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? _____

Nicotine Use

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

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

If not, would you be interested in quitting at some time in the future? ☐ Yes ☐ No

Social and Housing Status

Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Married ☐ 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 & 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	☐	☐
Seizures	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Headaches/Migraine	☐	☐
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 was your reaction?	Do you require treatment?

Current Medications and Supplements

Please list <u>ALL</u> prescriptions and over-the-counter (OTC) medications or supplements you are <u>CURRENTLY</u> taking, including ALL pain medication. If you need more space, please attach an additional page to the packet.

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

GOALS of Treatment

*Please list **3 very specific and measurable goals** for things you would like to do, and would return to doing, if your pain were more manageable. **PLEASE DO NOT SKIP THIS QUESTION**.*

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

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

Name_____ Date_____

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: _____

**** Due to the significant risks of sedation, respiratory depression, coma, seizure and/or death when consuming alcohol if being prescribed or consuming any other central nervous system depressants, anxiolytics, sedative/hypnotics or other similar substances, no alcohol can be consumed if receiving any such agents while in our program. Please sign your name below to acknowledge this expectation and to agree to this condition of treatment.***

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 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 you been PRESCRIBED 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 you been PRESCRIBED 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 or special studies you have obtained of your chronic pain locations:

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

Please list all of the providers you have seen for your chronic pain:

Name of Provider	Clinic Name	Year of last visit?

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? _____

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

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.	▢	▢	▢	▢
	XXXXXX			
Total Score	XXXXXX	XXXXXX	XXXXXX	

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

When thinking about drug or alcohol use, include illegal drug use and the use of prescription drug use other than prescribed. **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

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.	▢	▢	▢	▢
	XXXXX			
Total	XXXXX	XXXXX	XXXXX	

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 _____

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	