiden Name: _____

Date of Birth: _____ Age: _____

Referring physician: _____

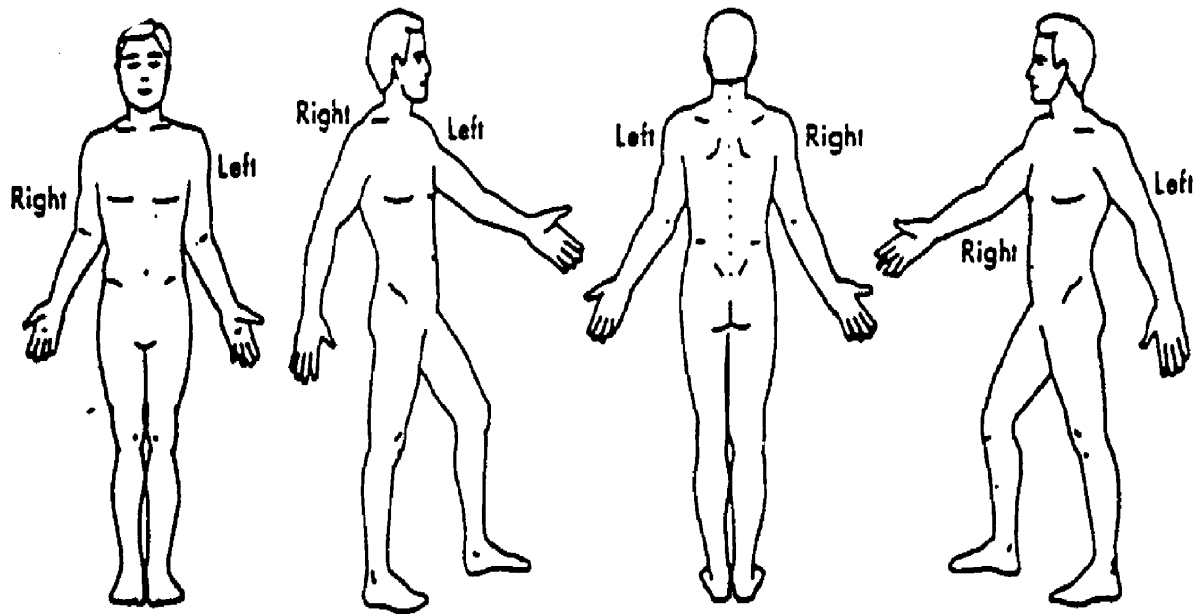
Primary care physician _____

Reason for your visit today: _____

When did your pain begin? _____

If an injury caused your pain, describe the injury and give the date it occurred: _____

Shade in the area(s) where you have pain



Circle the words that describe your pain:

- | | | | | |
|-----------|----------|---------|-------------|------------|
| Aching | Stabbing | Sharp | Penetrating | Unbearable |
| Throbbing | Gnawing | Tender | Tingling | |
| Shooting | Numbing | Burning | Crawling | |

Have you tried any of the following therapies for your pain?

	Yes	No	Did it help?
Pain Clinic	_____	_____	_____
Injections	_____	_____	_____
Medication	_____	_____	_____
Biofeedback, Relaxation or Hypnosis	_____	_____	_____
Counseling	_____	_____	_____
Physical Therapy	_____	_____	_____
Tens Unit	_____	_____	_____
Chiropractor	_____	_____	_____
Acupuncture	_____	_____	_____
Other _____	_____	_____	_____

If you have had surgery **for your pain** please list both type of surgery and date.

Have you had any of the following tests?

	When?	Where?
X-rays:	_____	_____
CT Scan	_____	_____
MRI:	_____	_____
Bone Scan	_____	_____
Myelogram	_____	_____
EMG Nerve Test	_____	_____
Other _____	_____	_____

Pain severity

During the past two weeks, my **average pain score** has been, from zero to ten, ten being the highest. _____

During the past two weeks, my **lowest pain score** has been, from zero to ten, ten being the highest. _____

During the past two weeks, my **highest pain score** has been, from zero to ten, ten being the highest. _____

My **pain score today** is, from zero to ten, ten being the highest. _____

What makes your pain worse? _____

What makes your pain better? _____

SLEEP QUESTIONS

Pain interferes with my sleep: (circle one)

Never Sometimes Every night

My sleep pattern is: (circle one)

Restless Broken Sound

In the morning I feel: (circle one)

Refreshed Fatigued

Describe sleep interference: _____

MOOD AND PAIN QUESTIONS

Describe your mental health history prior to the onset of your pain: _____

Describe your mental health history since the onset of your pain: _____

Are you actively seeing a psychologist at this time? Yes ___ No ___

Are you actively seeing a psychiatrist at this time? Yes ___ No ___

Your estimation of the effectiveness of treatment: _____

Describe how your mood influences your pain: _____

Describe how your pain influences your mood: _____

FUNCTION QUESTIONS

What time of day is your pain worse? (circle one)

Morning Afternoon Evening Nighttime

What time of day is your pain better? (circle one)

Morning Afternoon Evening Nighttime

Pain interferes with my daily activities: (circle one)

