Fireweed Health Care, Inc.

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New Patient PAIN Questionnaire

Name_____ **Date**_____

Referred by: _____ Primary Care Provider: _____

Which pharmacy will you be using? _____

Release(s) of Information (ROI's):
Having an accurate and comprehensive history of your pain condition is essential for creating a safe treatment plan for you. Are you willing to sign a Release of Information (ROI) for each record we feel is important for your treatment and on-going care? ▢ Yes ▢ No

SOCIAL AND HOUSING STATUS

Relationship Status: ▢ Single ▢ Separated ▢ Divorced ▢ Married ▢ Significant Other ▢ Widowed

Housing Situation: ▢ Live alone ▢ Live w/spouse or SO ▢ Live w/children ▢ Roommate ▢ Live w/other family ▢ Shared housing ▢ Couch surfing ▢ Homeless ▢ Staying in a shelter

Do you: ▢ Rent ▢ Own your home

Do you feel safe in your home environment? ▢ Yes ▢ No

Do you have children? ▢ Yes ▢ No **If yes, do they live with you?** ▢ Yes ▢ No

Their ages are: _____

PERSONAL AND FAMILY HEALTH HISTORY

(Please check-mark each item you or a family member has been diagnosed with)

	Self	Family		Self	Family
Cancer	▢	▢	Sleep Apnea	▢	▢
Heart Disease	▢	▢	Asthma	▢	▢
High Blood Pressure	▢	▢	COPD/Emphysema	▢	▢
Heart Attack	▢	▢	Osteoporosis	▢	▢
Stroke	▢	▢	Hepatitis B or C	▢	▢
Seizures	▢	▢	Liver Disease	▢	▢
Diabetes	▢	▢	Headaches/Migraines	▢	▢
Thyroid Problems	▢	▢	Anemia	▢	▢
Kidney Disease	▢	▢	Bowel Disorders	▢	▢

Please list all hospitalizations and surgeries you have ever had:

Surgery	Year	Hospital

Allergies: What are you allergic to?	What is your reaction?	What was thef treatment?

Current Medications and Supplements: *Please list ALL prescriptions and over-the-counter (OTC) medications or supplements you are CURRENTLY taking.*

Name of Medication/Supplement/Ointment	Strength	How often each day?

ACTIVITY IMPROVEMENT GOALS

*Please list **3 very specific and measurable goals** for activities you would like to participate in if your pain were more manageable. **PLEASE DO NOT SKIP THIS QUESTION**. **Less or no pain is not an activity goal.***

Specific activity/goal:	How many/often?	By what date?

REVIEW OF SYSTEMS

(Check the boxes of each symptom you have experienced in the past 30 days.)

Constitutional:

- ☐ Fatigue
- ☐ Restlessness
- ☐ Fever
- ☐ Chills
- ☐ Hot flashes
- ☐ Cold flushes
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Weight gain
- ☐ Weight loss
- ☐ Night sweats

Skin:

- ☐ Rash
- ☐ Hives
- ☐ Sweating
- ☐ Excessive itching
- ☐ Sores
- ☐ Goosebumps
- ☐ Blisters
- ☐ Painful lesions
- ☐ Moles changing size, shape or color

HEENT:

- ☐ Nasal congestion
- ☐ Runny nose
- ☐ Sore throat
- ☐ Loss of teeth
- ☐ Dentures
- ☐ Cavities/gum disease
- ☐ Dry mouth
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Yawning
- ☐ Watery eyes
- ☐ Visual changes
- ☐ Ringing in ears
- ☐ Hearing loss

Cardiovascular:

- ☐ Chest pain
- ☐ Heart racing
- ☐ Lightheaded
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Swollen ankles or legs

Respiratory:

- ☐ Shortness of breath
- ☐ Cough
- ☐ COPD/emphysema
- ☐ Wheezing
- ☐ Sleep Apnea

Musculoskeletal:

- ☐ Twitching
- ☐ Weakness
- ☐ Shaking
- ☐ General body aches
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Bone aches
- ☐ Cramps
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Joint redness

Genitourinary:

- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Pain w/urination
- ☐ Leaky bladder
- ☐ Loss of bladder control

If female: Are you pregnant? ☐ Yes ☐ No

Date of last cycle: _____

Please notify us immediately if you become pregnant.

