Pain Care Clinics
New Patient Questionnaire Part 1

PAIN CARE CLINICS

Patient Demographic

First Name | Last Name | D.O.B (YYYY-MM-DD)

Street Name | City | Province

Postal Code | Email

Phone (Home) | (Office) | (Mobile)

Height | Weight

Health Card Number | Version Code | Expiration (YYYY-MM-DD)

Gender Identity Male ☐ Female ☐ Other ☐ Hand Dominance Left ☐ Right ☐

Referring Healthcare Provider

Name | Preferred Pharmacy

Phone | Fax | Pharmacy Fax

Street Name | City | Province

Postal Code | Email

Insurance Information

Extended Health Benefits Company

Policy Number | Group Number

Have you been in a car accident in the last two years? No ☐ Yes ☐

WSIB Claim Number | WSIB Contact

Phone | Date of Injury (YYYY-MM-DD)

File Resolved? No ☐ Yes ☐ WSIB Referral Number

MVA Claim Number | Insurance Company

Emergency Contact

Name | Relationship

Phone

Area of Concern - Pain & Symptom History

Main Complaint (Why were you referred?)

What caused this problem? Work Injury ☐ Motor Vehicle Accident ☐ Unknown ☐

Illness ☐ Other ☐

If other, please explain

How long have you had this pain problem

Is your pain: Dull ☐ Achy ☐ Constant ☐ Sharp ☐ Shooting ☐ Other ☐

If other, please explain

Do you experience: Burning ☐ Tingling ☐ Cramping ☐ Numbness ☐ Shooting ☐ Other ☐

If other, please explain

Pain increased with Sitting ☐ Standing ☐ Lying Down ☐ Walking ☐ Other ☐

If other, please explain

Pain decreased with Sitting ☐ Standing ☐ Lying Down ☐ Walking ☐ Other ☐

If other, please explain

How long can you sit: ☐ Stand ☐ Walk ☐

Does your pain radiate to: Left Leg/Foot ☐ Left Arm/Hand ☐

Right Leg/Foot ☐ Right Arm/Hand ☐

Brief Pain Inventory

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

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

No Pain — Worst Imagainable

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

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

No Pain — Worst Imagainable

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

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

No Pain — Worst Imagainable

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

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

No Pain — Worst Imagainable

5. In the PAST WEEK, how much has pain interfered with each of the following? Select ONE number for each.

A. General activity

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Does Not Interfere — Interferes

B. Mood

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Does Not Interfere — Interferes

C. Walking ability

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Does Not Interfere — 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 — Interferes

E. Relations with other people

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Does Not Interfere — Interferes

F. Sleep

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Does Not Interfere — Interferes

G. Enjoyment of life

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Does Not Interfere — Interferes

