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Chronic Pain Clinic Intake

Revised June 26, 2018

Date:_____ PHN:_____Phone# _____

Name: First:_____Last:_____Preferred:_____DOB: _____

Do you consent to The Chronic Pain Management Clinic contacting you by email? ☐Yes ☐No
Email Address: (used by clinic to send educational information) _____

As part of our assessment of your chronic pain, were require some general health information and some specifics regarding your pain

Person providing the Information: ☐Self ☐Spouse ☐Child_____☐Other_____
☐ Interpreter_____ Language Spoken_____

Is this visit related to: ☐WorkSafeBC BC☐ ICBC ☐Legal claim ☐Future Legal Claim ☐ None
Claim/Case #_____
What was your main occupation before your pain/injury?

_____

Have you previously attended a pain clinic or seen a pain specialist?
☐ No ☐Yes If yes, please provide details (example: when where and what treatments)

_____

_____

Please describe the course of your pain. (How and when it began)

_____

_____

Past Health History

Height_____Weight_____
Weight Changes: ☐No ☐Yes if yes gain/loss_____over what period of time_
Tobacco Use ☐Yes ☐ No Year Quit_____#packs per day_____# years _____
Alcohol Use ☐Yes ☐ No Year Quit_____#drinks per day_____# years _____
Cannabis Use ☐Yes ☐ No Year Quit_____#grams per day_____# years _____
Other drugs_____☐Yes ☐ No Year Quit_____#use per day_____# years _____
Caffeine Use: examples include coffee, tea, cola, chocolate: Amount/day _____

Exercise: Type:_____Frequency/week_____Length of time_____
Sleep: Usual Bedtime_____Usual rising time_____
Number of times pain disturbs sleep each night (average)_____
What do you do to return back to sleep? _____
Do you live in a ☐ House ☐Condo ☐Apartment ☐ how many stairs #? _____
With whom do you live? ☐Alone ☐Spouse/partner ☐Children ☐other_____

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Please check any of the following conditions that you have been treated for in the past:

General Medical
Cancer ☐ Type _____
Diabetes ☐ Type_____

Cardiovascular/Hematologic
☐ Anemia
☐ Heart Attack
☐ Coronary Artery Disease
☐ Stroke/TIA
☐ Heart Valve Disorders

Gastrointestinal
☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ Constipation

Urological
☐ Chronic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinence
☐ Dialysis

Head/Ears/Eyes/Nose/Throat
☐ Headaches
☐ Migraines
☐Head Injury
☐Hyperthyroidism
☐Hypothyroidism
☐ Glaucoma

Musculoskeletal/Rheumatologic
☐ Bursitis
☐ Carpal tunnel Syndrome
☐ Fibromyalgia
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Chronic Joint Pain

Respiratory
☐ Asthma
☐ Bronchitis/Pneumonia
☐ Emphysema/ COPD

Neuropsychological
☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizures
☐ Depression
☐ Anxiety
☐ Schizophrenia
☐ Bipolar Disorder

Other Diagnosed Conditions/Surgeries
_____
_____
_____
_____
_____
_____

If you checked yes to any of the above conditions/surgeries please describe
_____
_____
_____
_____
_____
_____
_____

CURRENT Medications - (prescriptions, over the counter, herbals, vitamins) Please use blank paper if required					
Name	Dose (mg)	Frequency (how often)	Name	Dose (mg)	Frequency (how often)

Please list any allergies (food, medication, environmental) and the reactions you get from them:	
Allergy	**Reaction**

Please list all past **pain medications** that you have taken at any point for your current pain concerns					
Name	Dose (mg)	Frequency (how often)	Name	Dose (mg)	Frequency (how often)

Investigations Completed (X-ray, CT, MRI) please list below		
Type of Investigation	**Date**	**Frequency**

In the last week how much (%) relief has your current pain medications provided?

(None) 0 10 20 30 40 50 60 70 80 90 100% relief

Do you think you need more medication than you are currently taking?

1	2	3	4	5
agree strongly	agree	unsure	disagree	disagree strongly

Do you think you need stronger medication, than you are currently taking?

