

Pain Care Clinics

New Patient Questionnaire Part 1



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

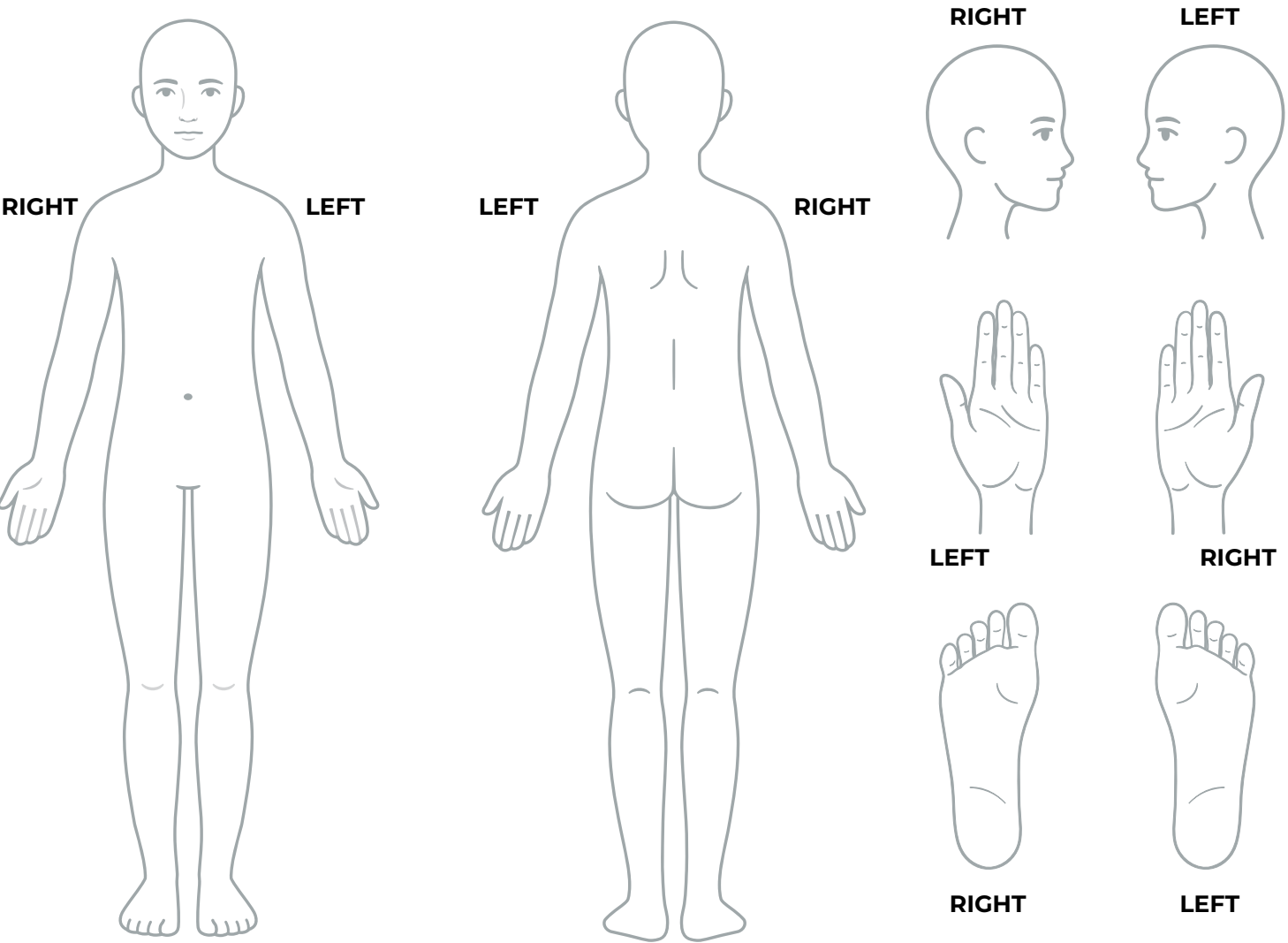
11. Do you think you need more pain medication than your doctor has prescribed? No Yes Not sure

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)**



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

If other, please explain

Massage

Other

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? If Yes, Which?

No

Yes

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

Illegal Drug Use (Select all that apply)

Cocaine Heroin Ecstasy 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



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



Review of Systems – HADS

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

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

(Doctor to fill out)

A score 2 + 4 + 6 + 8 + 10 + 12 + 14 =

D score 1 + 3 + 5 + 7 + 9 + 11 + 13 =

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
TOTAL number of "Yes" ticks		out of 6

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

Tingling	No	Yes	Numbness	No	Yes
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Pins & needles	No	Yes	Itching	No	Yes
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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
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4. In the painful area - can the pain be caused or increased by:

Brushing	No	Yes
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TOTAL number of "Yes" ticks out of 10

Notes

Please use space below if needed to provide more information:

Patient Signature