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

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

No Relief — Relief

7. If you take pain medication, how many HOURS does it take before the pain returns.

0	1	2	3	4	5	6	7	8	9	10	11	12	>12
Medication doesn't help													

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? No ☐ Yes ☐ Not sure ☐

11. Do you think you need more pain medication than your doctor has prescribed? No ☐ Yes ☐ Not sure ☐

12. Are you concerned that you use too much pain medication? No ☐ Yes ☐ Not sure ☐

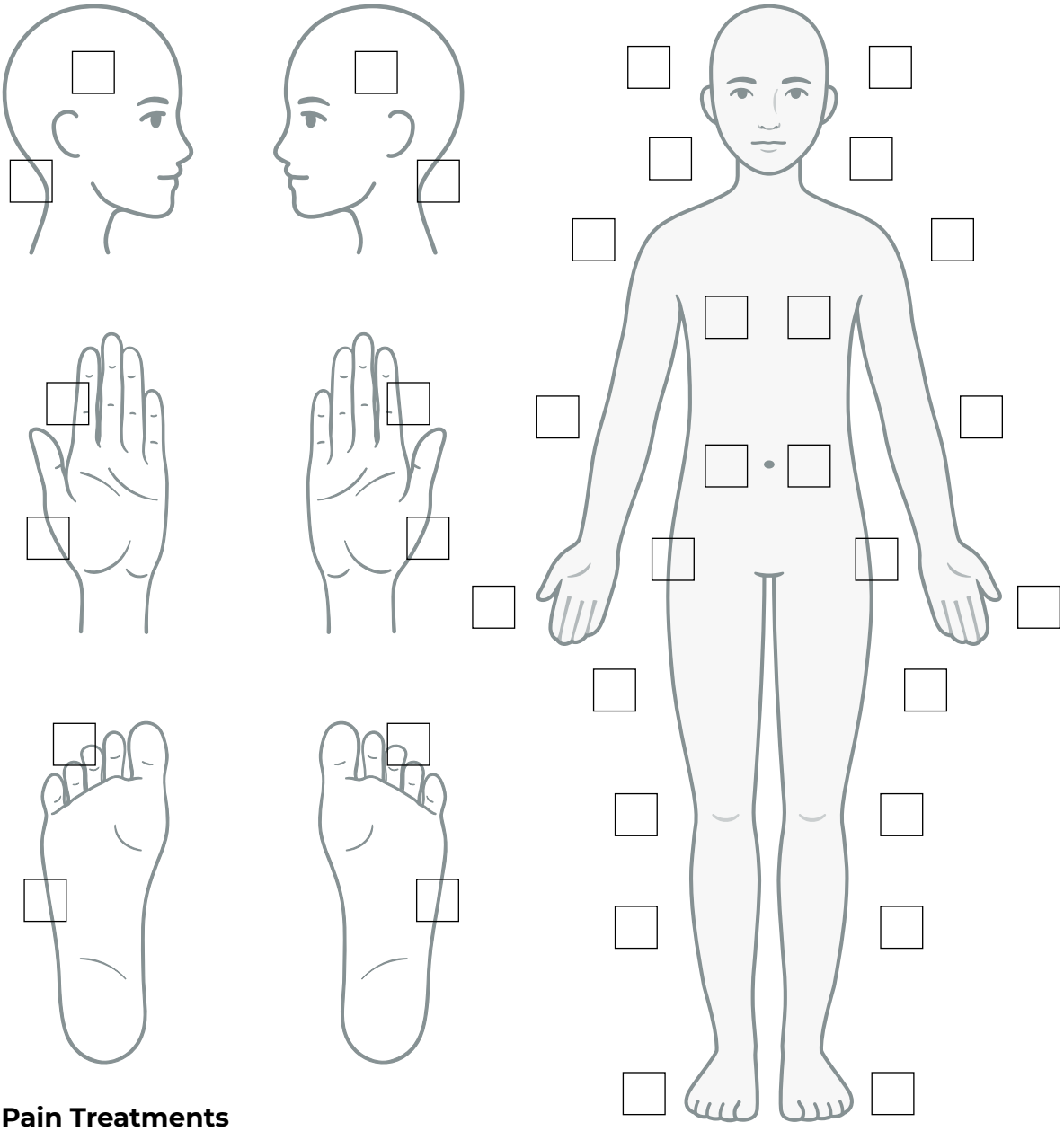
13. Are you experiencing side effects from your pain medication? No ☐ Yes ☐

If yes, which ones

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

If yes, which ones

Please click on the below diagram to select the areas where pain is bothering you. (you can click again to unselect)



Previous Pain Treatments

Surgery: (Type/Date/Surgeon)

Injections: (Type/Date/Doctor)

Injections: (Type/Date/Doctor)

Please list other specialists (neurologist, neurosurgeon, orthopedic, etc) that you have seen for your pain problem:

Have you tried: Physiotherapy ☐ Acupuncture ☐ Chiropractor ☐

Massage ☐ Other ☐

If other, please explain

Did they provide any relief:

Past Medical History

1. Surgical:

2. Medical:

3. Do You Have A History Of The Following?

☐ High blood pressure	☐ Stroke	☐ Lung disease	☐ Kidney disease
☐ Diabetes	☐ Liver disease/hepatitis	☐ Fracture	☐ Arthritis
☐ Heart disease	☐ Seizure	☐ Joint replacement	☐ HIV/AIDS
☐ Thyroid disease	☐ Headaches	☐ Anxiety	☐ Cancer
☐ Blood clots	☐ Depression	☐ Asthma	☐ Other

If Other, please explain

Details of above

4. Are you taking any blood thinners?

No ☐ Yes ☐

If Yes, Which?

5. Diagnostics Tests (Give details of test, date and where test was performed)

a. X-Ray

b. CT Scan

c. MRI

d. Ultrasound

e. EMG/Nerve conductions test

f. Other

Pain Medications and Reason for Stopping

Previous Medications

Current Medications and Dose

Allergies to Medications and Reaction (Rash, Hives, Difficulty Breathing)

Have you or a family member ever had a reaction to a local or general anesthetic? No ☐ Yes ☐

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 use):

Social History

Marital Status Single ☐ Married ☐ Common Law ☐ Divorced ☐ Widow ☐

Currently Residing With:

Ages of Children:

Occupation:

Full Time ☐ Part Time ☐ Retired ☐ Disability ☐ Unemployed ☐

If Disabled or Unemployed, please indicate date of onset

Education: Highest Level Completed

Diploma/ Degree(s):

