Pain Care Clinics

Review of Systems Form

Affix Patient Label

Patient's Name _____ Date Completed _____

Constitutional Symptoms	*Yes*	*No*
Fatigue	___	___
Recent weight loss/gain	___	___
Recurring fever	___	___
Eyes		
Eye disease or injury	___	___
Wear glasses/contacts	___	___
Blurred/double vision	___	___
Glaucoma	___	___
Ear, Nose, Mouth, Throat		
Hearing loss or ringing	___	___
Ear infection/drainage	___	___
Chronis sinus problems	___	___
Nosebleeds	___	___
Mouth sores	___	___
Bleeding gums	___	___
Hoarseness	___	___
Swollen glands in neck	___	___
Cardiovascular		
Chest pain	___	___
Heart attack	___	___
Palpitations	___	___
Swelling of feet, hands, ankles	___	___
Rheumatic fever	___	___
Heart valve replacement	___	___
High blood pressure	___	___
Low blood pressure	___	___
Mitral valve prolapse	___	___
Heart Murmur	___	___
High cholesterol	___	___
Pacemaker	___	___
Respiratory		
Chronic or frequent cough	___	___
Spitting up blood	___	___
Shortness of breath	___	___
Asthma or wheezing	___	___
Tuberculosis	___	___
Emphysema	___	___
Pulmonary Disease	___	___
Sleep Apnea	___	___
If yes, use breathing machine	___	___
Use home oxygen	___	___

Gastrointestinal	*Yes*	*No*
Loss of appetite	___	___
Nausea/Vomitting	___	___
Frequent diarrhea	___	___
Constipation	___	___
Rectal Bleeding	___	___
Abdominal pain	___	___
Stomach ulcer/heartburn	___	___
Hepatitis	___	___
Cirrhosis	___	___
Pancreatitis	___	___
Genitourinary		
Renal (Kidney) Disease	___	___
Frequent urination	___	___
Burning or painful urination	___	___
Blood in urine	___	___
Sexually transmitted disease	___	___
Prostate disease	___	___
Musculoskeletal		
Arthritis, degenerative	___	___
Arthritis, rheumatoid	___	___
Joint pain	___	___
Weakness of muscle/joints	___	___
Muscle pain or cramps	___	___
Back pain	___	___
Cold extremities	___	___
Difficulty walking	___	___
Muscular dystrophy	___	___
Osteoporosis	___	___
Joint replacement	___	___
Fibromyalgia	___	___
Skin		
Rash/itching	___	___
Change in skin colour	___	___
Change in hair	___	___
Hives	___	___
Psoriasis	___	___
Other		
_____		
_____		
_____		

Psychiatric	*Yes*	*No*
Alzheimer's disease	___	___
Memory loss/confusion	___	___
Depression	___	___
Suicidal thoughts	___	___
Chemical dependency	___	___
Neurological		
Frequent/recurring headaches	___	___
Migraines	___	___
Light headed/dizzy	___	___
Convulsions/seizures	___	___
Numbness or tingling	___	___
Paralysis	___	___
Stroke	___	___
Head injury	___	___
Polio	___	___
Multiple sclerosis	___	___
Cerebral Palsy	___	___
Endocrine		
Diabetes	___	___
If Diabetic, average blood sugar		
_____		
Insulin Dependent?	___	___
Non-Insulin Dependent?	___	___
Diet Controlled?	___	___
Thyroid disease	___	___
Glandular/hormonal prob.	___	___
Excessive thirst or urination	___	___
Hematologic/lymphatic		
Slow to heal after cuts	___	___
Bleeding or bruising	___	___
Anemia	___	___
Phlebitis/blood clots	___	___
Past transfusions	___	___
Leukemia	___	___
Lymphoma	___	___
HIV/AIDS	___	___
Sickle cell	___	___
Cancer	___	___
Radiation Treatment	___	___

X_____ _____

Patient/Legal Representative/Parent Signature Date Physician's Signature Date

For office use only:

_____ _____

Patient/Legal Representative/Parent Signature Date Physician's Signature Date

_____ _____

Patient/Legal Representative/Parent Signature Date Physician's Signature Date

PAIN CARE CLINICS
New Patient Questionnaire

PLEASE NOTE THIS DOCUMENT IS TWO-SIDED

PATIENT DEMOGRAPHIC

Patient Name (first, last): _____ Date: _____

Address: _____

Phone: (Home) _____ (Office) _____ (Mobile) _____

Date of Birth: (Month, Day, Year) _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Gender: (Please Circle) Male Female Hand Dominance: (Please Circle) Left Right