Never Sometimes Most of the time Always

Describe interference: _____

Describe your average day: _____

MEDICAL HISTORY

Please list all **PRESCRIPTION** medications you take:

Medication Name	Dose	How often	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all **OVER THE COUNTER** medications you take:

Medication Name	Dose	How often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you **allergic** to any medications? Yes No

If so please list:

Medication Name	Reaction
_____	_____
_____	_____
_____	_____

List any **surgeries** you have undergone:

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

List any **medical problems** you have that require you to see a physician or take medications. Please include past hospitalizations, illness and treatments, do not including surgeries:

_____	_____
_____	_____
_____	_____
_____	_____

FAMILY MEDICAL HISTORY

Do any medical problems run in your family? Yes No

- Allergies - seasonal Yes No
- Arthritis Yes No
- Asthma Yes No
- Cancer Yes No
- Diabetes Yes No
- Fibromyalgia Yes No
- Heart Problems Yes No
- High Blood Pressure Yes No
- High Cholesterol Yes No
- Kidney Disease Yes No
- Lupus Yes No
- Mental Illnesses Yes No
- Stroke Yes No
- Substance Abuse Yes No
- Thyroid Problems Yes No
- Other _____ Yes No

SOCIAL HISTORY

Do you drink alcohol? ___ Yes ___ No How often? _____

What do you drink? _____

Health related problems: _____

Alcohol treatment program? ___ Yes ___ No

Date(s): _____

Outcome: _____

Do you use caffeine? ___ Yes ___ No What do you drink? _____ How often? _____

Health related problems: _____

Do you smoke? ___ Yes ___ No Packs per day _____ # of years _____

Health related problems: _____

Street drug use?

Past? ___ Yes ___ No

Current? ___ Yes ___ No

Drugs used/using: _____

Treatment program ___ Yes ___ No

Date(s): _____

Outcome: _____

Marital Status: Please Circle

Married Divorced Widowed Single Separated

Children: ___ Yes ___ No How many? _____

Who lives with you? _____

Occupation: _____ Full time ___ Part time ___ Retired ___ Disabled ___

Hours per week _____

Do you receive disability compensation? ___ Yes ___ No

Is a lawyer involved for disability of injury? ___ Yes ___ No

Occupational hazards: ___ Yes ___ No

List any hazards:

Stress: _____

Substances: _____

Lifting: _____

Other: _____

Highest level of Education: _____

Currently a Student ___ Yes ___ No

MEDICAL QUESTIONNAIRE

Have you had any of these problems on a **regular** basis?

- Weight loss Yes No
- Regular fevers or chills Yes No
- Night sweats Yes No
- Spinning Yes No
- Blackout Yes No
- Eyes
 - Visual changes Yes No
 - Flashes or halos Yes No
 - Acuity Yes No
 - Eye pain Yes No
 - Eye discharge Yes No
- Head and Neck
 - Ear pain Yes No
 - Unusual hearing loss Yes No
 - Ringing in ears Yes No
 - Change in smell Yes No
 - Change in taste Yes No
 - Change in swallowing Yes No
 - Sinus problems Yes No
 - Nose bleeds Yes No
 - Neck pain Yes No
 - Neck decreased range of motion Yes No
- Cardiovascular
 - Chest pain Yes No
 - Palpitations Yes No
 - Leg Swelling Yes No
 - Shortness of Breath - Lying down Yes No
 - High blood pressure Yes No
 - Low blood pressure Yes No
- Pulmonary
 - Shortness of breath Yes No
 - Persistent cough Yes No
 - Increased sputum production Yes No
 - Wheezing Yes No
 - Coughing up Blood Yes No
- Gastrointestinal
 - Decreased appetite Yes No
 - Bloating Yes No
 - Abdominal pain Yes No
 - Stomach ulcers Yes No
 - Acid Reflux Yes No
 - Liver problems Yes No
 - Change in bowel habit Yes No
 - Loss of control of your bowels Yes No
 - Vomiting Blood Yes No
 - Blood in Stool Yes No
- Genitourinary
 - Painful Urination Yes No

Blood in Urine	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Kidney disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Frequent urinary tract infections	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Lack of bladder control	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If you are a female of child bearing age, could you possible be pregnant?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Musculoskeletal				
Arthritis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bursitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Fractures	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Decrease range of motion in a joint	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Surgically replaced joints	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Pain or weakness in an extremity	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Skin				
Skin rashes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bruise easily	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Poor healing sores	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Breast lump	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Nipple discharge	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Neurological				
Forgetfulness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Loss of sleep	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Stroke	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Seizure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Frequent headaches	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Inability to maintain balance	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Loss of strength	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Loss of sensation	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hormone				
Pituitary gland	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Thyroid	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Parathyroid	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Adrenal gland	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Male hormones	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Female hormones	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Psychiatric				
Anxiety	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bulimia/anorexia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Depression	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Blood/Lymphatic				
Anemia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Anticoagulants - Blood Thinners	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Benign tumors	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bleeding disorders	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Allergic/immunologic				
AIDS	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Itching	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hives	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No