FOR PAIN PATIENTS

PAIN EXPERIENCE

EACH OF THE FOLLOWING QUESTIONS IS ABOUT YOUR EXPERIENCE OF PAIN. USUALLY THE QUESTION CAN BE ANSWERED BY CIRCLING A WORD OR WORDS, BY MAKING A MARK ALONG A LINE, OR BY A BRIEF DESCRIPTION.

(P1) CHIEF COMPLAINT: ______________________________

____

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(P2) DO YOU THINK THAT YOUR CURRENT PAIN IS DUE TO SOMETHING MORE SERIOUS THAN, OR DIFFERENT FROM, WHAT THE DOCTORS HAVE TOLD YOU?

_____ Yes _____ No

(P3) INDICATE WHAT YOU THINK IS THE CAUSE OF YOUR CONTINUED DISCOMFORT.

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(P4) PLEASE LIST THE APPROXIMATE DATE THE PROBLEM BEGAN AND INDICATE THE CIRCUMSTANCES RELATED TO THE ONSET OF THE PROBLEM BY CHECKING THE APPROPRIATE BOX:

A) Date pain began: ______________________________

B) Circumstances of onset:

	Accident at home		Auto Accident
	Accident at work		Following illness
	Pain "just began"		Following surgery
	Other injury (Explain):		

Comments: ______________________________

____

(P5) RATE HOW OFTEN YOUR PAIN OCCURS:

	Continuously
	Several times a day
	Once a day
	Several times a week
	Several times a month
	Once a month
	Less frequent than once a month
	Never

(P6) ON A SCALE OF 0-10, WHAT IS THE INTENSITY OF YOUR PAIN? (0 IS NO PAIN, 10 IS MOST SEVERE)

(P7) HOW HAS THE INTENSITY OF THE PAIN CHANGED THROUGHOUT THE TIME YOU HAVE HAD IT?

_____ Increased   _____ Decreased   _____ Stayed the Same

(P8) WHAT MAKES YOUR PAIN WORSE?

A) ____________________

B) ____________________

C) ____________________

D) ____________________

(P9) HOW CAN YOU LESSEN YOUR PAIN?

