Addressograph or Patient Name and Medical Record Number

**Clinics – Pain Mngmt –New Patient Health Questionnaire**

Patient Name:

_____

Last First Middle Maiden

Address:

_____

Street City State Zip

Phone (Home)_____ Phone (Work or other)_____

Primary Care Physician: _____

PCP Address: _____ Phone: _____

Referring Physician (if different than PCP): _____

Referring Physician Address: _____ Phone: _____

Primary Insurance Company: _____

Phone (toll free): _____ Member or Subscriber No.

_____

Group No. _____ Employer Group Name (if applicable): _____

Workers Compensation Claim No. _____ Adjustor: _____

*If your insurance requires pre-authorization, you are responsible for securing the authorization before treatment has begun. We will be happy to assist by providing the insurance with the treatment plan, and other documentation.*

Secondary or additional Insurance: _____

Phone (toll free): _____ Member or Subscriber No. _____

Group No. _____ Employer Group Name (if applicable): _____

Attorney's Name: _____ Phone: _____

Attorney's Address: _____

Stanford University Medical Center
**Stanford Pain Management Center**
300 Pasteur Dr., Boswell Bldg., Room A408
Stanford, CA 94305
(650)723-6238 Fax: (650)725-7544
Web site: http://paincenter.stanford.edu

Addressograph or Patient Name and Medical Record Number

**Clinics – Pain Mngmt – New Patient Health Questionnaire**

1. Distance from your home to Stanford Pain Clinic:_____(approx. miles) _____(driving time – minutes/hours)
2. Marital Status: □Married. □Separated . □Widowed □Never Married □Living together
3. Your Age: _____ Number of Children:_____ Ages of Children:_____
4. Is there a specific question that you or your doctor wants answered today?_____
   _____
5. Where is your pain located (also please draw on the diagram on the next page)? _____
   _____
6. How long have you had your pain problem?_____
7. Briefly describe how your pain started:

8. Explain what you believe is the cause of your pain? Please try to be specific._____
   _____
9. If your pain were 50% less tomorrow, what would you be doing differently?_____
   _____
10. How has your pain affected your life?_____
11. Describe your present pain (i.e. aching, throbbing, sharp, hot, cold, etc.)?_____
12. Describe the timing of your pain: □Brief Constant □Comes and goes □Continuous
    □Always there □Appears and disappears □Intermittent
13. What do you do to ease or relieve your pain?_____
14. What makes your pain worse?_____

15. What do you believe is the appropriate treatment that would make your pain problem improve? _____

_____

16. What percentage improvement do you expect our program to make in your pain (0-100%)?_____

17. Current or former occupation:_____ Working now? Yes □ No □

If no, last day you worked? _____

Are you receiving any kind of disability?_____ If so, what kind? _____

18. Please describe your activities in an average day._____

_____

19. List the activities you can no longer do because of your pain problem: _____

_____

20. Are you involved in a legal action related to your pain problem? Yes □ No □

21. Any other legal problems?_____

22. Have you seen another pain doctor for your problem in the past 5 years? Yes □ No □

If Yes, please list the pain doctors names: _____

**Pain Score**

Please circle the number that best describes your baseline or constant level of pain over the past few days

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No pain | | | | | | | | | | worst possible pain |

Please rate your worst pain

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | worst possible pain |

On average over the past few days how many times did your worst pain occur?

| 1-2 | 3-4 | 5-6 | 7-8 | more than 8 |
|---|---|---|---|---|

Please circle the number that represents the baseline level of pain you would like to achieve through treatment