1 2 3 4 5

0 1 2 3 4 5 6 7 8 9 10

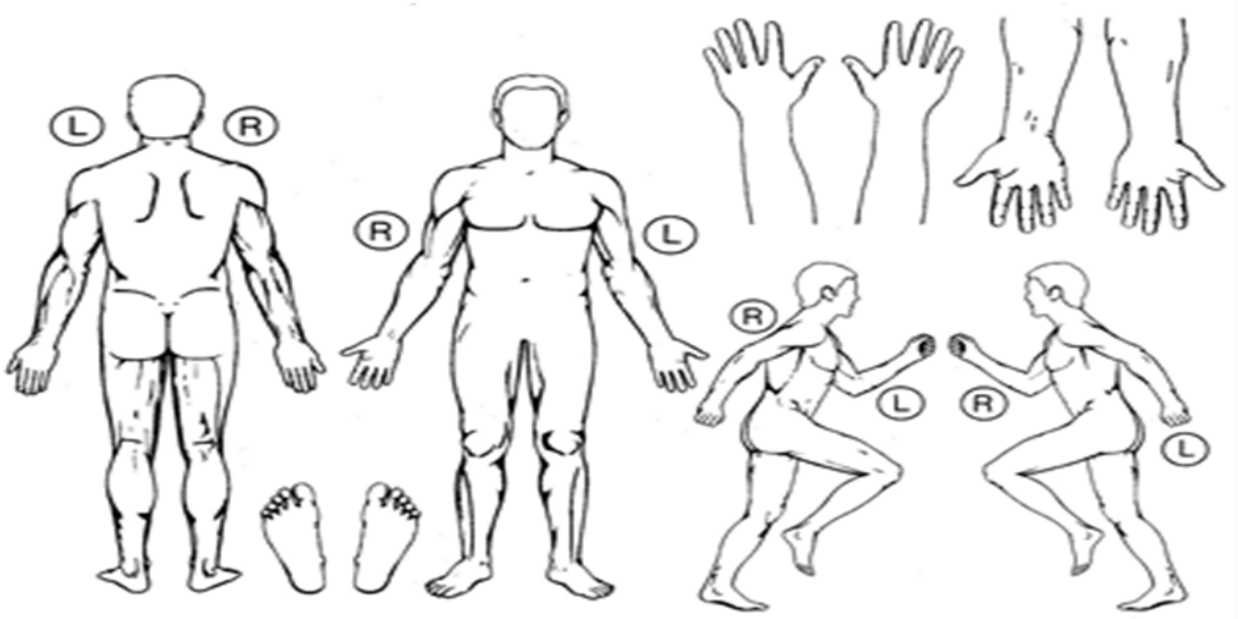
No Pain Moderate Worst Pain

Please Rate Your Pain over the last week using 0-10 scale (0=no pain, 10=worst pain)

Please list the area of pain and rate the intensity using 0-10 scale (0=no pain, 10=worst pain)				
Area	Worst	Best	Average	Comments

Treatments Tried							
	better	worse	date last tried		better	worse	date last tried
Heat				Cough			
Cold				Sneeze			
Massage				Lying on back			
Stretching				Relaxation			
Walking				Lifting			
Sitting				Exercise			
Changing positions				Lying on stomach			
Driving				Chiropractor			
Bending				Acupuncture			
Computer work				Other:			

On the diagram below, indicate the areas where you feel pain using the letters indicated below



S=	Sharp/stabbing	A=	Aching
N=	Numbness	B=	Burning
P=	Pins + needles	X=	Other

Please answer the following questions		
Item	Item score if female	Item score if male
1. Family History of Substance Abuse:		
Alcohol	1	3
Illegal Drugs	2	3
Prescription Drugs	4	4
2. Personal History of Substance Abuse:		
Alcohol	3	3
Illegal Drugs	4	4
Prescription Drugs	5	5
3. Age (mark box if 16-45)	1	1
4. History of Preadolescent Sexual Abuse	3	0
5. Psychological Disease		
Attention Deficit Disorder, Obsessive-Compulsive Disorder or Bipolar, Schizophrenia	2	2
Depression	1	1
Total	____	____

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Neuropathic Pain Questionnaire (NPQ)		
Patient response	Yes	No
1. Does the pain have one or of the following characteristics?		
Burning		
Painful cold		
Electric Shocks		
2. Is the pain associated with one or more of the following symptoms in the same area?		
Tingling		
Pins and Needles		
Numbness		
Itching		
Physical Examination (to be completed by clinician)		
3. Is the pain located in an area where the physical examination may reveal on of the following characteristics?		
Hypoesthesia to touch		
Hypoesthesia to pinprick		
4. In the painful areas, can the pain be caused or increased by:		
Brushing?		