Gastrointestinal:

- ☐ Nausea
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Stomach cramps
- ☐ Loss of bowel control
- ☐ Vomiting
- ☐ Constipation
- ☐ Red blood in stool
- ☐ Black, tarry stool
- ☐ Yellow eyes or skin
- ☐ Abdominal pain, cramping or distension

Bowel Movements are:

- ☐ Daily
- ☐ Every other day
- ☐ 2x/week
- ☐ Every 5-6 days
- ☐ Once weekly

Is this your normal frequency? ☐ Yes ☐ No

Is this ☐ LESS or ☐ MORE frequent than normal?

Neurological:

- ☐ Tremors
- ☐ Tingling
- ☐ Fainting
- ☐ Frequent falls
- ☐ Numbness
- ☐ Headache
- ☐ Seizures
- ☐ Involuntary movements

Endocrine:

- ☐ Diabetes
- ☐ Excessive thirst
- ☐ Heat/Cold Intolerance
- ☐ Thyroid Issues
- ☐ Low libido

Hematologic/Lymphatic:

- ☐ Abnormal bleeding
- ☐ Swollen lymph nodes
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Bruising easily
- ☐ Lymphedema
- ☐ Clotting disorder

Immunologic/Allergic:

- ☐ Asthma
- ☐ Current cold
- ☐ Seasonal allergies
- ☐ Current flu

Psychiatric

- ☐ Suicidal thoughts
- ☐ Anxiety
- ☐ Depression
- ☐ Craving drugs
- ☐ Anger issues
- ☐ Irritability
- ☐ Changes in mood
- ☐ Homicidal thoughts
- ☐ Hallucinations
- ☐ Difficulty sleeping
- ☐ Panic attacks
- ☐ Hearing voices

MENTAL HEALTH DIAGNOSIS HISTORY

*Please **check-mark** any of the following issues **you have now or have had in the past**.*

▢ Suicidal thoughts	▢ Homicidal thoughts	▢ PTSD	▢ ADD/ADHD
▢ Anger	▢ Hearing voices	▢ Anxiety	▢ Eating Disorders
▢ Irritability	▢ Hallucinations	▢ Depression	▢ OCD
▢ Changes in mood	▢ Schizophrenia	▢ Panic attacks	
▢ Difficulty sleeping	▢ Bi-polar disorder	▢ Personality Disorders	

Do you have any thoughts of suicide or of wanting to hurt yourself or others? ▢ Yes ▢ No

If yes, do you have a plan? ▢ Yes ▢ No If yes, please describe _____

_____

Have you ever attempted suicide in the past? ▢ Yes ▢ No If yes, when and what method did you use?

_____

Nicotine Use:

Do you use nicotine? ▢ Yes ▢ No If yes, what form? _____

Average daily amount: _____ Would you like help quitting now? ▢ Yes ▢ No

Would you be interested in quitting at some time in the future? ▢ Yes ▢ No

Alcohol Use

Do you drink alcohol? ▢ Yes ▢ No When was your most recent use? _____

How often do you drink? ▢ Most days ▢ Weekly ▢ Monthly ▢ Special occasions ▢ _____

Approximately how many standard drinks do you normally consume? _____

What kind of alcohol do you consume? ▢ Beer ▢ Wine ▢ Wine coolers ▢ Liquor

Are you in recovery from alcohol addiction or abuse? ▢ Yes ▢ No Recovery date: _____

There are significant potential risks associated with consuming any amount of alcohol if being prescribed CNS depressants, anxiolytics, sedative/hypnotics, or any other similar medications. Those risks include, but are not limited to, sedation, motor impairment, respiratory depression, coma, seizure and/or death. You (patient) agree to a NO alcohol policy in our program if you receive any medications which affect the central nervous system, whether from us or from any other provider. Additionally, mitragynine (Kratom) cannot be consumed. There may be other substances which pose similar risks which also cannot be consumed, whether or not the substance(s) is "legal". Failure to abide by this policy may result in treatment plan modifications and/or termination of your pain management treatment at Fireweed Health Care, Inc.

Name_____ Date_____

PEG Pain Screening Tool *(1-10 with 10 being the worst pain for the **PAST WEEK ONLY**)*

1. What number best describes your pain on average in the past week? _____
2. What number best describes how pain has interfered with your enjoyment of life? _____
3. What number best describes how pain has interfered with your general activity? _____

PAIN TREATMENT HISTORY

Where is your WORST pain? _____ Does the pain radiate anywhere? ☐ Yes ☐ No

Where does your pain radiate to? _____

When did your pain first start: _____ Was the onset of your pain ☐ Gradual OR ☐ Sudden?

