

Name: _____ DOB: _____ Date: _____

Can you **READ** all this OK? Yes No Do you want **HELP** with this? Yes No

1. Where is your **ONE worst** pain area most of the time? _____
2. How good is your **pain** with the medicine? OK Not OK
3. How good is your **activity** with the medicine? OK Not OK
4. How good is your **sleep** with the medicine? OK Not OK
5. Do you take all your **medicine** like it says on the bottle? Yes No
6. Does your **medicine** make you **feel bad** or worse? Yes No
a. (In what way? _____)
7. Do you have **DAYTIME sleepiness**? Yes No
8. Do you want to **change** your medicine? Yes No

9. Does your pain medicine (as prescribed) reduce your pain enough to make a significant difference in your quality of life? Yes No Don't know

10. HOW **OFTEN** (when taking your medicine as prescribed) do you have ANY pain?
 never sometimes a lot of the time most of the time constantly

11. How has your **PAIN CHANGED** with the use of current medicine / treatments?
 better unchanged worse

If **better or worse**, how much? a little somewhat much a lot

12. How has your ability to **FUNCTION** changed since your last office visit here?
 Got somewhat better Stayed the same Got somewhat worse

13. Does your worst pain **RADIATE** / TRAVEL / SPREAD anywhere from usual site?
 never occasionally frequently usual constant

14. **IF** the pain radiates / travels, **WHERE** does it spread to?
 shoulder arm forearm hand hip thigh knee leg foot
 other: _____

PAIN DESCRIPTIONS

How would you describe your pain? (check all boxes that you think apply)

- | | | | | |
|---------------------------------|-------------------------------------|----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> aching | <input type="checkbox"/> stabbing | <input type="checkbox"/> burning | <input type="checkbox"/> squeezing | <input type="checkbox"/> throbbing |
| <input type="checkbox"/> sharp | <input type="checkbox"/> electrical | <input type="checkbox"/> gnawing | <input type="checkbox"/> shooting | <input type="checkbox"/> _____ |

What especially makes your pain worse?

What especially makes your pain LESS?

PAIN SEVERITY

How bad has your pain **USUALLY** been in the **past week (WITH YOUR PAIN MEDS)?**

(No pain = "0";

Pain as bad as it COULD be = "10")

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

How bad has your **WORST (BAD DAY)** pain been in past week **with medicine?** (Circle one)

(No pain = "0";

Pain as bad as it COULD be = "10")

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

How bad **WAS** your pain **WITHOUT** pain medicine? (Circle one)

(No pain = "0";

Pain as bad as it COULD be = "10")

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

What are **your GOALS** for pain you could **still** have and be **content?** (Circle one)

(No pain = "0";

Pain as bad as it COULD be = "10")

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

ARE YOU TAKING YOUR MEDICINE THE WAY IT IS PRESCRIBED?

Yes, as prescribed No, MORE than prescribed No, LESS than prescribed

If not, why not?

CHECK ANY MEDICATION "SIDE EFFECTS"; HOW SEVERE; HOW WELL CONTROLLED:

"Side Effect"	None	Mild	Moderate	Severe	Controlled?	Uncontrolled?
Nausea						
Vomiting						
Constipation						
Itching						
Mental cloudiness						
Sweating						
Fatigue						
Drowsiness						
Other:						

If constipated -- do you take any of the following?

WHAT	YES	NO	HOW OFTEN	WHICH ONE?
Fiber supplement (like Metamucil)				
Stool softener (like Colace)				
Laxative (like Senokot, ExLax)				
Enema (like Fleets)				

TESTING AND TREATMENT SINCE LAST VISIT:

Since your last visit here, have you seen any other doctor, had any tests, or had any treatment elsewhere? No Yes _____

QUESTIONS ABOUT YOUR ABILITY TO DO THINGS:

Since your last visit here, has your function changed? (put a mark in correct column)

FUNCTION	BETTER	SAME	WORSE
Physical function			
Family relationships			
Social relationships			
Mood			
Sleep			
Overall functioning			

Since your last visit, have you changed how **active** you are? No change

More active (a little / frequently / usually / most of the time) _____

LESS active (a little / frequently / usually / most of the time) _____

Questions about your SLEEP

Are you **using any medication** to help you sleep? Yes No

IF SO, **what** do you use? _____

IF SO, **how often** do you use the sleeping medicine? _____

IF SO, how well does that medicine **help** you sleep? _____

Describe your sleep:

I sleep OK through most nights except to urinate I wake from (*pain OR other things*) _____ times most nights for _____ min.

