Swedish Hospital
Part of NorthShore

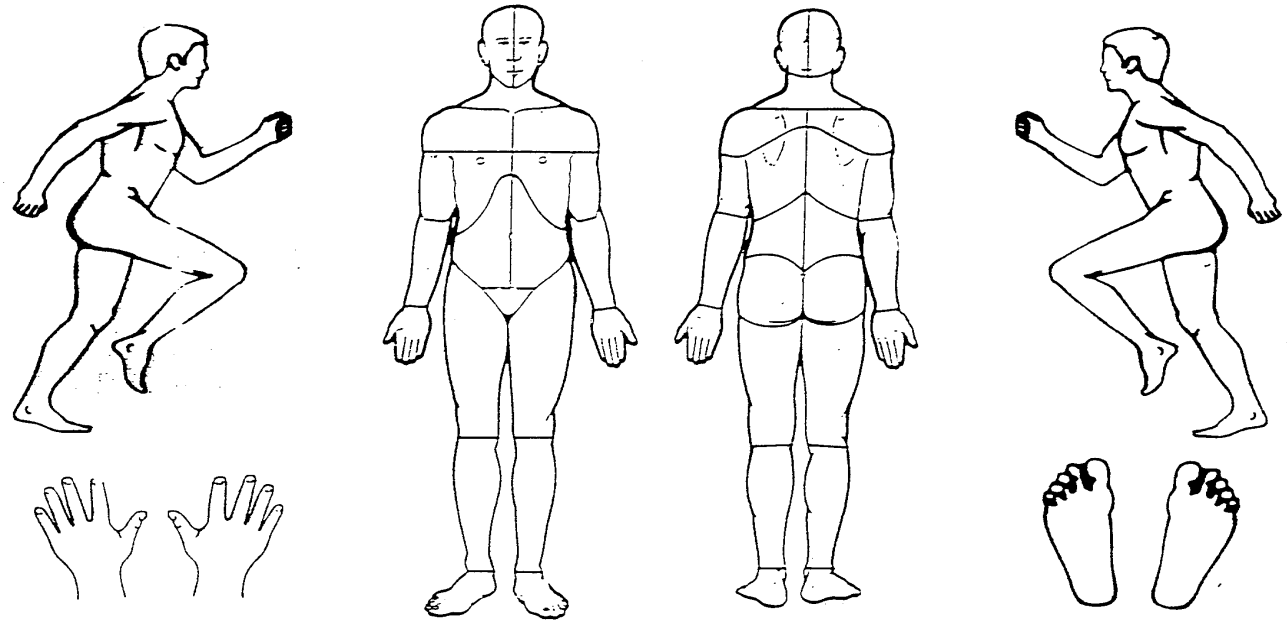
Patient's Name:

PAIN MANAGEMENT SERVICES
New Patient Questionnaire

Date: _____ Primary MD: _____ Referring MD:_____

Pain

Shade all areas of pain or discomfort in your body with a red pen. Shade all areas of numbness in your body with a black pen. Mark #1 next to the most painful area in your body. Mark #2 next to the second most painful area in your body.



1. Rate your current pain on a scale of 0-10.

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Discomforting Distressing Horrible Excruciating Pain

2. What pain score is acceptable to you? _____

3. How would you describe your pain and in which location? (Circle one)

Burning	Stabbing	Throbbing	Numbness
Tingling	Shooting	Cramps	Aching
Dull	Diffuse	Sharp	Heaviness

Other: _____

4. When did your pain start? Month: _____ Year: _____

5. How and when did this pain start? _____

_____

6. What part of the day is it worse? Morning Afternoon Evening

What part of the day is it better? Morning Afternoon Evening

7. Which statement best describes your pain? (Please circle)
Constant Frequent Occasional

8. What INCREASES you pain?

Standing	Sitting	Walking	Bending
Lying down	Lifting	Stress	Other

9. What DECREASES your pain?

Standing	Sitting	Walking	Bending
Lying down	Lifting	Stress	Other

10. Bladder or bowel control problems Yes No

11. Have you been treated at any pain clinic before? Yes No
Where: _____

12. Injections: Have you had any injections for your problem? Yes No (Please circle)
What kind of injection did you receive? _____
Where / Date: _____
Did you get pain relief? Yes No
How long did you feel pain relief? _____

