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F/U PAIN Questionnaire

Name____ **Date**__________________

New Allergies - what substance?		**What was your reaction?**	**Did you require treatment?**

Any **medication changes** since your last visit? ☐ Yes ☐ No If yes, please tell us what changed:

Medicine	**Instructions**

Pain Medication Use:

When did you take your last dose of pain medication? ____________________________________

How much medication do you have left? ____

Have you received any medication from any other provider, for any reason including dental work, acute pain, surgery or other procedures, **since your last visit?** ☐ Yes ☐ No

If yes, what happened and what did they give you? ______________________________________

Any **alcohol use** since your last visit? ☐ Yes ☐ No If yes, please explain: ____________________

Are you experiencing any **side effects** from your pain medication? ☐ Yes ☐ No

If yes, what are they? ____

How often do you have a bowel movement? ☐ Daily ☐ Every other day ☐ 2x/week ☐ weekly

Are you experiencing any recent changes in or new loss of bowel or bladder control? ☐ Yes ☐ No

Any difficulty urinating? ☐ Yes ☐ No Any nausea or vomiting? ☐ Yes ☐ No

Have you ever had a seizure? ☐ Yes ☐ No When was your last seizure? ____________________

If female, are you or could you become pregnant? ☐ Yes ☐ No Do you use birth control? ☐ Yes ☐ No

Check all that you experience:

☐ muscle aches ☐ muscle spasms ☐ weakness in my ______________________

☐ joint pain ☐ muscle cramps ☐ numbness or tingling in my _______________

☐ joint swelling ☐ joint redness ☐ shooting/radiating pain in my ______________

Functional Gains: *With my pain regimen I am better able to:*

- ☐ Walk further
- ☐ Work harder or longer at job
- ☐ Need less help from others to perform ADL's
- ☐ Able to go shopping
- ☐ ____________________
- ☐ Able to do own yard work
- ☐ Interact with family more
- ☐ Able to perform more domestic chores
- ☐ Interact with friends more
- ☐ ____________________

PEG Pain Screening Tool *(1-10 with 10 being the worst pain)*

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

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.

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

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

Nicotine Use:

Do you use nicotine? ☐ Yes ☐ No In what form? ________________________________

Average daily amount: ______________________ Would you like help quitting? ☐ Yes ☐ No

Employment, Volunteering or other Participation:

Are you working or volunteering in the community? ☐ Yes ☐ No How many hours/week? _________

Are you raising children full-time? ☐ Yes ☐ No If retired, do you have an active hobby? ☐ 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 ________________________________

Use any **topical products for pain**? ☐ Yes ☐ No Which ones?____________________________

Current Physical Therapy or other Manual Treatment Modalities:

Current participation in: ☐ PT ☐ Acupuncture ☐ Chiropractic ☐ Licensed Massage

How many times/week? ___________ For what pain condition? ____________________________