PATIENT INFORMATION QUESTIONNAIRE

Name:_____ Date of Birth_____
Last First Middle

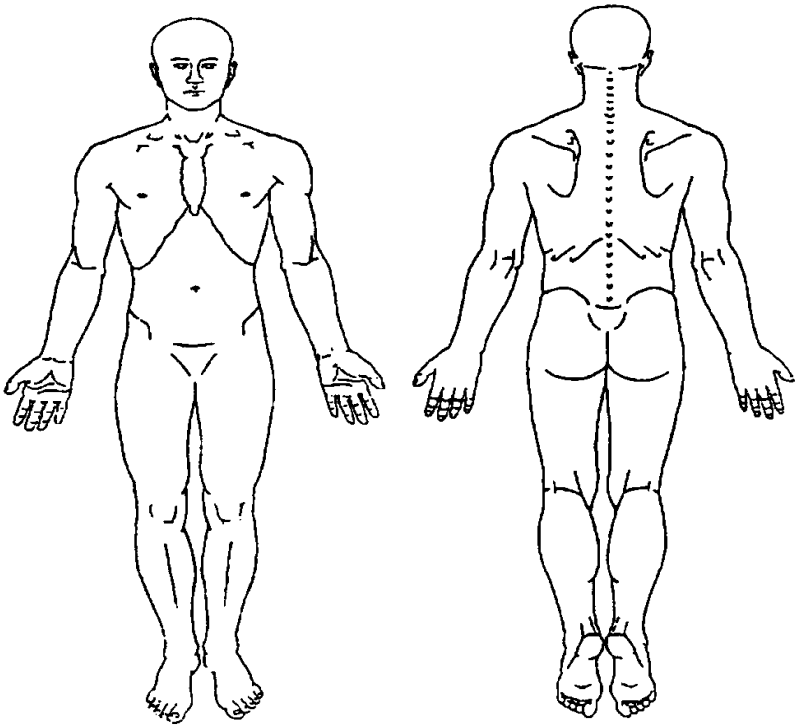
Sex:_____(male, female, male-to-female, female-to-male) Preferred pronouns: _____

Referring Physician
Practice Name:_____
Physicians Name:_____
Address: _____
_____
Phone: _____

Primary Care Physician
Practice Name: _____
Physicians Name: _____
Address:_____
_____
Phone: _____

Describe your most disabling/severe pain:
_____
_____

right left left right



Approximately when did your pain begin?

_____

Describe the circumstances around the beginning of your pain (e.g. type of injury or trauma or surgery, etc):

_____
_____
_____

Does the pain radiate anywhere? If so, where?

_____
_____
_____

Please mark the area(s) on the diagram in which you are in pain.

Circle the number that best describes how severe your pain is currently?

|----------|----------|

0 no pain 1 2 mild 3 4 discomfort 5 6 distress 7 8 horrible 9 10 worst pain imaginable

Based on this scale what number (0-10) is your pain at its best? _____ and at its worst? _____

How long has this episode of pain been going on?
☐ < 1 week ☐ 1-4 wks ☐ 1-3 months
☐ 3-6 months ☐ 6-12 months ☐ > 1 year

How often does the pain occur?
☐ Continuously ☐ Several times per day
☐ Intermittent ☐ Occasionally ☐ Less than daily

How has the pain intensity changed since it began? ☐ Increased ☐ Decreased ☐ No change

Select one or more items below to describe the nature of your pain:
☐ Throbbing ☐ Shooting ☐ Sharp ☐ Cramping ☐ Hot/burning ☐ Aching ☐ Stabbing
Other: _____

Is the pain associated with any other symptoms (numbness/tingling/weakness/incontinence/etc.)?

_____

How do the following factors affect your pain? (check one blank per number)

	Better	Worse	No effect		Better	Worse	No effect
1. Heat	☐	☐	☐	6. Standing	☐	☐	☐
2. Cold	☐	☐	☐	7. Stairclimbing	☐	☐	☐
3. Lying down	☐	☐	☐	8. Massage	☐	☐	☐
4. Sitting	☐	☐	☐	9. Lifting objects	☐	☐	☐
5. Walking	☐	☐	☐	10. Coughing	☐	☐	☐
				Other:_____	☐	☐	☐

Which of the following activities are affected by your pain?
☐ Falling asleep ☐ Social Interaction ☐ Household Chores
☐ Staying asleep ☐ Sexual Activity ☐ Work/School ☐ Leisure

What goals do you wish to achieve with pain management?