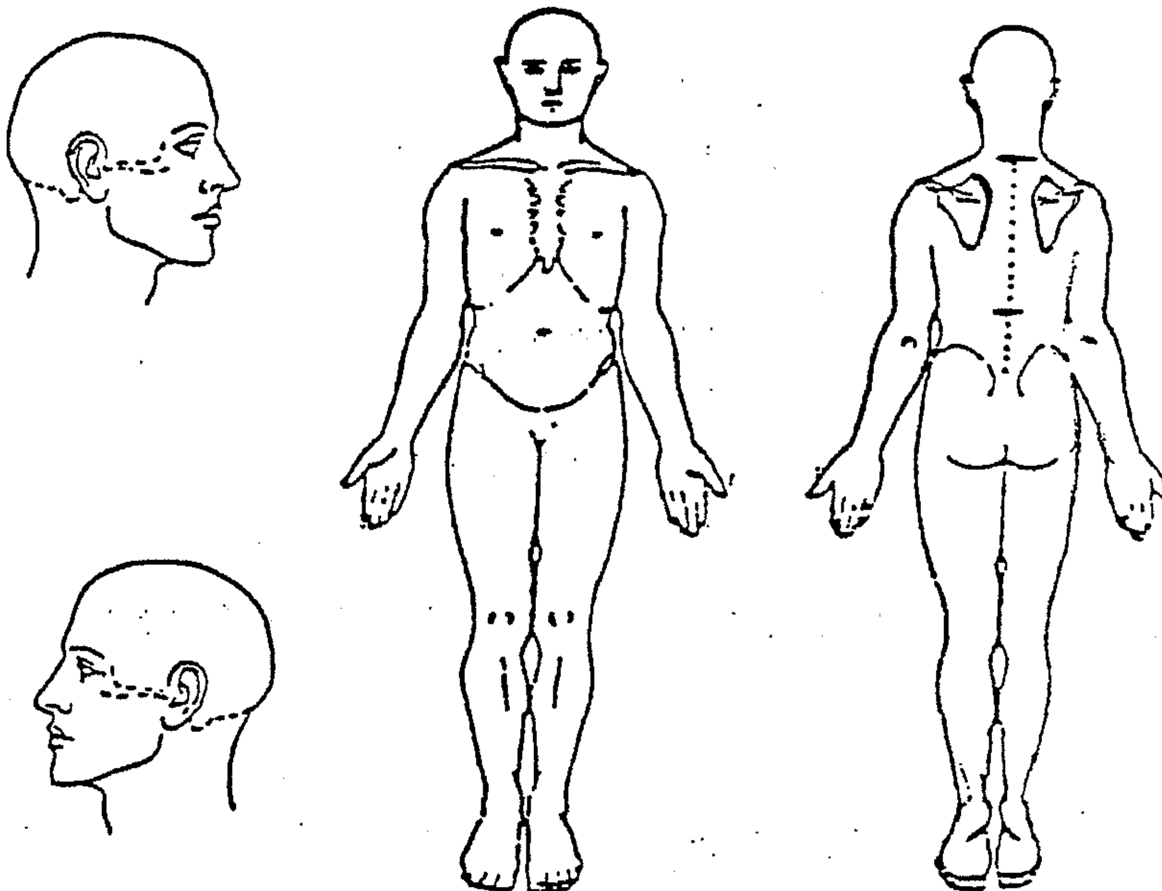
A) ____________________

B) ____________________

C) ____________________

D) ____________________

(P10) USE THE FIGURES BELOW TO INDICATE (1) WHERE THE PAIN IS LOCATED, (2) HOW MUCH AREA IS INVOLVED, AND (3) WHETHER THERE IS MORE THAN ONE LOCATION.



DO YOUR SENSATIONS SPREAD AS THEIR INTENSITIES INCREASE? IF SO, WHERE DO THEY SPREAD? WRITE AN "X" ON THE ABOVE FIGURE(S) TO INDICATE THE MAIN PAIN AREA AND ARROW(S) SHOWING WHERE IT SPREADS.

(P11) WHAT KIND OF FEELINGS ACCOMPANY YOUR PAIN? CHECK THE BOXES THAT APPLY DIRECTLY TO YOUR CHRONIC EXPERIENCE OF PAIN.

	None	Mild	Moderate	Severe
Depression				
Anxiety				
Frustration				
Anger				
Fear				
Guilt				

(P12) PLACE A SLASH (/) SOMEWHERE ALONG THE LINE INDICATING HOW MUCH YOUR PAIN STOPS YOU FROM DOING WHAT YOU WANT TO DO.

____

Doesn't stop me at all — Completely stops me

(P13) RATE HOW MUCH YOUR PAIN INTERFERES WITH YOUR ACTIVITIES:

	Continuously
	Several times a day
	Once a day
	Several times a week
	Several times a month
	Once a month
	Less frequent than once a month
	Never

(P14) IN GENERAL, HOW LIKELY DO YOU FEEL THAT YOUR PAIN WILL BE REMOVED OR CURED? CIRCLE ONE OF THE FOLLOWING:

Unlikely Certain Likely

Impossible Uncertain

(P15) LABEL THE WORST PAIN YOU HAVE EVER FELT AS 100%. HOW DOES YOUR CURRENT PAIN COMPARE WITH THIS. THIS CAN BE OVER 100%.

Current Pain Level = ______________ %

(P16) IF IT IS NOT POSSIBLE TO COMPLETELY ALLEVIATE YOUR PAIN (THAT IS 0%), WHAT PERCENTAGE OF PAIN IS AN ACCEPTABLE PAIN LEVEL FOR YOU TO LIVE WITH?

Acceptable Pain Level = ______________ %

(P17) IF YOUR PAIN WERE REDUCED TO THE ACCEPTABLE PAIN LEVEL, LIST THE KIND OF ACTIVITIES THAT YOU WOULD ENGAGE IN THAT YOUR CURRENT PAIN LEVEL PREVENTS YOU FROM DOING. BE SPECIFIC:

A) ____

B) ____

C) ____

D) ____

E) ____

(P18) SINCE YOUR PAIN CONDITION BEGAN, WHICH OF THE FOLLOWING PEOPLE HAVE YOU CONSULTED FOR TREATMENT AND PAIN RELIEF?