Family/ Referring Doctor: _____ Phone: _____

Address: _____ Fax: _____

INSURANCE INFORMATION (as Applicable)

WSIB Claim Number: _____ WSIB Contact: _____ Phone: _____

Date of Index Injury: _____ File Resolved: Yes No WSIB Referrals: _____

Insurance Claim Number: _____ Insurance Company: _____

Extended Health Benefits Company: _____ Policy Number: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

HISTORY OF PRESENTING COMPLAINT

Main Complaint: (Why were you referred) _____

What caused this problem: (Please Circle) Work Injury Auto Accident Unknown Other: _____

_____

How long have you had this pain problem: _____

Is your pain: (Circle all that apply) Dull Achy Constant Sharp Shooting Other: _____

_____

_____

Do you experience: (Circle all that apply) Burning Tingling Cramping Numbness Shooting Other: _____

_____

Pain increased with: (Please Circle) Sitting Standing Walking Lying down Other: _____

Pain decreased with: Sitting Standing Walking Lying down Other: _____

How Long Can you: Sit _____ No limit Stand: _____ No limit Walk: _____ No limit

Does your pain radiate to: (Please Circle) **Leg/Foot** Right Left **Arm/Hand** Right Left

BRIEF PAIN INVENTORY

1. Please rate your pain by circling the one number that best describes your pain at its WORST in the past week.

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)

2. Please rate your pain by circling the one number that best describes your pain at its LEAST in the past week.

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)

3. Please rate your pain by circling the one number that best describes your AVERAGE pain in the past week.

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)

4. Please rate your pain by circling the one number that best describes your pain RIGHT NOW.

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)

5. 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)

6. During the last week, please circle the one number that best describes how much RELIEF you have received from your pain medications.

(No relief) 0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (Complete relief)

7. If you take pain medication, how many HOURS does it take before the pain returns. (medication doesn't help)

0 1 2 3 4 5 6 7 8 9 10 11 12 >12

8. I prefer to take my pain medication:

On a regular basis *Only when necessary* *I do not take pain medication*

9. I take my pain medication (in a 24 hour period):

Not every day *1-2 times per day* *3-4 times per day* *5-6 times per day* *> 6 times per day*