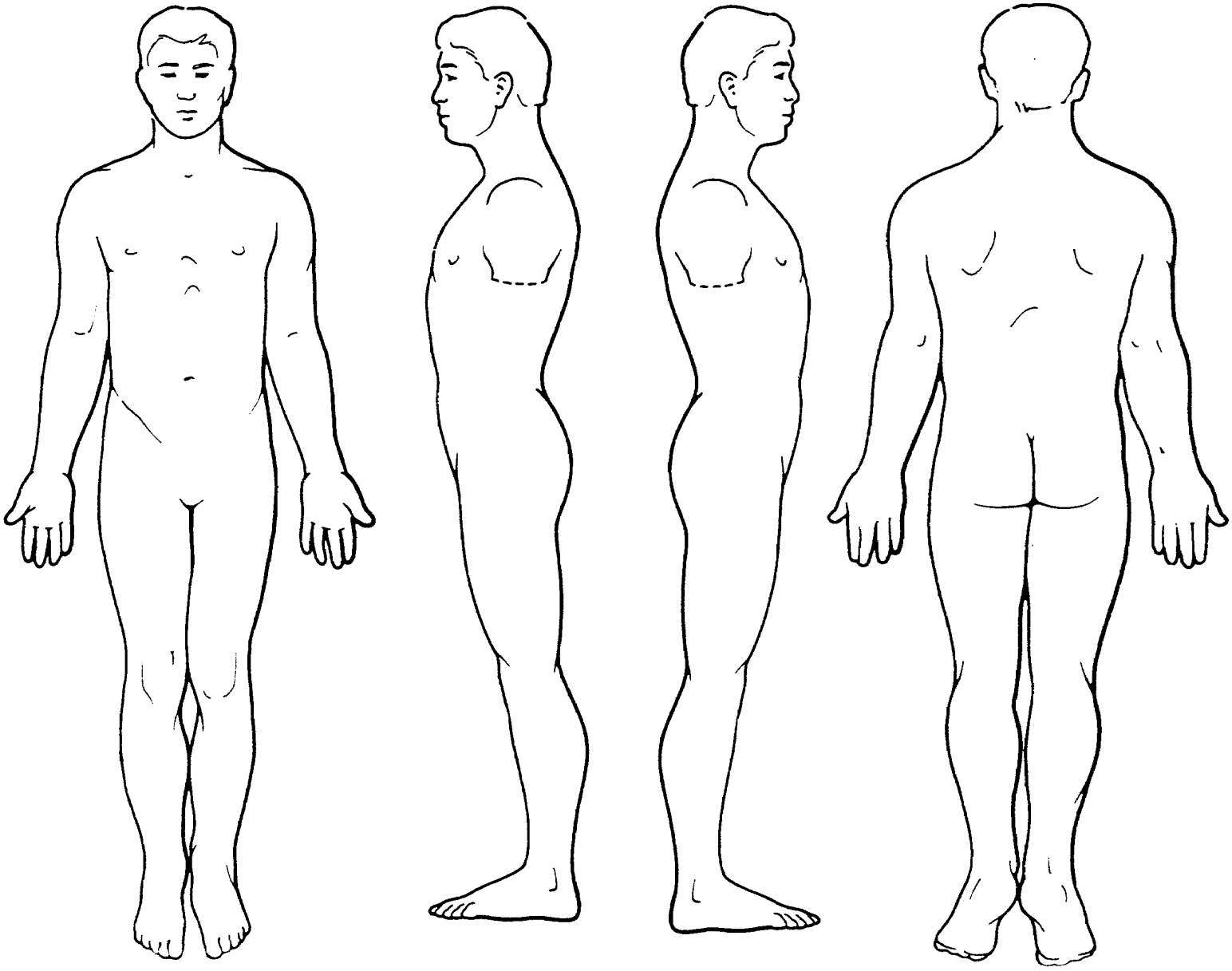
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | worst possible pain |

**Pain Location**

Mark on the drawing below the exact spot where your pain is located. Use a solid black dot (•). If the pain starts at that spot and radiates elsewhere (travels to another part of your body), draw a line from the spot where the pain starts to where it ends. If it is a whole area that hurts, shade in that area with a pencil.

Next to the places on the drawing where you showed pain, put an "E" if the pain is external (on the outside surface). If the pain is internal (inside the body) mark it with an "I." If the pain is both internal and external, mark "EI."

