BURLINGTON PAIN CARE
New Patient Questionnaire

PATIENT DEMOGRAPHIC

Patient Name (first, last): Date:

Address:

Phone: (Home) (Office) (Mobile)

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

Gender: (Please Circle) Male Female Hand Dominance: (Please Circle) Left Right

Family/ Referring Doctor: Phone:

Address: Fax:

INSURANCE INFORMATION (as Applicable)

WSIB Claim Number: WSIB Contact: Phone:

Date of Index 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 PRESENTING COMPLAINT

Main Complaint: (Why were you referred)

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

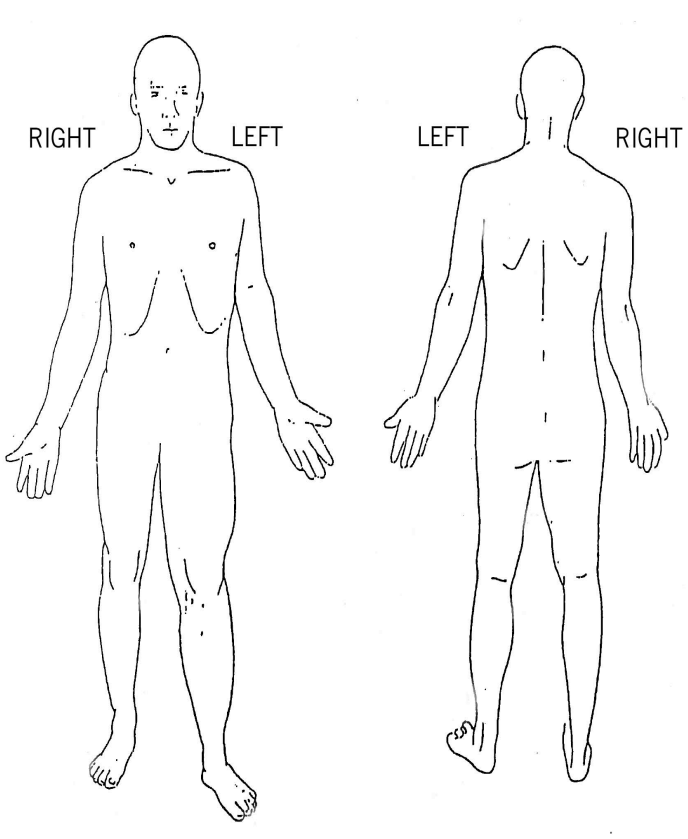
13. Are you experiencing side effects from your pain medication? *Yes* *No*

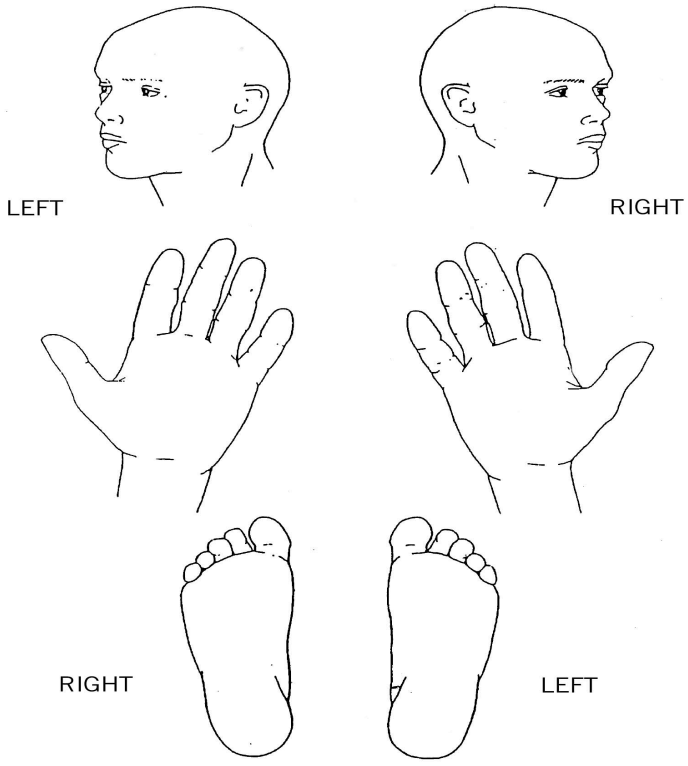
If yes, which ones: _____
_____
_____

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?

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

Do you have trouble falling asleep? Yes No

Do you have trouble staying asleep? Yes No

Do you wake up because of pain? Yes No

Do you take medication to help you sleep? Yes No

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 Marijuana 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: _____