NOBLE Pain Management

VICTUS DOLORE

Your Warrior in the Fight Against Pain

New Patient Consultation Questionnaire

Name: ____________________ Date of Birth: ______________ Today's Date: ____________

Physician Referred by: ____________________ Family Physician: ____________________ ❐ Same

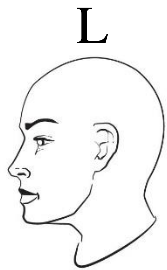
Briefly describe your pain: ____

At this time are you having any of the following? (Check Yes or No)

Chest Pain	❐ Yes	❐ No	Diarrhea	❐ Yes	❐ No	Skin Rash	❐ Yes	❐ No
Shortness of Breath	❐ Yes	❐ No	Pain or Burning w/Urination	❐ Yes	❐ No	Fever	❐ Yes	❐ No
Nausea	❐ Yes	❐ No	Headache	❐ Yes	❐ No	Sweating	❐ Yes	❐ No
Vomiting	❐ Yes	❐ No	Double Vision	❐ Yes	❐ No			

Where is your pain? Mark the areas of pain:

L



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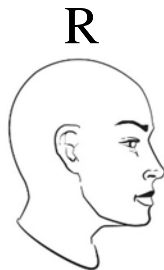

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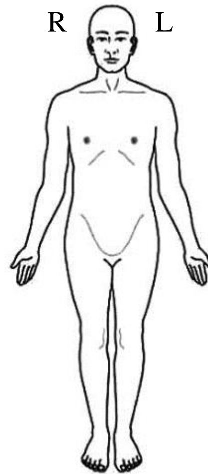

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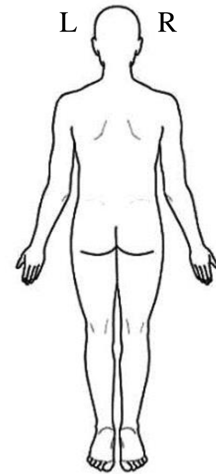


Does your pain travel anywhere? ❐ Yes ❐ No If yes, where? ________________________

When did you first notice your pain? ________________________

Under what circumstances did your pain begin?

❐ Accident at Work ❐ Accident at Home ❐ Other Accident
❐ Following Illness ❐ Following Surgery ❐ Pain "just began"

Comments: ____

____

Check which of the following best describes your pain:

❐ Burning ❐ Tingling ❐ Throbbing
❐ Sharp ❐ Aching ❐ Shooting

Do you have:

❐ Numbness ❐ Weakness ❐ Skin Discoloration ❐ Coldness

If you checked any of the above, describe where: ________________________

____

Which of the following words best describes the patterns of your pain? (Check all that apply.)

❐ Continuous ❐ Comes and goes ❐ Brief/momentary

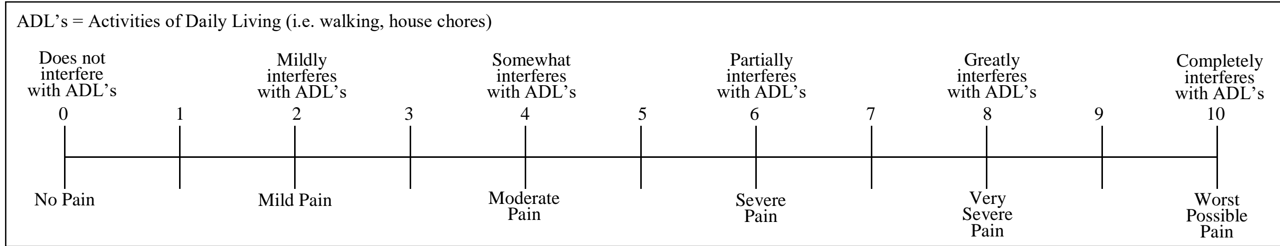
Family History

Mother
Spine Surgery? ❐ Yes ❐ No If yes, please describe: ________________________

Father
Spine Surgery? ❐ Yes ❐ No If yes, please describe: ________________________

New Patient Consultation Questionnaire

Please use the following chart to complete pain scale questions:



Circle the number which best describes the intensity of your pain. (0 = NO PAIN 10 = WORST PAIN IMAGINABLE)

Your pain right now______ 0 1 2 3 4 5 6 7 8 9 10

Your pain at its worst______ 0 1 2 3 4 5 6 7 8 9 10

Your average pain score this month 0 1 2 3 4 5 6 7 8 9 10

What makes your pain "Better" "Worse" or "No Effect? Please check the appropriate boxes below:

	Better	Worse	No Effect
Heat	❒	❒	❒
Cold	❒	❒	❒
Bath/Shower	❒	❒	❒
Walking	❒	❒	❒
Sitting	❒	❒	❒
Standing	❒	❒	❒

	Better	Worse	No Effect
Bending	❒	❒	❒
Lying Down/Sleeping	❒	❒	❒
Turning	❒	❒	❒
Stress/Worry	❒	❒	❒
Exercise/Activity	❒	❒	❒
Sexual Activity	❒	❒	❒
Reading/TV	❒	❒	❒

