Fireweed Health Care, Inc.

F/U Pain Questionnaire

Name_____ **Date**_____

Allergies &
reaction:_____

Nicotine and Alcohol Use
Do you use nicotine? Yes or No What form? _____
Average daily amount: _____ Would you like help quitting? Yes or No
Any alcohol use since your last visit? Yes or No
If yes, please record when and how many standard drinks consumed: _____

Pain Medication Use

When did you take your last dose of pain medication? _____
How much medication do you have left? _____
Have you received any controlled substances from any other provider, for any reason including dental work, acute pain, surgery or other procedures, since your last visit? _____
If yes, what happened and what did they give you? _____
Are you experiencing any side effects from your pain medication? _____
If female, are you pregnant? _____

PEG Pain Screening Tool

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

Review of Systems - Circle all symptoms you have experienced since your last visit.

Constitutional: Unintentional weight loss or gain, chills, fever, night sweats

HEENT: Visual problems, hearing problems

Pulmonary: Shortness of breath, wheezing, cough, COPD/emphysema

Cardiology: High blood pressure, chest pain, palpitations, lightheaded, swollen ankles

GU: Difficulty urinating, loss of bladder control, blood in urine

GI: Constipation, diarrhea, loss of bowel control, nausea, vomiting, black stools

My BM's are: Daily Every other day 2x/week Every 5-6 days Weekly

Is this a normal frequency for you? Yes No

Musculoskeletal: joint pain, morning stiffness, muscle pain, muscle weakness

Integumentary: Rashes, hives, moles changing size, shape or color

Neurological: Numbness/tingling, weakness, frequent falls, seizures

Endocrine: Diabetes, thyroid problems, hot flashes, low libido

Immunologic/Allergic: asthma, seasonal allergies, current cold or flu

Psychiatric: depression, anxiety, change in mood, difficulty sleeping, suicidal thoughts, thoughts of wanting to hurt yourself, thoughts of wanting to hurt others.

Quality of Sleep: Good Fair Poor
Average number of hours per night:_____, Interrupted or uninterrupted?
Have you been diagnosed with sleep apnea? Yes or No
If yes, are you using CPAP or BiPAP? Yes or No

Current Physical Therapy or other Manual Treatment Modalities
Are you participating in physical therapy, chiropractic care or massage therapy? (Circle which one)
If yes, how many times per week? _____

Home Exercise Routine
Regular aerobic exercise? Yes or No How many minutes/day: _____
How many days/week: _____

Regular walking program? Yes or No How many minutes/day: _____
How many days/week: _____
Are you performing daily stretches or exercises? Yes or No

Employment, Volunteering or other Participation

I am employed at _____ as a _____ for approx. _____ hours/week.
If unemployed, are you seeking work? Yes or No
Are you receiving disability? _____ If yes, when did it start? _____
What is the disability based on? _____
Are you attending school, or trade or vocational program? _____
Are you raising children or grandchildren full-time?_____
Are you a full-time caregiver for a family member? _____
Are you retired? _____ Do you have an active hobby? _____

Please list three daily activities you are able to perform with greater ease with your pain regimen:

1) _____
2) _____
3) _____