13. Have you had any of the following for pain relief? (Please circle)
If yes, did it relieve the pain? Where, when, and how long?
Physical therapy Y N _____
Acupuncture Y N _____
Pain counseling Y N _____
Chiropractic Y N _____
Other _____

14. Do you exercise regularly? Yes No

15. Sleep: Do you have difficulty sleeping at night? Yes No
How many times at night are you waking up? _____
On average, how many hours do you sleep at night? _____
Do you feel this awakening is due to: (Circle all that apply)
Pain Anxiety Insomnia Having to urinate Other: _____
Are you taking any medication to help you sleep at night? Yes No
If Yes, what is it? _____

16. Nutrition: In the past month, have you lost or gained weight without trying to?
Yes No

17. Have you had any recent dental work/ surgery in the last 2 weeks?
Yes No

Health Habits

18. Smoking: Do you smoke? Yes No
If so, how many packs per day? _____

19. Do you drink alcohol? Yes No
How often? _____ How much? _____

20. Do you use recreational drugs? (Marijuana, heroine, cocaine, etc.)
Yes No if yes, which do you use? _____

21. Are you a recovering alcoholic or recovering drug user? Yes No

Other

22. Do you live alone? Yes No

23. Do you have a support system such as family or friends? Yes No

24. What is the highest grade of education completed? Grade School/ High School/College

Employment History

25. Are you working? Yes No

Full time / Part time / Retired / Unemployed / Disabled (circle one)

26. What is your job title? _____

27. Are you on work restrictions? Yes No if yes, what are the restrictions?

_____

28. Which Doctor placed you on work restrictions/ disability? _____

29. Do you consider your work: Sedentary Active Heavy (Circle one)

30. Does your job involve any of the following?

Sitting	Standing	Walking	Bending	Pushing	Pulling	Driving	Squatting
Climbing	Overhead work		Repetitive Movement		Lifting- 10/20/50/100lbs/more		

31. Is there any litigation or a lawyer involved in your case? Yes No

Past Medical History

32. Past Medical Conditions: Please circle the medical conditions that you have

Angina/chest pain	Skin problems
Irregular heart beat	Irritable bowel syndrome
High blood pressure	Fibromyalgia
Heart attack / Coronary artery disease	Diabetes
Stroke	Thyroid problems
Asthma/ emphysema/COPD	Kidney problems
Prostate problems	Arthritis
Liver problems or Hepatitis A / B / C	Cancer
Bleeding / Clotting Disorder	Stomach ulcer/ GI bleeding
HIV / AIDS	Lupus
Depression/ Anxiety	Migraines/ Headaches
Seizures	Parkinson's
Multiple Sclerosis	Immune disorders
Herpes / Shingles	

Other: _____

33. Surgical History: (Please circle and write date)

Back/ Neck surgery ____ Abdominal surgery ____
Hip /Knee replacement ____ Aneurysm surgery ____

Hysterectomy ____ Angioplasty/Open heart Surgery ____
Pacemaker ____ Implanted stimulator/ pump ____
Hernia surgery ____ Breast surgery ____
Fractures ____ Anesthesia complications: Yes No
Other: _____

34. GOALS: goals for treatment here. What do you want to be able to do?

_____

_____

Permission to call or leave messages: Is it OK for us to leave verbal messages for you regarding your care or future appointments either on voice mail or with others at your phone number?
Yes No Preferred phone number: _____

Signature: _____

Completed by: (circle one)

Patient Staff Other: _____

Information reviewed by Dr. _____

Patient Questionnaire

PAIN MEDICATIONS: Please list ALL CURRENT PAIN MEDICATIONS

MEDICATION	DOSE	FREQUENCY	PROVIDER

MEDICATION: Please list ALL current medications & supplements

ALLERGIES: Please list ALL known allergies