10. Do you feel you need a stronger type of pain medication? *Yes* *No* *Uncertain*

11. Do you think you need more pain medication than your doctor has prescribed? *Yes* *No* *Uncertain*

12. Are you concerned that you use too much pain medication? *Yes* *No* *Uncertain*

13. Are you experiencing side effects from your pain medication? *Yes* *No*

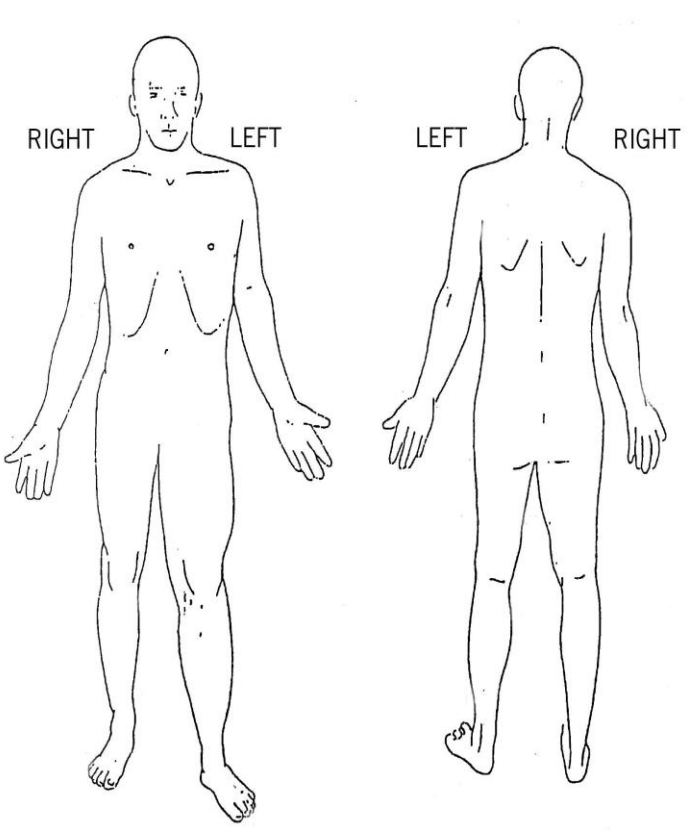
If yes, which ones: _____
_____
_____

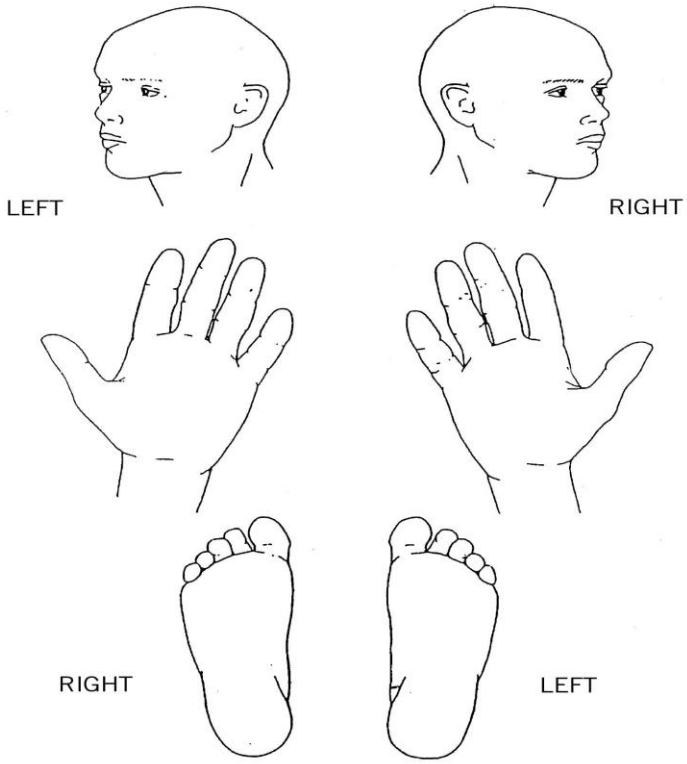
14. Do you feel you require more information about your pain medication? *Yes* *No*

If yes, which ones: _____

_____
_____

Please ***shade*** in the areas where pain is bothering you. You may use ***arrows*** to show where pain shoots or radiates. You may also use ***symbols*** to represent different types of pain (eg. +++ is burning pain). Please identify symbols if you choose to use them.





PREVIOUS PAIN TREATMENTS

Surgery: (Type/Date/Surgeon) _____
_____
_____
_____
_____

Injections: (Type/ Date/ Doctor) _____

Injections: (Type/ Date/ Doctor) _____

Please list other specialist doctors you have seen for your pain problem: _____
_____
_____

Have you tried: Physiotherapy Acupuncture Chiropractor Massage Other:
_____

Did they provide any relief: _____
_____
_____
_____

PAST MEDICAL HISTORY

Surgical:

_____
_____
_____

Medical:

_____
_____
_____

Do You Have A History Of The Following?

High blood pressure Diabetes Heart disease Stroke Liver disease/hepatitis Kidney disease Seizure

Lung disease Asthma Fracture Joint replacement Arthritis HIV/AIDS Thyroid disease Cancer

Blood clots Headaches Depression Anxiety
OTHER_____

Details of above: _____

Are you taking any blood thinners? If so which? _____

DIAGNOSTICS TESTS *(Please give details of test date and where test was performed)*

X-Ray: _____
_____
_____

CT-Scan: _____
_____
_____

MRI: _____
_____
_____

Ultrasound: _____
_____
_____

EMG/Nerve conduction tests: _____

_____
_____

Other: _____
_____
_____
_____

PREVIOUS PAIN MEDICATIONS AND REASON FOR STOPPING

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

CURRENT MEDICATIONS AND DOSE

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

ALLERGIES (Rash/hives/difficulty breathing) TO MEDICATIONS AND REACTION

1. _____ 3. _____
2. _____ 4. _____

Have you or a family member ever had a reaction to an local or general anesthetic: Yes No
Details: _____
_____

FAMILY HISTORY

Please list all known medical conditions in parents/siblings/children (Please include any history of alcoholism, street drug abuse, and/or prescription drug abuse): _____
_____

SOCIAL HISTORY

Marital Status: single married common law divorced widow other:
_____

Currently residing with: _____ Ages of children: _____

Occupation: _____ Full-time Part-time Retired Disability Unemployed/Disabled since:
_____

Education: highest level completed_____ diploma/degree (s):
_____

SLEEP HISTORY

Do you have any difficulty with your sleep? Yes No

Do you have trouble falling asleep? Yes No

Do you have trouble staying asleep? Yes No

Do you wake up because of pain? Yes No

Do you take medication to help you sleep? Yes No

What sleep aids do you (have you) use: _____
_____
_____

SEXUAL HISTORY (If Applicable)