My goals are:

_____

_____

_____

Your Story

If you wish to, this section is reserved for you to tell your story. This may be the story of your pain and how it affects you and your lifestyle, or what you do now to limit your pain's effect on your life.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

We would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would.
Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.
A score of 0 means no disability at all and a score of 10 means that all of the activities in which you would normally be involved have been prevented by your pain.
(Pain Disability Index)

Family/home responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving children to school).										
0 No disability	1	2	3	4	5	6	7	8	9	10 Worst disability
Recreation: This category refers to hobbies, sports, and other similar leisure-time activities.										
0 No disability	1	2	3	4	5	6	7	8	9	10 Worst disability
Social Activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theatre, concerts, dining out, and other social functions.										
0 No disability	1	2	3	4	5	6	7	8	9	10 Worst disability
Occupation: This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such that of a homemaker or volunteer worker.										
0 No disability	1	2	3	4	5	6	7	8	9	10 Worst disability
Sexual Behaviour: this category refers to the frequency and quality of one's sex life.										
0 No disability	1	2	3	4	5	6	7	8	9	10 Worst disability
Self-Care: This category includes activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.).										
0 No disability	1	2	3	4	5	6	7	8	9	10 Worst disability
Life Support activity: This category refers to basic life-supporting behaviours such as eating, sleeping, and breathing.										
0 No disability	1	2	3	4	5	6	7	8	9	10 Worst disability

In these days of high tech medicine, one of the most important sources of information about you is often missing from your medical records; your own feelings or intuitions about what is happening with your body. We hope that the following information will help to fill the gap. Please answer the following questions according to the scale on the right. Please answer according to your true feelings, not according to what others think you should believe. This is not a test of medical knowledge; we want to know how you see it.

	Circle the number next to each question that best corresponds to how you feel	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
1	I'm afraid that I might injure myself if I exercise.	1	2	3	4
2	If I were to try to overcome it, my pain would increase.	1	2	3	4
3	My body is telling me I have something dangerously wrong.	1	2	3	4
4	My pain would probably be relieved if I exercise.	1	2	3	4
5	People aren't taking my medical condition seriously enough.	1	2	3	4
6	My pain/injury/accident has put my body at risk for the rest of my life.	1	2	3	4
7	Pain always means I injured my body.	1	2	3	4
8	Just because something aggravates my pain does not mean it is dangerous.	1	2	3	4
9	I'm afraid that I might injure myself accidentally.	1	2	3	4
10	Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening.	1	2	3	4
11	I wouldn't have this much pain if there wasn't something potentially dangerous going on in my body.	1	2	3	4
12	Although my condition is painful, I would be better off if I were physically active.	1	2	3	4
13	Pain lets me know when to stop exercising so that I don't injure myself.	1	2	3	4
14	It is not really safe for a person with a condition like mine to be physically active.	1	2	3	4
15	I can't do all the things normal people do because it's too easy for me to get injured.	1	2	3	4
16	Even though something is causing me a lot of pain I don't think it is actually dangerous.	1	2	3	4
17	No one should have to exercise when s/he is in pain.	1	2	3	4
	Total				

(Miller,Kori and Todd, 1991)

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery. We are interested in the types of thoughts and feelings that you have when you are in pain.
Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	The rating scale is as follows: (PCS)	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
1	I worry all the time about whether the pain will end.	0	1	2	3	4
2	I feel I can't go on.	0	1	2	3	4
3	It's terrible and I think it's never going to get any better.	0	1	2	3	4
4	It's awful and I feel that it overwhelms me.	0	1	2	3	4
5	I feel I can't stand it anymore.	0	1	2	3	4
6	I become afraid that the pain will get worse.	0	1	2	3	4
7	I keep thinking of other painful events.	0	1	2	3	4
8	I anxiously want the pain to go away.	0	1	2	3	4
9	I can't seem to keep it out of my mind.	0	1	2	3	4
10	I keep thinking about how much it hurts.	0	1	2	3	4
11	I keep thinking about how badly I want the pain to stop.	0	1	2	3	4
12	There's nothing I can do to reduce the intensity of the pain.	0	1	2	3	4
13	I wonder whether something serious may happen.	0	1	2	3	4
	Total					

Over the last 2 weeks how often have you been bothered by any of the following problems? (Generalized Anxiety Disorder-7 GAD-7) (Use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total				

Over the last 2 weeks how often have you been bothered by any of the following problems? (Patient Health Questionnaire-9 PHQ-9) (Use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping to much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or over eating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some away	0	1	2	3
Total				

If you checked off any problems, how difficult have these problems 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**
☐	☐	☐	☐