**Left** **Right**



**Past Medications** (Medications you have previously tried for pain) Please check appropriate box

| YES, TRIED | NOT TRIED | NAME OF MEDICATION | STILL TAKING (if known) | IF STOPPED WHY | |
|---|---|---|---|---|---|
| | | | | Side effects | Not Effective |
| | | ***Pain Killers*** | | | |
| | | Actiq | | | |
| | | Codeine, Tylenol #3,#4 | | | |
| | | Fentanyl patches (Duragesic) | | | |
| | | Hydrocodone (Vicodin, Lortab, Norco) | | | |
| | | Hydromorphone (Dilaudid) | | | |
| | | Methadone | | | |
| | | Morphine (MS Contin, Avinza, Kadian) | | | |
| | | Meperidine (Demerol) | | | |
| | | Oxycodone (Percocet, Oxycontin) | | | |
| | | Propoxyphene (Darvon) | | | |
| | | Stadol | | | |
| | | Duloxetine (Cymbalta) | | | |
| | | Pregabalin (Lyrica) | | | |
| | | Other | | | |
| | | | | | |
| | | ***Anti Seizure Medicines*** | | | |
| | | Carbamazepine (Tegretol) | | | |
| | | Gabapentin (Neurontin) | | | |
| | | Lamotrigine (Lamictal) | | | |
| | | Leveteracitam (Keppra) | | | |
| | | Oxycarbazepine (Trileptal) | | | |
| | | Tiagabine (Gabatril) | | | |
| | | Topiramate (Topamax) | | | |
| | | Zonisamide (Zonegram) | | | |
| | | | | | |
| | | ***Muscle Relaxants*** | | | |
| | | Baclofen | | | |
| | | Carisprodol (Soma) | | | |
| | | Clonazepam (Klonopin) | | | |
| | | Cyclobenzaprine (Flexeril) | | | |
| | | Diazepam (Valium) | | | |
| | | Metaxolone (Skelaxin) | | | |
| | | Methocarbamol (Robaxin) | | | |
| | | Tizanidine (Zanaflex) | | | |
| | | Other | | | |
| | | | | | |
| | | ***Anti-Depressants*** | | | |
| | | Amitriptyline (Elavil) | | | |
| | | Buproprion (Wellbutrin) | | | |
| | | Citalopram (Celexa) | | | |
| | | Desipramine | | | |
| | | Duloxetine (Cymbalta) | | | |

| YES TRIED | NOT TRIED | NAME OF MEDICATION | STILL TAKING (if known) | IF STOPPED WHY | |
|---|---|---|---|---|---|
| | | ***Anti-Depressants*** | | **Side Effects** | **Not Effective** |
| | | Fluoxetine (Prozac) | | | |
| | | Hyp. Perforatum (St. John's Wort) | | | |
| | | Lexapro | | | |
| | | Mitrazepine (Remoron) | | | |
| | | Nefazadone (Serzone) | | | |
| | | Nortriptyline (Pamelor) | | | |
| | | Paroxetine (Paxil) | | | |
| | | Sertraline (Zoloft) | | | |
| | | Trazadone (Deseryl) | | | |
| | | Venlafaxine (Effexor) | | | |
| | | Other | | | |
| | | | | | |
| | | ***Anti-Anxiety*** | | | |
| | | Alprazolam (Xanax) | | | |
| | | Chlordiazepoxide (Librium) | | | |
| | | Diazepam (Valium) | | | |
| | | Lithium (Eskalith) | | | |
| | | Lorazepam (Ativan) | | | |
| | | OlazepineZyprexa) | | | |
| | | Phenelzine (Nardil) | | | |
| | | Resperidone (Risperdal) | | | |
| | | Other | | | |
| | | | | | |
| | | ***Sleep*** | | | |
| | | Temazepam (Restoril) | | | |
| | | Triazolam (Halcion) | | | |
| | | Zaleplon (Sonata) | | | |
| | | Zolpidem (Ambien) | | | |
| | | | | | |
| | | ***Anti-inflammatories*** | | | |
| | | Celecoxib (Celebrex) | | | |
| | | Ibuprofen (Motrin, Advil) | | | |
| | | Mobic | | | |
| | | Naprosyn (Aleve) | | | |
| | | Relafen | | | |
| | | Rofecoxib (Vioxx) | | | |
| | | Valdecoxib (Bextra**)** | | | |

**Narcotic (opioid) medication (vicodin, percocet, darvocet, morphine, fentanyl, methadone)**

Have you been given opioid (narcotic) medication for your pain NO YES
If *YES*, have they improved your activity or general level of function? NO YES

If you answered *NO* to last question, how did the opioid (narcotic) affect your pain level (please choose one):

□ "just take the edge off" □ somewhat helpful □ quite a bit □ very much

Are you taking your pain medications any differently than prescribed by your doctor (i.e. taking more than prescribed, changing the dosing frequency, not taking them, etc.) NO YES
If yes, why:
Are you having any problematic side effects? NO YES
If so, please describe:

