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/Vomiting | ___ | ___ |
| 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

_____ _____

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

# PAIN CARE CLINICS
## New Patient Questionnaire

***PLEASE NOTE THIS DOCUMENT IS TWO-SIDED***

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***PATIENT DEMOGRAPHIC***

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

Address: _____ Email: _____

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

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

Gender Identity: (Circle) Male Female Other:_____ Hand Dominance: (Please Circle) Left / Right

Family/ Referring Doctor: _____ Phone: _____

Address: _____ Fax: _____

***INSURANCE INFORMATION (as Applicable)***

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

Date of 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 AREA OF CONCERN***

Main Complaint: (Why were you referred) _____

What caused this problem: (Please Circle) Work Injury Auto Accident Illness 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*

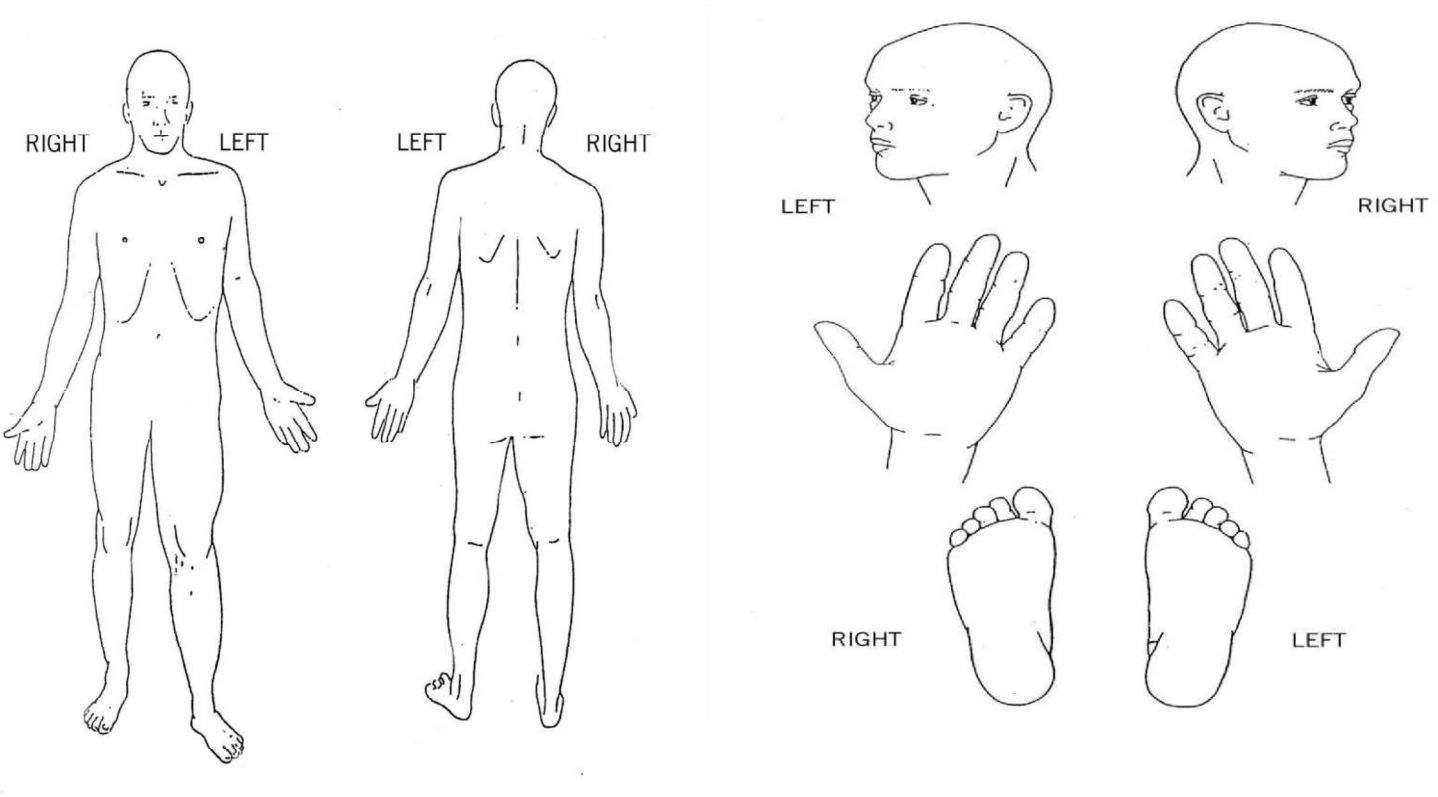
13. Are you experiencing side effects from your pain medication? *Yes* *No*

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? (CIRCLE)*

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 | Occasional |
| Do you have trouble falling asleep? | Yes | No | Occasional |
| Do you have trouble staying asleep? | Yes | No | Occasional |
| Do you wake up because of pain? | Yes | No | Occasional |
| Do you take medication to help you sleep? | Yes | No | Occasional |

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 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:**

***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, Always | 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**