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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

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)*

	<u>Self</u>	<u>Family</u>		<u>Self</u>	<u>Family</u>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Disorders	<input type="checkbox"/>	<input type="checkbox"/>

Please list all hospitalizations and surgeries you have ever had:

Surgery	Year	Hospital

Allergies

What are you allergic to?	What is your reaction?	Do you require treatment?

Current Medications and Supplements

Please list ALL prescriptions and over-the-counter (OTC) medications or supplements you are CURRENTLY 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?

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?

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 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 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:

- | | | | |
|------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Shooting | <input type="checkbox"/> Numbness | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

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:

- | | | | |
|--------------------------------|-----------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Rest | <input type="checkbox"/> Walking | <input type="checkbox"/> Meditation/Mindfulness |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Exercise | <input type="checkbox"/> Lying down | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

The following activities & movements WORSEN my pain:

- | | | | |
|-----------------------------------|---|--|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Lifting | <input type="checkbox"/> Turning head | <input type="checkbox"/> Stairs |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting too long | <input type="checkbox"/> Bending forward | <input type="checkbox"/> Bending backwards |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

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?

- | | | | |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Surgery | <input type="checkbox"/> TENS unit | <input type="checkbox"/> Facet Blocks |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Traction | <input type="checkbox"/> Braces | <input type="checkbox"/> Radiofrequency Ablation |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Exercise/Stretching | <input type="checkbox"/> Trigger Point Injections |
| <input type="checkbox"/> Massage | <input type="checkbox"/> _____ | <input type="checkbox"/> 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 who have treated your chronic pain:

Name of Provider	Clinic Name	Year of Last Visit?

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:

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, do you have a disability 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 _____

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.

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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it's hard to sit still.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you often feel tired, fatigued, or sleepy during the daytime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone observed you stop breathing during sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have (or are you being treated for) high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have people annoyed you by criticizing your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Illegal drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal history of substance abuse	
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Illegal drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Age between 16-45 years	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of pre-adolescent sexual abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychological disease	
ADD, OCD, bi-polar, schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> 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	

REVIEW OF SYSTEMS

(Check the box of all symptoms you have been experiencing since your last visit)

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
- Moles changing size, shape or color
- Sores
- Goosebumps
- Blisters
- Painful lesions

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
- Abdominal pain, cramping or distension
- Vomiting
- Constipation
- Red blood in stool
- Black, tarry stool
- Yellow eyes or skin

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
- Bi-polar disorder
- PTSD
- Hearing voices
- Irritability
- Changes in mood
- Homicidal thoughts
- Hallucinations
- Schizophrenia
- Panic attacks
- ADD/ADHD
- Anger issues
- OCD
- Difficulty sleeping