Trouble falling asleep _____ nights/week Trouble staying asleep _____ nights/week

Questions about your QUALITY OF LIFE

OVERALL, please CIRCLE how **satisfied** you USUALLY feel about your **quality of life**, with your current level of pain control and function?

Not satisfied	Minimally satisfied	Somewhat satisfied	Fairly satisfied
Pretty well satisfied	Mostly satisfied	Very satisfied	Completely satisfied

What symptoms OTHER than pain have you had regularly or recently?

- | | | |
|--|--|--|
| <input type="checkbox"/> increased stress | <input type="checkbox"/> depression | <input type="checkbox"/> thoughts of suicide |
| <input type="checkbox"/> NEW loss of bladder control | <input type="checkbox"/> NEW numbness | <input type="checkbox"/> NEW weakness |
| <input type="checkbox"/> loss of bowel control | <input type="checkbox"/> involuntary movements | <input type="checkbox"/> other: _____ |

Please tell us about your work and your "chemical habits" SINCE YOUR LAST VISIT:

Are you working? No Yes (IF so, what? _____)

Are you smoking? No Yes (____ packs per day) **When will you quit?** _____

Have you used ANY **alcohol**? No Yes (How often _____? How many per time? _____)

Since your last visit, have you used ANY of the following?

Marijuana? Yes No **Cocaine?** Yes No

Heroin? Yes No **Amphetamines?** Yes No

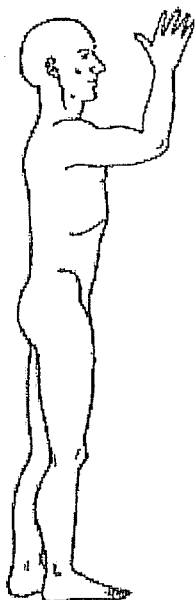
Methamphetamines? Yes No **Ecstasy?** Yes No

Narcotic / opioid pain medicine from another person or doctor? No Yes _____

Benzos (Valium, Xanax, Ativan, etc) from another person or doctor? No Yes

What ONE specific problem, do you **most** want to talk to the doctor about today?

Patient Name: _____ Date: _____



PAIN CHART

Use the following symbols;
make the areas of the body
where you feel the
described sensations.
Include ALL affected areas.

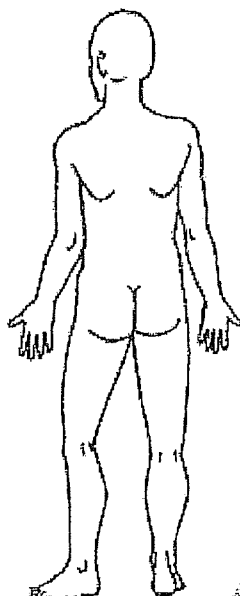
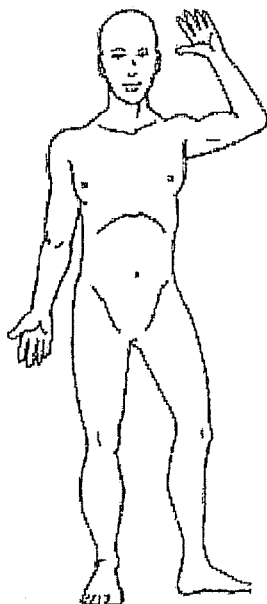
Aching Pain – AAAA

Stabbing – SSSS

Burning Pain -- BBBB

Numbness – NNNN

**Pins and Needles –
PPPP**



Patient Signature: _____

OTHER THINGS I WANT THE DOCTOR TO KNOW

1)

2)

3)

4)

5)