Are you concerned about this issue? Yes No

Have you noticed that your sexual function has been impacted by your pain problem? Yes No

Do you think it is related to your pain medicine? Yes No

Is the issue primarily lack of desire? (Yes No), lack of physical ability? (Yes No), or both? (Yes No)

Addiction Risk

Smoking History: how many years have you smoked? _____ How many cigarettes or packs per day? _____

Alcohol - Do you drink: ____ If so how often: _____ Preferred Drink(s): _____

Average number consumed when you drink: _____ Average per week: _____

Have you ever felt you should cut down on your drinking? Yes No

Have people annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink in the morning to steady your nerves? Yes No

Illegal Drug Use (please circle all that apply, past or present):

Cocaine Marijuana Heroine Ecstacy Steroids Amphetamines

Other: _____

Details/When last used: _____

Have you ever purchased prescription drugs off the street? (Please circle all that apply, past or present):

Oxycontin Percocet Tylenol with Codeine Methadone Benzodiazepine (eg; Valium, Lorazepam/Ativan, Clonazepam ,etc.) Other: _____

Details/when last used: _____

Have you ever abused PRESCRIPTION DRUGS acquired from a Medical Doctor? Yes No

Details _____

NOTES:

_____
_____
_____
_____
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Thank you for completing this questionnaire.

Patient Signature: _____ Doctors Signature: _____

HADS

Please read each statement below and circle the number which best describes how true the feeling is for you.

Please circle one number per question	Yes, please	Yes, sometimes	No, not much	No, not at all
1. I wake early and then sleep badly for the rest of night	3	2	1	0
2. I get very frightened or have panic feeling for apparently no reason at all.	3	2	1	0
3. I feel miserable and sad	3	2	1	0
4. I feel anxious when I go out of the house	3	2	1	0
5. I lost interest in things	3	2	1	0
6. I get palpitations or sensations of butterflies in my stomach or chest	3	2	1	0
7. I have a good appetite	0	1	2	3
8. I feel scared or frightened	3	2	1	0
9. I feel life is not worth living	3	2	1	0
10. I still enjoy the things I used to	0	1	2	3
11. I am restless and can't keep still	3	2	1	0
12. I am more irritable than usual	3	2	1	0
13. I feel as if I have slowed down	3	2	1	0
14. Worrying thoughts constantly go through my mind	3	2	1	0

A score = 2 + 4 + 6 + 8 + 11 + 12 + 14

D score = 1 + 3 + 5 + 7 + 9 + 10 + 13

Pain Care Clinics
FiRST

Patient Name: _____
Date Completed: _____

Fibromyalgia Rapid Screening Tool 2010

	Y / N
I have pain all over my body	
My pain is accompanied by a continuous and very unpleasant general fatigue	
My pain feels like burns, electric shocks or cramps	
My pain is accompanied by other unusual sensations throughout my body, such as pins and needles, tingling or numbness	
My pain is accompanied by other health problems such as digestive problems, urinary problems, headaches or restless legs	
My pain has a significant impact on my life, particularly on my sleep and my ability to concentrate, making me feel slower generally	
TOTAL	**/6**

Cut-off score	Sensitivity[a]	Specificity[a]
1	100	7.1
2	98.8	12.5
3	98.8	28.5
4	94.1	75.0
5	90.5	85.7
6	62.3	96.5

[a] The values in the table are percentages.

Pain. 2010 May 18. [Epub ahead of print], Development and validation of the Fibromyalgia Rapid Screening Tool (FiRST). Perrot S, Bouhassira D, Fermanian J

DN4 – QUESTIONNAIRE

To estimate the probability of neuropathic pain, please answer yes or no for each item of the following four questions.

INTERVIEW OF THE PATIENT

QUESTION 1:

Does the pain have one or more of the following characteristics?	**YES**	**NO**
Burning	❑	❑
Painful cold	❑	❑
Electric shocks	❑	❑

QUESTION 2:

Is the pain associated with one or more of the following symptoms in the same area?	**YES**	**NO**
Tingling	❑	❑
Pins and needles	❑	❑
Numbness	❑	❑
Itching	❑	❑

EXAMINATION OF THE PATIENT

QUESTION 3:

Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?	**YES**	**NO**
Hypoesthesia to touch	❑	❑
Hypoesthesia to pinprick	❑	❑

QUESTION 4:

In the painful area, can the pain be caused or increased by:	**YES**	**NO**
Brushing?	❑	❑

YES = 1 point
NO = 0 points

Patient's Score: /10