THE PAIN TREATMENT CENTER *of the Bluegrass*

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PATIENT HISTORY QUESTIONNAIRE

Today's Date: _____

Name: _____
Last First Middle

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____ Phone Number: _____

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

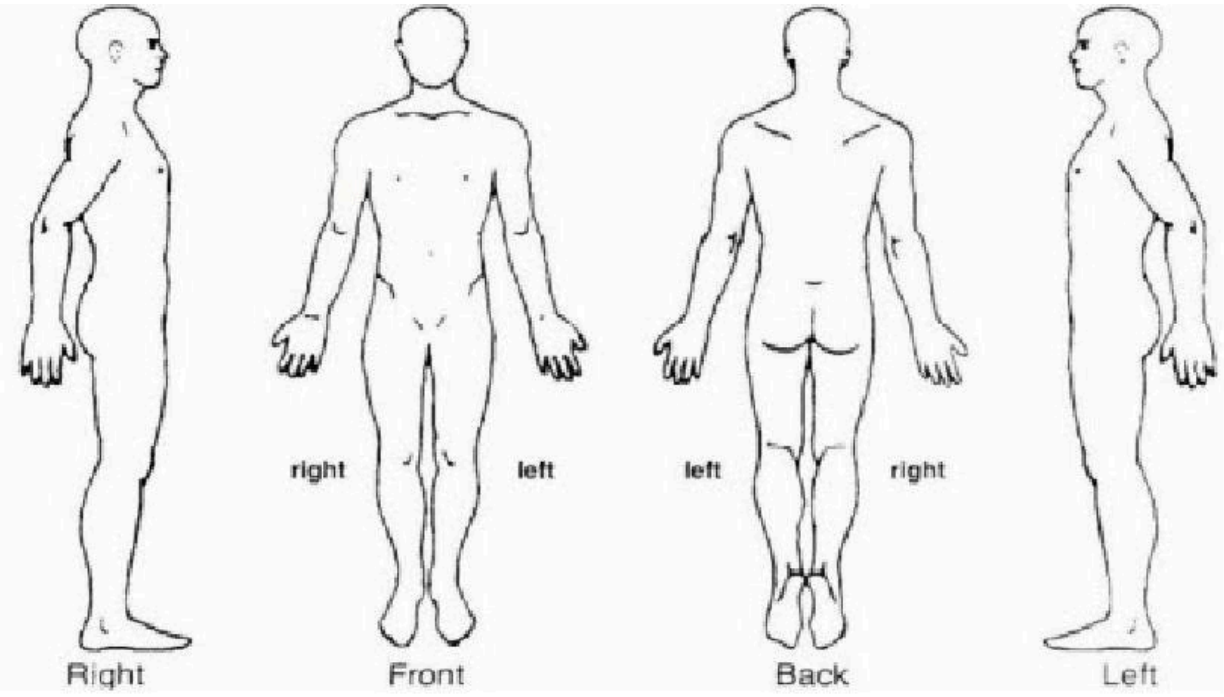
If Primary Language is not English, please list: _____

I. DESCRIPTION OF YOUR PAIN

1. Where is your pain? _____

2. Is your pain the result of work injury or motor vehicle accident? ☐ Yes ☐ No
   If Yes, Insurance Company: _____ Ins. Phone: _____
   Date of Injury: _____ Claim Number: _____

3. On the diagram below, please indicate your pain (shade in all areas of the body where you feel pain).
   (If filling this out digitally/online, you may skip this step)



BALLARD WRIGHT, M.D., PSC **Name:** _____
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4. How long have you had this pain?
   Days: _____
   Months: _____
   Years: _____

5. How would you describe the duration of your pain?
   - ☐ It is constant and does not change.
   - ☐ It comes in separate attacks or episodes, and I am pain-free in between.
   - ☐ It is constant with periodic increases and decreases.
   - ☐ Other: _____

6. How would you describe your pain?
   - ☐ Aching
   - ☐ Burning
   - ☐ Cramping
   - ☐ Sharp
   - ☐ Stabbing
   - ☐ Shooting
   - ☐ Crushing
   - ☐ Dull
   - ☐ Throbbing
   - ☐ Numb
   - ☐ Tingling
   - ☐ Other: _____

7. Using the following scale, rate your pain by circling the number on the questions below:
   0) Pain Free
   1) Very minor annoyance; occasional minor twinges.
   2) Minor annoyance; occasional strong twinges.
   3) Annoying enough to be distracting.
   4) Can be ignored if you are really involved in your work, but still distracting.
   5) Can't be ignored for more than 30 minutes.
   6) Can't be ignored for any length of time, but you can still go to work and participate in social activities.
   7) Makes it difficult to concentrate; interferes with sleep. You can still function with effort.
   8) Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.
   9) Unable to speak. Crying out or moaning uncontrollably; near delirium.
   10) Unconscious. Pain makes you pass out.