_____

Give the dates of the tests you have had to diagnose your pain:
X-rays _____ Myelogram _____
CT Scan _____ Nerve conduction/EMG _____
MRI _____ Other _____

List the name(s) of other specialists including previous pain clinics/specialists you have seen for you pain:

Name	Specialty	Dates seen

Give the dates of treatments you have had for your pain

Acupuncture	_____	Exercise	_____	Physical Therapy	_____
Biofeedback	_____	Facet block	_____	Psychotherapy	_____
Brace	_____	Hypnosis	_____	Surgery	_____
Chiropractor	_____	Massage	_____	TENS unit	_____
Epidural	_____	Nerve block	_____	Trigger Point	_____

Other_____

Do you have any drug allergies?
☐ ***No*** known drug allergies ☐ ***Yes*** (please list drug and reaction):

_____

List all medications you are currently taking:

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

Past pain medications tried with dosage and duration of treatment:

_____
_____
_____

Past Surgical History

Surgery	Year	Surgery	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Please check any of the conditions below that run in your family:

☐ Arthritis ☐ Stroke ☐ Depression ☐ Diabetes ☐ Heart disease
☐ Lupus ☐ Cancer -type:_____ ☐ Other:_____

Past Medical History

_____
_____
_____

Review of Systems

Constitutional

☐ Obesity ☐ Weight Gain ☐ Chills ☐ Fever
☐ Weight loss ☐ Night Sweats ☐ Fatigue

Musculoskeletal

☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Fibromyalgia ☐ Numbness ☐ Weakness

Neurological

☐ Headache ☐ Seizures ☐ Confusion ☐ Light sensitivity
☐ Migraines ☐ Stroke ☐ Dizziness ☐ Loss of consciousness

Psychiatric

☐ Depression ☐ Substance use ☐ Anxiety ☐ Suicidal thoughts
☐ Difficulty Sleeping disorder

Cardiovascular

☐ Angina ☐ Heart Stent ☐ Chest Pain ☐ Palpitations
☐ Heart Attack ☐ Pacemaker

Respiratory

☐ Asthma ☐ Emphysema ☐ Shortness of breath

Gastrointestinal

☐ Reflux ☐ Hepatitis ☐ Abdominal Pain ☐ Diarrhea
☐ Incontinence ☐ Ulcers ☐ Bloating ☐ Heartburn
☐ Irritable bowel syndrome ☐ Constipation ☐ Nausea

Genitourinary

☐ Impotence ☐ Kidney stones ☐ Decreased libido ☐ Urinary frequency
☐ Urinary Incontinence ☐ Urinary tract infection ☐ Prostate problems ☐ Urinary hesitancy

Integumentary

☐ Herpes Zoster ☐ Skin Cancer ☐ Rash ☐ Swelling

Endocrine, Hematologic, Allergy/Immunologic, HEENT

☐ Cancer:_____ ☐ HIV ☐ Bruise easily ☐ Visual changes
☐ Diabetes ☐ Thyroid problems ☐ Ringing in ears

Rheumatologic

☐ Lupus ☐ Polymyalgia Rheumatica ☐ Other:_____

Social History

Please list everyone with whom you live:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which of the following describes your marital status?

☐ Single ☐ Married
☐ Separated ☐ Divorced
☐ Widow(er) ☐ Other:_____

What is your employment status? (Current or former profession:_____)

☐ Full time ☐ Part time ☐ On disability ☐ Retired ☐ Workman's Comp ☐ Unemployed

How much education have you completed? ☐ Grade-yrs___; ☐ high school; ☐ college; ☐ other:_____

Do you having pending settlement for disability, workman's comp or a legal matter? ☐ Y ☐ N

Do you use or have used at any time any of the following?

☐ Alcohol
☐ Yes ☐ No
☐ Present ☐ Past

☐ Tobacco products
☐ Yes ☐ No
☐ Present ☐ Past

☐ Recreational Drugs (including narcotics)
☐ Yes ☐ No
☐ Present ☐ Past
Please list: _____

Services and Treatment Policy

We are pleased that your physician has requested a consultation for you at the Rex Pain Management Center. Our goal is to provide you with a proper diagnosis and plan for the most effective treatment of your pain.

We expect that you may have had previous attempts to treat your pain prior to your consultation with us. In some instances, the use of pain medications on a long-term basis is appropriate. However, the Rex Pain Management Center is not obligated to prescribe narcotic drugs or provide any treatment procedures during your consultation with us. We firmly believe it is in your best interest to have a complete evaluation to determine the most effective method to reduce pain and restore function. Continuing a therapy that does not achieve those goals would defeat the purpose of the evaluation. Additionally, please do not terminate care with another physician because you have an appointment in the Rex Pain Management Center. Based on the outcome of your evaluation, we may make recommendations to your current physicians without arranging further follow-up in the Rex Pain Management Center.

Unfortunately, many conditions, which cause chronic pain also, cause disability. The process of disability evaluation and filing of claims is quite extensive. At the current time, the Rex Pain Management Center does not perform disability evaluations. Your referring physician should be able to assist you in coordinating disability evaluations when appropriate.

Appointment Policy

If you are unable to make your scheduled appointment, you must call to cancel the appointment no later than 24 hours before the scheduled time. Repeated “no shows” and cancellations of your scheduled appointments may result in your being discharged from care at the Rex Pain Management Center. You will be referred back to your primary care physician or to another chronic pain management facility.

My signature below confirms that I have read and agree to abide by the above policies.

Patient Signature_____ Date _____