How did it start? ☐ I'm not sure ☐ Accident ☐ Injury ☐ MVA/MVC ☐ Domestic violence

Pain is: ☐ Constant ☐ Intermittent Do you hurt at night while in bed? ☐ Yes ☐ No

Is there ☐ Less or ☐ More pain with movement? Is there morning aching with stiff joints? ☐ Yes ☐ No

If yes, how long does the morning aching/stiff joints last? _____

Please describe your pain:

☐ Aching	☐ Sharp	☐ Burning	☐ Tingling
☐ Throbbing	☐ Shooting	☐ Numbness	☐ _____
☐ _____	☐ _____	☐ _____	☐ _____

How would you rate the severity of your pain?

☐ Mild ☐ Mild-Moderate ☐ Moderate ☐ Moderate-Severe ☐ Severe

The following at-home interventions & activities provide some RELIEF:

☐ Heat	☐ Rest	☐ Walking	☐ Meditation/Mindfulness
☐ Ice	☐ Exercise	☐ Lying down	☐ Stretching
☐ _____	☐ _____	☐ _____	☐ _____

The following activities & movements WORSEN my pain:

☐ Walking	☐ Lifting	☐ Turning head	☐ Stairs
☐ Standing	☐ Sitting too long	☐ Bending forward	☐ Bending backwards
☐ _____	☐ _____	☐ _____	☐ _____

Please list any other painful areas of concern to you from the WORST to LEAST painful:

☐ _____ ☐ _____ ☐ _____ ☐ _____

Which of these treatments have YOU TRIED that were HELPFUL?

☐ Physical Therapy	☐ Surgery	☐ TENS unit	☐ Facet Blocks
☐ Chiropractic	☐ Traction	☐ Braces	☐ Radiofrequency Ablation
☐ Acupuncture	☐ Biofeedback	☐ Exercise/Stretching	☐ Trigger Point Injections
☐ Massage	☐ _____		☐ Epidural Steroid Injections

Which of these TREATMENTS have YOU TRIED but they were NOT helpful?

▢ Physical Therapy	▢ Surgery	▢ TENS unit	▢ Facet Blocks
▢ Chiropractic	▢ Traction	▢ Braces	▢ Radiofrequency Ablation
▢ Acupuncture	▢ Biofeedback	▢ Exercise/Stretching	▢ Trigger Point Injections
▢ Massage	▢ _____		▢ Epidural Steroid Injections

Which of these medications have been PRESCRIBED to you in the past that were HELPFUL?

▢ Aspirin	▢ Ultram/tramadol	▢ Percocet/oxycodone	▢ _____
▢ Advil/ibuprofen	▢ BuTrans/buprenorphine	▢ Methadone	▢ _____
▢ Aleve/naproxen	▢ Norco/hydrocodone	▢ Fentanyl patches	▢ _____
▢ Tylenol/acetaminophen	▢ Morphine	▢ Dilaudid/hydromorphone	▢ _____

Which of these medications have been PRESCRIBED to you in the past that were NOT helpful?

▢ Aspirin	▢ Ultram/tramadol	▢ Percocet/oxycodone	▢ _____
▢ Advil/ibuprofen	▢ BuTrans/buprenorphine	▢ Methadone	▢ _____
▢ Aleve/naproxen	▢ Norco/hydrocodone	▢ Fentanyl patches	▢ _____
▢ Tylenol/acetaminophen	▢ Morphine	▢ Dilaudid/hydromorphone	▢ _____

IMAGING & EVALUATIONS OF YOUR CHRONIC PAIN COMPLAINTS

Name of Clinic	Body Part	Type of Imaging (MRI, x-ray, CT, EMG, etc)	Approx. Date

Please list all of the providers <u>who have treated your chronic pain conditions</u>:

Name of Provider	Clinic Name	Year of Last Visit?

LIFESTYLE CHOICES AND HOME INTERVENTIONS FOR RELIEF OF PAIN (Stop Pain Scale)

Home Exercise Routine:

☐ I obtain regular aerobic exercise. How many min/day: _____ Days/week: _____

☐ I am on a regular walking program. How many min/day: _____ Days/week: _____

☐ I am working out with weights, or doing other types of resistance exercise at least 3x/week.

☐ I am performing daily stretches or engaging regularly in exercise like yoga or Tai Chi at least 3x/week.

☐ Pain prevents me from exercising.

Quality of Sleep: ☐ Good ☐ Fair ☐ Poor Number of hours nightly? _____

Do you suffer from insomnia? ☐ Yes ☐ No

Are you diagnosed with sleep apnea? ☐ Yes ☐ No If yes, do you use CPAP/BiPAP? ☐ Yes ☐ No

Employment, Volunteering or other Participation:

I am employed at _____ as a _____ for _____ hours/week.