(Mankowski Pain Scale)

Your pain right now?	X	1	2	3	4	5	6	7	8	9	10
Your pain at its worst?	0	1	2	3	4	5	6	7	X	9	10
Your pain at its best?	0	1	2	X	4	5	6	7	8	9	10
Your pain most of the time?	0	1	2	3	4	5	6	7	8	X	10

8. What caused your pain? _____
9. What causes your pain to INCREASE? _____
10. What causes your pain to DECREASE? _____

11. What is your pain goal? (ex.: To be able to climb stairs, work in the garden, work, etc.)

_____

_____

12. Check/List any barriers you might have or anticipate concerning your ability to report pain or be treated for your pain problem.
    - ☐ Difficulty understanding my pain problem.

- ☐ Fear of what increased pain might mean (that I am getting worse/sick).
- ☐ Previous side-effects/intolerances to medications/procedures.
- ☐ Fear of addiction to medications.
- ☐ Inability to get medications because they cost too much.
- ☐ Transportation issues (don't have a car, can't drive, can't afford gas, etc).
- ☐ Difficulty understanding treatment plan because I do not understand English (well).
- ☐ Other: _____
- ☐ No anticipated concerns.

13. Have you ever been treated at a pain facility before? ☐ Yes ☐ No
If Yes, where: _____ when: _____

II. TREATMENT OF YOUR PAIN

1. What operations have you had for your Pain Problem?

DATE	OPERATION	SURGEON/WHERE	RESULT

☐ No operations for pain problem.

2. What treatments have you had for your Pain Problem (injections, nerve blocks, chiropractic, exercise, massage, braces, etc)?

DATE	TREATMENT	WHERE	RESULT

☐ No treatments for pain problem.

3. Have you ever attended physical therapy for this pain problem? ☐ Yes ☐ No
If Yes, where: _____ when: _____

4. List diagnostic studies related to your Pain Problem (X-Rays, MRI, CT Scan, EMG/NCV, Bone scan, Myelogram, etc)?

DATE	TEST	WHERE	RESULT

☐ No diagnostic studies related to pain problem.

5. Please describe any drug allergies or bad reactions that you have had to medication.

MEDICATION	REACTION

☐ No known drug allergies.

6. What medications are you currently taking for your Pain Problem?

MEDICATION	DOSE (mg)	NO. OF PILLS	TIMES PER DAY	HOW MUCH RELIEF YOU GET 0: None; 10: Complete
				0 1 2 3 4 5 6 7 8 9 10
				0 1 2 3 4 5 6 7 8 9 10
				0 1 2 3 4 5 6 7 8 9 10
				0 1 2 3 4 5 6 7 8 9 10

☐ Currently not taking any medication for Pain Problem.

7. What other pain medications have you taken in the past?

MEDICATION	REASON FOR STOPPING MEDICATION

☐ Have never taken any medication.

III. MEDICAL HISTORY

1. Have you had a different pain problem in the past (before your current problem)? ☐ Yes ☐ No
   If Yes, please describe: _____

2. Check illnesses or conditions you have or have had in the past. Write in any not listed.

HEART & BLOOD VESSELS: ☐ coronary artery disease ☐ high cholesterol ☐ theumatic fever ☐ high blood pressure ☐ heart attack(s) ☐ irregular heart rhythm ☐ neck artery blockage ☐ congestive heart failure ☐ heart valve problems ☐ peripheral vascular disease ☐ deep vein thrombosis ☐ other: _____

SKIN: ☐ rashes ☐ eczema ☐ psoriasis ☐ cancer ☐ other: _____

GLANDS: ☐ diabetes mellitus ☐ hypothyroidism ☐ hyperthyroidism ☐ pituitary ☐ other: _____