Sleep History

Do you have any difficulty with your sleep? No ☐ Yes ☐ Occasional ☐

Do you have trouble falling asleep? No ☐ Yes ☐ Occasional ☐

Do you have trouble staying asleep? No ☐ Yes ☐ Occasional ☐

Do you wake up because of pain? No ☐ Yes ☐ Occasional ☐

Do you take medications to help you sleep? No ☐ Yes ☐ Occasional ☐

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

Sexual History

Are you concerned about this issue? No ☐ Yes ☐

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

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

Is the issue primarily lack of desire? No ☐ Yes ☐

Is the issue primarily a lack of physical ability? No ☐ Yes ☐

Or both? No ☐ Yes ☐

Addiction Risk

Smoking: Do you smoke? No ☐ Yes ☐

If yes, how many years have you smoked?

How many cigarettes or packs per day?

Alcohol: Do you drink? No ☐ Yes ☐

If so, how often:

Preferred drink:

Average number consumed when you drink:

Average number per week:

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

Have people annoyed you by criticizing your drinking? No ☐ Yes ☐

Have you ever felt bad or guilty about your drinking?

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

llegal Drug Use (Select all that apply)

Cocaine ☐ Heroin ☐ Ecstacy ☐ Steroids ☐ Amphetamines ☐ Other ☐

If other, please specify:

Details/When last used:

Have you ever purchased prescription drugs off the street? No ☐ Yes ☐

If yes, select all that apply Oxycontin ☐ Percocet ☐ Tylenol with Codeine ☐ Methadone ☐

Benzodiazepine (Valium, Lorazepam etc) ☐ Other ☐

If other, please specify:

Details/When last used:

Have you ever abused prescription drugs acquired from a Medical Doctor? No ☐ Yes ☐

If yes, please explain:

Patient Signature D.O.B

(YYYY-MM-DD)

Pain Care Clinics
New Patient Questionnaire Part 2

PAIN CARE CLINICS

Review of Systems Form

Constitutional Symptoms

Fatigue	No ☐	Yes ☐
Recent weight loss/gain	No ☐	Yes ☐
Recurring fever	No ☐	Yes ☐

Eyes

Eye disease or injury	No ☐	Yes ☐
Wear glasses/contacts	No ☐	Yes ☐
Blurred/double vision	No ☐	Yes ☐
Glaucoma	No ☐	Yes ☐

Ear, Nose, Mouth, Throat

Hearing loss or ringing	No ☐	Yes ☐
Ear infection/drainage	No ☐	Yes ☐
Chronic sinus problems	No ☐	Yes ☐
Nosebleeds	No ☐	Yes ☐
Mouth sores	No ☐	Yes ☐
Bleeding gums	No ☐	Yes ☐
Hoarseness	No ☐	Yes ☐
Swollen glands in neck	No ☐	Yes ☐

Cardiovascular

Chest pain	No ☐	Yes ☐
Heart attack	No ☐	Yes ☐
Palpitations	No ☐	Yes ☐
Swelling of feet, hands, ankles	No ☐	Yes ☐
Rheumatic fever	No ☐	Yes ☐
Heart valve replacement	No ☐	Yes ☐
High blood pressure	No ☐	Yes ☐
Low blood pressure	No ☐	Yes ☐
Mitral valve prolapse	No ☐	Yes ☐
Heart murmur	No ☐	Yes ☐
High cholesterol	No ☐	Yes ☐
Pacemaker	No ☐	Yes ☐

Respiratory

Chronic or frequent cough	No ☐	Yes ☐
Spitting up blood	No ☐	Yes ☐
Shortness of breath	No ☐	Yes ☐
Asthma or wheezing	No ☐	Yes ☐
Tuberculosis	No ☐	Yes ☐
Emphysema	No ☐	Yes ☐
Pulmonary Disease	No ☐	Yes ☐
Sleep Apnea	No ☐	Yes ☐
If yes, use breathing machine	No ☐	Yes ☐
Use home oxygen	No ☐	Yes ☐

Gastrointestinal

Loss of appetite	No ☐	Yes ☐
Nausea/Vomiting	No ☐	Yes ☐
Frequent diarrhea	No ☐	Yes ☐
Constipation	No ☐	Yes ☐
Rectal bleeding	No ☐	Yes ☐
Abdominal pain	No ☐	Yes ☐
Stomach ulcer/heartburn	No ☐	Yes ☐
Hepatitis	No ☐	Yes ☐
Cirrhosis	No ☐	Yes ☐
Pancreatitis	No ☐	Yes ☐