Have you or your doctor ever felt that you had a problem with narcotics? NO YES
Have you felt you should cut down on your alcohol or drug use? NO YES
Have people annoyed you by criticizing your alcohol or drug use? NO YES
Have you ever felt bad or guilty about your alcohol or drug use? NO YES
Have you had a drink or used drugs first thing in the morning to steady your nerves or get rid of hangover? (eye opener) NO YES

**Have you ever had any of the following treatments for your pain problem and what was the result?**
Please check the appropriate box and give comments.

| No | Yes | Treatment Type | Impr-oved | No Change | Worse | Comments |
|---|---|---|---|---|---|---|
| | | Physical therapy | | | | |
| | | Occupational Therapy | | | | |
| | | Aquatic/Pool therapy | | | | |
| | | Passive (heat, ice, gentle massage, ultrasound) | | | | |
| | | Mobilizations | | | | |
| | | Traction | | | | |
| | | Exercises/aerobic conditioning | | | | |
| | | TENS | | | | |
| | | Orthotics (i.e. corrective foot inserts) | | | | |
| | | Prosthetics (braces, supports, etc) | | | | |
| | | Chiropractic | | | | |
| | | Deep tissue Massage | | | | |
| | | Psychological counseling | | | | |
| | | Alcohol/Drug Detoxification | | | | |
| | | Accupuncture | | | | |
| | | Extended Bed Rest | | | | |
| | | Biofeedback or relaxation therapy | | | | |
| | | Radiation treatment | | | | |
| | | Trigger point injections | | | | |
| | | Epidural steroid injections | | | | |
| | | Facet joint injections | | | | |
| | | Nerve blocks | | | | |
| | | Spinal cord stimulation | | | | |
| | | Acupuncture | | | | |
| | | Acupressure | | | | |

**Medications** - List all you are **currently** taking and dosages (prescriptions, over the counter, herbal):

| Medication | Dose | Frequency | Date Started | Prescribing Doctor |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Allergies –** Have you ever had and allergic reaction to any medication?
**(an allergy means a rash, swelling, difficulty in breathing. It does NOT mean causing a stomach upset or dizziness)** YES NO
If YES please list them**:**

_____

**Past Medical History** Have you had any of these conditions either now or in the past?
***Please check YES or NO***

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| | | **Heart:** | | | **Lungs:** |
| | | High blood pressure | | | Bronchitis |
| | | High cholesterol | | | Asthma |
| | | Angina | | | Shortness of Breath |
| | | Heart attack | | | **Liver / Kidneys:** |
| | | Congestive cardiac failure | | | Hepatitis |
| | | Cardiac surgery | | | Liver problems |
| | | Irregular heart beat | | | Kidney problems |
| | | **Nervous system:** | | | Bladder problems |
| | | Seizures | | | **Metabolic / Digestive:** |
| | | Stroke | | | Diabetes: Insulin or Non-Insulin Dependent? |
| | | Paralysis | | | Thyroid disease |
| | | Peripheral neuropathy | | | Acid reflux |
| | | **Musculoskeletal:** | | | Stomach ulcer |
| | | Arthritis | | | **Cancer**: |
| | | Neck/back problems | | | Site: |
| | | Artificial joints (replacement) | | | **Alcohol/Drug Dependency or Addiction** |
| | | Other: | | | List: |
| | | **Blood Disorder:** | | | **Psychological/Psychiatric:** |
| | | Anemia | | | Depression/Anxiety |
| | | Bruising | | | Panic Disorder |
| | | Bleeding Problems | | | Post-Traumatic Stress Disorder |
| | | **Immune Disorder**: | | | **Other Medical Problems (Please Describe):** |
| | | HIV | | | |
| | | Other: | | | |

**Diagnostic Tests**

List any diagnostic tests (i.e. MRI, XRAY, EMG, etc.) you have had related to your pain problem including dates and results:

| Date | Exam | Where performed | Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Surgical History**

Have you had any surgeries directly related to your pain problem(s)? YES NO
(If yes, please complete the information below)

Name and year of surgery (i.e. lumbar fusion, abdominal surgery)

| | | |
|---|---|---|
| 1. | | Year: |
| 2. | | Year: |
| 3. | | Year: |
| 4. | | Year: |
| 5. | | Year: |

Have you had other surgeries that weren't related to your pain?
(e.g., appendectomy, tonsillectomy) YES NO (If yes, please complete the information below)
Name and year of surgery

| | | |
|---|---|---|
| 1. | | Year: |
| 2. | | Year: |
| 3. | | Year: |
| 4. | | Year: |
| 5. | | Year: |