	Type of Doctor	Treatment Recommended	Results of Treatment			
			Major Relief	Some Relief	No Effect	Pain Worse
01	Acupuncturist					
02	Allergist					
03	Anesthesiologist					
04	Chiropractor					
05	Dentist					
06	Ear, Nose, Throat					
07	Endocrinologist					
08	Faith Healer					
09	General Practitioner					
10	Hypnotist					
11	Internal Medicine					
12	Neurologist					
13	Neurosurgeon					
14	Nutritionist					
15	Ophthalmologist					
16	Orthopedist					
17	Osteopath					
18	Physical Therapist					
19	Plastic Surgeon					
20	Psychiatrist					
21	Psychologist					
22	Surgeon (General)					
23	Other					

(P19) HOW MANY PAINFUL DISORDERS HAVE YOU BEEN TREATED FOR THIS YEAR, OTHER THAN YOUR PRESENT PROBLEM? (EXAMPLE: sore throat, painful ulcer, cystitis, cramp, etc.)

____

(P20) HOW MANY TIMES THIS YEAR HAVE YOU BEEN TO THE EMERGENCY ROOM BECAUSE OF A PAIN PROBLEM?

(P21) HOW MANY TIMES HAVE YOU BEEN ADMITTED TO A HOSPITAL THIS YEAR FOR ANY PROBLEM ASSOCIATED WITH PAIN? _______________

(P22) HOW MANY TIMES HAVE YOU HAD SURGERY FOR YOUR PAIN? ____________________

(P23) LIST SURGERY & YEAR ____________________

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____

____

____

PAST AND PRESENT MEDICATIONS FOR PAIN

(P24) PLEASE LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING FOR YOUR PAIN AND THE AVERAGE NUMBER TAKEN PER DAY (OR PER WEEK).

MEDICATION NAME & DOSAGE (mg) # TAKEN DAILY

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

(P25) PLEASE INDICATE WHICH OF THE FOLLOWING DRUGS YOU HAVE TAKEN IN THE PAST FOR YOUR PAIN. INDICATE THE DOSAGE, THE DEGREE OF RELIEF, AND SIDE EFFECTS FOR EACH DRUG. USE SPACE AT THE END TO DESCRIBE TYPE OF SIDE EFFECT OR DRUG REACTION BY THE DRUG NUMBER IN CHART.

		Degree of Relief				Side Effects		
Past Drug	Dosage	Major	Some	None	Worse	Major	Some	None
01 Aspirin								
02 Anacin								
03 Bufferin								
04 Excedrin								
05 Empirin								
06 Tylenol								
07 Talwin								
08 Dilaudid								
09 Codeine Mixtures								
10 Darvon								
11 Darvon Mixtures								
12 Percodan								
13 Percocet								
14 Methadone								

	Past Drug	Dosage	Degree of Relief				Side Effects		
			Major	Some	None	Worse	Major	Some	None
15	Morphine								
16	Demerol								
17	Heroin								
18	Dilantin								
19	Tegretol								
20	Cafergot								
21	Sansert								
22	Ergotrate								
23	Ergomar								
24	Valium								
25	Librium								
26	Robaxin								
27	Nembutal								
28	Seconal								
29	Phenobarbital								
30	Fiorinal								
31	Placidyl								
32	Dalmane								
33	Periactin								
34	Tofranil								
35	Lithium								
36	Elavil								
37	Sinequan								
38	Triavil								
39	Thorazine								
40	Mellaril								
41	Compazine								
42	Stelazine								
43	Haldol								
44	Phenergan								
45	Motrin								
46	Indocin								
47	Zomax								
48	Cortisone								
49	DMSO								
50	Marijuana								
51	Alcohol								
52	Cocaine								
53	Coffee								
54	Tea								
55	Tobacco								
56	Sweets/Chocolate								
57	Other								