Genitourinary

Renal (Kidney) disease	No ☐	Yes ☐
Frequent urination	No ☐	Yes ☐
Burning or painful urination	No ☐	Yes ☐
Blood in urine	No ☐	Yes ☐
Sexually transmitted disease	No ☐	Yes ☐
Prostate disease	No ☐	Yes ☐

Musculoskeletal

Arthritis, degenerative	No ☐	Yes ☐
Arthritis, rheumatoid	No ☐	Yes ☐
Joint pain	No ☐	Yes ☐
Weakness of muscle/joints	No ☐	Yes ☐
Muscle pain or cramps	No ☐	Yes ☐
Back pain	No ☐	Yes ☐
Cold extremities	No ☐	Yes ☐
Difficulty walking	No ☐	Yes ☐
Muscular dystrophy	No ☐	Yes ☐
Osteoporosis	No ☐	Yes ☐
Joint replacement	No ☐	Yes ☐
Fibromyalgia	No ☐	Yes ☐

Skin

Rash/itching	No ☐	Yes ☐
Change in skin colour	No ☐	Yes ☐
Change in hair	No ☐	Yes ☐
Hives	No ☐	Yes ☐
Psoriasis	No ☐	Yes ☐

Psychiatric

Alzheimer's disease	No ☐	Yes ☐
Memory loss/confusion	No ☐	Yes ☐
Depression	No ☐	Yes ☐
Suicidal thoughts	No ☐	Yes ☐
Chemical dependency	No ☐	Yes ☐

Endocrine

Diabetes	No ☐	Yes ☐
If Diabetic, average blood sugar	☐	
Insulin Dependent?	No ☐	Yes ☐
Non-Insulin Dependent?	No ☐	Yes ☐
Diet controlled?	No ☐	Yes ☐
Thyroid disease	No ☐	Yes ☐
Glandular/hormonal prob.	No ☐	Yes ☐
Excessive thirst or urination	No ☐	Yes ☐

Neurological

Frequent/recurring headaches	No ☐	Yes ☐
Migraines	No ☐	Yes ☐
Light headed/dizzy	No ☐	Yes ☐
Convulsions/seizures	No ☐	Yes ☐
Numbness or tingling	No ☐	Yes ☐
Paralysis	No ☐	Yes ☐
Stroke	No ☐	Yes ☐
Head injury	No ☐	Yes ☐
Polio	No ☐	Yes ☐
Multiple sclerosis	No ☐	Yes ☐
Cerebral Palsy	No ☐	Yes ☐

Hematologic/lymphatic

Slow to heal after cuts	No ☐	Yes ☐
Bleeding or bruising	No ☐	Yes ☐
Anemia	No ☐	Yes ☐
Phlebitis/blood clots	No ☐	Yes ☐
Past transfusions	No ☐	Yes ☐
Leukemia	No ☐	Yes ☐
Lymphoma	No ☐	Yes ☐
HIV/AIDS	No ☐	Yes ☐
Sickle cell	No ☐	Yes ☐
Cancer	No ☐	Yes ☐
Radiation treatment	No ☐	Yes ☐

Other ☐

Pain Care Clinics
New Patient Questionnaire Part 3

PAIN CARE CLINICS

Review of Systems Form

HADS

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

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

Fibromyalgia Rapid Screening Tool 2010

I have pain all over my body	No ☐	Yes ☐
My pain is accompanied by a continuous and very unpleasant general fatigue	No ☐	Yes ☐
My pain feels like burns, electric shocks or cramps	No ☐	Yes ☐
My pain is accompanied by other unusual sensations throughout my body, such as pins and needles, tingling or numbness	No ☐	Yes ☐
My pain is accompanied by other health problems such as digestive problems, urinary problems, headaches or restless legs	No ☐	Yes ☐
My pain has a significant impact on my life, particularly on my sleep and my ability to concentrate, making me feel slower generally	No ☐	Yes ☐

DN4 Questionnaire

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

1. Does the pain have one or more of the following characteristics?

Burning No ☐ Yes ☐ Painful cold No ☐ Yes ☐ Electric shocks No ☐ Yes ☐

2. Is the pain associated with one or more of the following symptoms in the same area?

Tingling No ☐ Yes ☐ Numbness No ☐ Yes ☐

Pins & needles No ☐ Yes ☐ Itching No ☐ Yes ☐

3. Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?

Hypoesthesia to touch No ☐ Yes ☐ Hypoesthesia to pinprick No ☐ Yes ☐

4. In the painful area - can the pain be caused or increased by:

Brushing No ☐ Yes ☐ untitled No ☐ Yes ☐ untitled No ☐ Yes ☐

Notes

Please use space below if needed to provide more information:

Patient Signature

PAIN CARE CLINICS