I am currently unemployed and have not been employed since _____.

Are you seeking work? ☐ Yes ☐ No Would you like to work if pain is more manageable? ☐ Yes ☐ No

Are you volunteering in the community? ☐ Yes ☐ No If yes, how many hours/week? _____

Are you raising children or grandchildren full-time? ☐ Yes ☐ No

Are you a full-time caregiver for a family member? ☐ Yes ☐ No

Are you retired? ☐ Yes ☐ No If yes, do you have an active hobby? ☐ Yes ☐ No

What is your hobby? _____

Are you attending a trade or vocational program or attending school? ☐ Yes ☐ No

☐ Full-time or ☐ part-time?

Are you receiving disability benefits? ☐ Yes ☐ No Since when? _____

What is your disability based on? _____

If you are NOT currently receiving disability benefits, have you applied for them? ☐ Yes ☐ No

If you have applied for disability, do you have an attorney? ☐ Yes ☐ No

Natural and Topical Medicine Use:

Vitamin D3 ☐ Yes ☐ No **Omega-3's or Fish Oil** ☐ Yes ☐ No **Vitamin B12** ☐ Yes ☐ No

List other **natural substances** you use for pain _____

Do you use any **topical products for pain**? ☐ Yes ☐ No Name?_____

Current Physical Therapy or other Manual Treatment Modalities:

Are you currently participating in any type of professional hands-on treatment? ▢ Yes ▢ No

If yes, which kind? ▢ Physical Therapy ▢ Acupuncture ▢ Chiropractic ▢ Licensed Massage

▢ Other _____

How many times/week? _____ For what pain condition? _____

Generalized Anxiety Disorder (GAD-7) Questionnaire

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	▢	▢	▢	▢
2. Not being able to stop or control worrying.	▢	▢	▢	▢
3. Worrying too much about different things.	▢	▢	▢	▢
4. Trouble relaxing.	▢	▢	▢	▢
5. Being so restless that it's hard to sit still.	▢	▢	▢	▢
6. Becoming easily annoyed or irritable.	▢	▢	▢	▢
7. Feeling afraid as if something awful might happen.	▢	▢	▢	▢

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Stop Bang Questionnaire

Do you snore loudly? (Louder than talking or loud enough to be heard through closed doors)	▢ Yes ▢ No
Do you often feel tired, fatigued, or sleepy during the daytime?	▢ Yes ▢ No
Has anyone observed you stop breathing during sleep?	▢ Yes ▢ No
Do you have (or are you being treated for) high blood pressure?	▢ Yes ▢ No

Age: _____ Gender: ▢ Male ▢ Female Neck Circumference: _____cm

(MA will obtain this for you)

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle your response)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	▢	▢	▢	▢
2. Feeling down, depressed, or hopeless.	▢	▢	▢	▢
3. Trouble falling or staying asleep, or sleeping too much.	▢	▢	▢	▢
4. Feeling tired or having little energy.	▢	▢	▢	▢
5. Poor appetite or overeating.	▢	▢	▢	▢
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down.	▢	▢	▢	▢
7. Trouble concentrating on things, such as reading the newspaper or watching television.	▢	▢	▢	▢
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	▢	▢	▢	▢
9. Thoughts that you would be better off dead, or of hurting yourself.	▢	▢	▢	▢

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

CAGE-AID Questionnaire - At any time in your life, have you:

Have you ever felt that you ought to **cut down** on your drinking or drug use?	▢ Yes ▢ No
Have people **annoyed** you by criticizing your drinking or drug use?	▢ Yes ▢ No
Have you ever felt bad or **guilty** about your drinking or drug use?	▢ Yes ▢ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**eye-opener**)?	▢ Yes ▢ No

Opioid Risk Tool

Please mark each box that applies to you or your family member **now or at any time in the past.**

Family history of substance abuse	
Alcohol	☐ Yes ☐ No
Illegal drugs	☐ Yes ☐ No
Prescription drugs	☐ Yes ☐ No
Personal history of substance abuse	
Alcohol	☐ Yes ☐ No
Illegal drugs	☐ Yes ☐ No
Prescription drugs	☐ Yes ☐ No
Age between 16-45 years	☐ Yes ☐ No
History of pre-adolescent sexual abuse	☐ Yes ☐ No
Psychological disease	
ADD, OCD, bi-polar, schizophrenia	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Scoring totals (provider will do this)	
Questionnaire developed by Lynn R. Webster, MD, to assess risk of opioid addiction. Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain Med. 2005; 6 (6): 432	