STOMACH & DIGESTIVE SYSTEM: ☐ hiatal hernia ☐ acid reflux ☐ ulcer ☐ pancreatitis ☐ poor appetite ☐ liver disease ☐ hepatitis ☐ cancer ☐ Crohn's disease ☐ obesity ☐ irritable bowel syndrome ☐ malnutrition ☐ other: _____

URINARY SYSTEM: ☐ kidney stones ☐ urinary tract infection ☐ kidney failure ☐ cancer ☐ other: _____

FEMALE ORGANS: ☐ ovarian cysts ☐ endometriosis ☐ ovarian/uterine/cervical/breast cancer ☐ other: _____

MALE ORGANS: ☐ enlarged prostate ☐ prostate/testicular cancer ☐ other: _____

EYES: ☐ cataracts ☐ injury ☐ glaucoma ☐ vision loss/difficulty ☐ other: _____

EARS, NOSE, THROAT: ☐ sinus/allergy problems ☐ hearing loss ☐ inner ear disease ☐ dentures ☐ TMJ disease ☐ speech difficulty ☐ other: _____

BLOOD: ☐ anemia ☐ bleeding easily ☐ blood clots ☐ lymphoma ☐ chemotherapy ☐ other: _____

ALLERGY/IMMUNE: ☐ lupus ☐ rheumatoid arthritis ☐ fibromyalgia ☐ HIV ☐ other: _____

MUSCULOSKELETAL: ☐ osteoarthritis ☐ broken bone ☐ rotator cuff disease ☐ carpal tunnel syndrome ☐ scoliosis ☐ osteoporosis ☐ degenerative disc disease ☐ degenerative joint ☐ other: _____

NEUROLOGICAL: ☐ headache ☐ migraine ☐ seizure ☐ epilepsy ☐ stroke ☐ tumor ☐ meningitis ☐ head injury ☐ blackouts ☐ multiple sclerosis ☐ organic brain disease ☐ confusion ☐ memory loss ☐ other: _____

LUNGS: ☐ asthma ☐ emphysema ☐ cancer ☐ bronchitis ☐ tuberculosis ☐ COPD ☐ black lung ☐ sleep apnea ☐ other: _____

PSYCHIATRIC: ☐ depression ☐ anxiety/panic ☐ bipolar disease ☐ schizophrenia ☐ PTSD ☐ other: _____

3. Have you ever seen a psychologist, psychiatrist, or other mental health counselor?

☐ No.
☐ Yes, in the past. When? _____
☐ Yes, currently. Who? _____
If Yes, what problems were you seen for? _____

4. List all surgeries you have had (except those listed previously relating to your Pain Problem)?

DATE	OPERATION	SURGEON/WHERE

☐ No previous surgeries (unrelated to pain problem).

5. Family History:

					State of Health or Cause of Death
Is your mother	Living:	☐	Deceased:	☐	_____
Is your father	Living:	☐	Deceased:	☐	_____
How many brothers	Living:	____	Deceased:	____	_____
How many sisters	Living:	____	Deceased:	____	_____

IV. SOCIAL HISTORY

1. What is your current marital status? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

2. Do you have any relatives who are, or have been patients at The Pain Treatment Center?
☐ Yes ☐ No If Yes, who/relation: _____

3. With whom do you currently live? ☐ Spouse ☐ Children, # _____ ☐ Parents ☐ In-laws
☐ Other relatives ☐ Friends ☐ Alone ☐ Other: _____

4. How many years of school did you complete? _____

5. What is your present work situation? (check and provide details, if needed)
☐ Disabled: ☐ Temporary ☐ Permanent Date declared disabled: _____
Physician or court that declared you disabled? _____
☐ Employed full-time. What kind of work? _____
☐ Employed part-time/Light duty. What kind of work? _____
(continued on next page…)
☐ Homemaker.
☐ Inactive homemaker because of pain.
☐ Unemployed for other reasons. Why? _____
☐ In school or vocational training. Where? _____
☐ Retired. Occupation prior to retiring? _____