**ER visits**

In the past year have you been treated in the Emergency Room for your pain problem: NO YES
If yes, please circle the number of times: 1 2-3 4-6 7-10 More than 10 times

**Health care visits**

In the past three months, how many times have you been to your regular health care provider or specialist for your pain problem (MD, ARNP, PA, PT)?
Please circle the number of visits: 1 2-3 4-6 7-10 More than 10 times

In the past three months how many times have you seen an alternative health care provider for your pain problem (Chiropractor, homeopath, naturopath, acupuncturist)?
Please circle the number of visits: 1 2-3 4-6 7-10 More than 10 times

**Sleep History**

Can you estimate the average number of hours you sleep per night?_____
Can you estimate the average number of hours you sleep during the daytime?_____

On the worst night during the last two weeks, how badly did your pain affect your sleep?

- □ Not affected at all
- □ I didn't lose any sleep but needed pain medication
- □ It interfered with my sleep, and as a result, I slept for more than 4 hours
- □ It interfered with my sleep, and as a result, I slept for 2-4 hours
- □ It interfered with my sleep, and as a result, I slept less than 2 hours

If you have difficulty sleeping is it related more to:

- □ Getting to sleep initially
- □ Maintaining sleep throughout the night
- □ Both

Have you been told you snore a lot? YES NO
Have you been told you often gasp for breath at night? YES NO
Are you a restless sleeper? YES NO
Do you often have problems with restlessness of your legs keeping you awake? YES NO
Do you feel tired or fatigued during the day? YES NO
Do you take naps more than twice a week or fall asleep inappropriately during the day? YES NO

**Social History**

Did you have a happy childhood? NO YES
Have you ever been sexually and or physically abused? NO YES
Do you currently feel threatened in your environment? NO YES
Have you ever seriously considered or attempted suicide? NO YES
Do you have a suicide plan at the moment? NO YES
Have you ever been psychiatrically hospitalized? NO YES
If your pain is from a traumatic event, do you ever experience distressing dreams about the event? N/A NO YES
Have you ever participated in psychotherapy? NO YES
Are you currently participating in psychotherapy?
If YES to the above, through which provider(s)?

_____

Do you smoke? YES NO
If yes, how much per day?
If you are a former smoker when did you stop?
Do you drink alcohol? YES NO
If yes, how many drinks per day?
If yes, how many drinks per week?
If yes, do you drink to intoxication or binge drink?
If yes, do you drink to decrease your pain?
In the past 10 years have you ever tried street drugs? YES NO
Have you or anyone around you ever felt you had a problem with alcohol or drugs? YES NO
Have you ever received alcohol or drug treatment?

**Family History**

| Family Member | Age (or age at death) | Sex | Living | Medical Problems |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Grandparents | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| Father | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| Mother | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| Siblings | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| Children | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |
| | | ⍰ M ⍰ F | ⍰ yes ⍰ no | |

**REVIEW OF SYSTEMS**

Do you have any problems/symptoms in the following areas? Check "Yes" or "No". If "Yes", give an explanation

| **Yes** | **No** | | **Patient Comments** | **Physician Comments** |
|---|---|---|---|---|
| | | Eyes | | |
| | | Ears/Nose/Mouth/Throat | | |
| | | Respiratory (lungs/breathing) | | |
| | | Cardiovascular (heart/blood vessels/circulation) | | |
| | | Gastrointestinal (stomach/intestines) | | |
| | | Constitutional (weight loss/gain, fever/chills/fatigue) | | |
| | | Genitourinary (genitals/sexual function/kidney/bladder) | | |
| | | Neurological (brain/nervous system) | | |
| | | Integumentary (skin areas and/or breasts) | | |
| | | Psychiatric (emotions/mood/memory) | | |
| | | Musculoskeletal (bones/joints/muscles) | | |
| | | Endocrine (hormones/metabolism/thyroid) | | |
| | | Allergic/Immunologic (allergies/immune system) | | |
| | | Hematologic/Lymphatic (blood or bleeding problems; lymph nodes or "swollen glands" | | |

Form Completed by: _____ Relationship to Patient: _____ Date: _____

*Instructions to Attending Physician*

*Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key findings must be summarized in your progress notes; however, the questionnaire may be referenced for additional details.*

Attending MD Signature:_____ Date: _____

Also Reviewed By: _____ Date: _____