Fireweed Health Care, Inc.

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F/U PAIN Questionnaire

Name_____ **Date**_____

New Allergies - what substance?		**What is your reaction?**	**Do you require treatment?**

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

Drug AND Strength	**Instructions**

Current weight: _____

Nicotine and Alcohol Use:

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

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

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

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? _____

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	▢ Able to do own yard work
▢ Work harder or longer at job	▢ Interact with family more
▢ Need less help from others to perform ADL's	▢ Able to perform more domestic chores
▢ Able to go shopping	▢ 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?

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? _____

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

Employment, Volunteering or other Participation:

Are you working? ▢ Yes ▢ No How many hours/week? _____ Volunteering? ▢ Yes ▢ No

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: ▢ Physical therapy ▢ Acupuncture ▢ Chiropractic ▢ Licensed massage

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

▢ **None at this time.**