6. If you are currently not working, when did you last work? _____
What kind of work did you do at that time? _____

7. How many cups of coffee, tea, or soft drinks with caffeine do you drink daily? _____

8. Do you smoke cigarettes? ☐ Yes ☐ No
   If Yes, how many packs per day? _____ How many years have you smoked cigarettes? _____

9. How often do you drink alcohol?
   ☐ Not at all ☐ 1-2 times per week
   ☐ Less than once a month ☐ 2-4 times per week
   ☐ 1-2 times per month ☐ Everyday
   What effect does alcohol have on your pain? _____

10. Have you use illegal drugs in the past (marijuana, cocaine, amphetamines)? ☐ Yes ☐ No
    Illegal drug used? _____ Date last used: _____

11. Have you been diagnosed or treated for substance abuse problems (alcoholism, drug addiction, etc)?
    ☐ Yes ☐ No If Yes, when and where? _____

12. Have you ever been arrested for an alcohol or drug-related offense (DUI, public intoxication, possession, diversion, trafficking, etc)? ☐ Yes ☐ No
    If Yes, what was the offense? _____ Date of the arrest: _____

13. Have you ever been arrested for any other reason? ☐ Yes ☐ No
    If Yes, explain: _____ Date of the arrest: _____

V. EFFECT OF PAIN ON LIFESTYLE

1. Check **one** number that best describes your normal day-to-day activity:
   0) ☐ Stay in bed all day. Feel hopeless and helpless about life.
   1) ☐ Stay in bed at least half the day. Have no contact with outside world.
   2) ☐ Get out of bed, but don't get dressed. Stay at home all day.
   3) ☐ Get dressed in the morning. Minimal activities at home. Contact with friends via phone, email.
   4) ☐ Do simple chores around the house. Minimal activities outside of home, two days a week.
   5) ☐ Struggle, but fulfill daily home responsibilities. No outside activity. Not able to work/volunteer.
   6) ☐ Work/volunteer limited hours. Take part in limited social activities on weekends.
   7) ☐ Work/volunteer for a few hours daily. Can be active at least five hours a day. Can make plans to do simple activities on weekends.
   8) ☐ Work/volunteer for at least six hours daily. Have energy to make plans for one evening of social activity during the week. Active on weekends.
   9) ☐ Work/volunteer/be active eight hours daily. Take part in family life. Outside social activities limited.
   10) ☐ Go to work/volunteer each day. Normal daily activities each day. Have a social life outside of work. Take an active part in family life.

   (Quality of Life Scale, American Chronic Pain Association)

2. How has your pain changed your activity level?
   ☐ Not at all
   ☐ Slightly
   ☐ Moderately
   ☐ Significantly
   ☐ Severely

   Is your activity level affected by anything other than pain? ☐ Yes ☐ No
   If Yes, please explain: _____

   How far can you **walk** before you have to stop because of pain? _____
   How long can you **stand** before you have to stop because of pain? _____
   How long can you **sit** before you have to get up because of pain? _____

3. Does your pain problem affect your ability to concentrate?
   ☐ Always ☐ Rarely
   ☐ Usually ☐ Never
   ☐ Sometimes

4. How many hours of sleep do you actually get each night? _____ hours.
   How many hour do you spend trying to get to sleep (lie in bed)? _____ hours.

5. How long does it take you to get to sleep once lying down? _____

6. How often does pain interfere with your sleep?
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never

7. What sort of sleep problems do you have?
   - ☐ No problems with sleep
   - ☐ Takes a long time getting to sleep
   - ☐ Awaken frequently during night
   - ☐ Fitful and disturbed sleep
   - ☐ Nightmares
   - ☐ Awaken too early in the morning
   - ☐ Awaken unrested and exhausted
   - ☐ Frequent napping during the day
   - ☐ Daytime fatigue from poor sleep
   - ☐ Other: _____

8. Please use the following scale to evaluate your sleepiness:
   0) Would never doze
   1) Slight chance of dozing
   2) Moderate chance of dozing
   3) High chance of dozing

(Epworth Scale)

	Circle the number			
Sitting and reading	0	1	2	X
Watching TV	0	1	2	3
Sitting inactive in a public place (theater or a meeting)	X	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	X
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	X	2	3

9. Have you ever had a sleep study? ☐ Yes ☐ No
   If Yes, what were the results of the study: _____

Thank you for taking the time to complete this questionnaire.