Does your pain interfere with sleep? ______________________________

List specific activities you could do better if you had less pain: ______________________________

____

____

Realistic goals or expectations from treatment at Noble Pain Management: ______________________________

____

____

What pain-related evaluations have you had? Hospital/Facility

X-rays ______________

Myelogram ______________

CAT Scan ______________

MRI ______________

Nerve & Muscle Tests/EMG ______________

Bone Scan ______________

Do you know the findings of these studies? ______________________________

New Patient Consultation Questionnaire

Do you Smoke? ❒ Yes ❒ No If yes, are you interested in obtaining information regarding how to quit? ❒ Yes ❒ No

Do you drink alcohol? ❒ Yes ❒ No

Do you use any illegal drugs? ❒ Yes ❒ No

If yes, please list: ______________________________

Have you ever had a problem with drugs or alcohol? ❒ Yes ❒ No

What is your job? ______________________________

Are you still working? ❒ Yes ❒ No If no, who ordered? ______________________________

If you are no longer working, how long have you been off work? ______________________________

Are you currently receiving disability benefits? ❒ Yes ❒ No

If yes, when does your case come up for review again? ______________________________

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed

If your pain is the result of injury, accident, or surgery, have there been any lawsuits? ❒ Yes ❒ No

If your injury is job-related, is there a Worker's Compensation claim filed? ❒ Yes ❒ No

Do you currently retain an attorney? ❒ Yes ❒ No

Referring Physician: ______________________________ Primary Physician: ______________________________

Address: ______________________________ Address: ______________________________

______________________________ ______________________________

Telephone#: ______________________________ Telephone#: ______________________________

Listed below are procedures commonly used in pain treatment. Please indicate ALL treatments you have tried <u>even if not successful</u>.

❒ Surgery Related to Pain
❒ Nerve Block
❒ Steroid Injections
❒ Physical Therapy
❒ Psychological Counseling
❒ Relaxation Training
❒ Massage
❒ Biofeedback
❒ Chiropractic Treatment/Manipulation
❒ Heat
❒ Ice
❒ Implanted Device
❒ Acupuncture
❒ TENS

❒ Neurontin (Gabapentin)
❒ Lyrica (Pregabalin)
❒ Tylenol (Acetaminophen)
❒ Motrin/Advil/Aleve (Ibuprofen)
❒ Amitriptyline (Elavil)
❒ Effexor (Venlafaxine)
❒ Cymbalta (Duloxetine)
❒ Muscle Relaxers (Valium, Flexeril, Tizanidine, Skelaxin, etc.)
❒ Hydrocodone (Norco)
❒ Oxycodone (Percocet)
❒ Morphine
❒ Fentanyl
❒ Methadone
❒ Hydromorphone (Dilaudid)
❒ Other Medication: ______________________________

New Patient Consultation Questionnaire

Personal Health History

- ❒ Acid Reflux
- ❒ Anxiety
- ❒ Arthritis (specify location): ______________________
- ❒ Blood Clots
- ❒ Cirrhosis of the Liver
- ❒ Cancer (location/type): ______________________
- ❒ Congestive Heart Failure
- ❒ COPD
- ❒ Depression
- ❒ Diabetes
- ❒ Epilepsy/Seizures
- ❒ Heart Attack
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Multiple Sclerosis
- ❒ Osteoporosis
- ❒ PVD (Peripheral Vascular Disease)
- ❒ Renal Failure
- ❒ Sleep Apnea
- ❒ Stroke
- ❒ Thyroid Disorder
- ❒ Other: ______________________

Height:_______________ **Weight:**_______________

Please list any major or chronic illnesses not listed above: ❒ None

____

____

Other Surgeries in Last 10 Years:

Surgery	Date	Hospital

Medication Profile

Medication Allergies

Medication Allergic To	Reaction

All Current Medications

Date Started	Medication/Dose/Strength	Date Started	Medication/Dose/Strength

New Patient Consultation Questionnaire

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2, or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

(0) I do not feel sad. (1) I feel sad. (2) I am sad all the time and I can't snap out of it. (3) I am so sad or unhappy that I can't stand it.	(0) I do not feel disappointed in myself. (1) I am disappointed in myself. (2) I am disgusted with myself. (3) I hate myself.
(0) I am not particularly discouraged about the future. (1) I feel discouraged about the future. (2) I feel I have nothing to look forward to. (3) I feel that the future is hopeless and that things cannot improve.	(0) I do not feel I am any worse than anybody else. (1) I am critical of myself for my weaknesses or mistakes. (2) I blame myself all the time for my faults. (3) I blame myself for everything bad that happens.
(0) I do not feel like a failure. (1) I feel I have failed more than the average person. (2) As I look back on my life, all I can see is a lot of failure. (3) I feel I am a complete failure as a person.	(0) I do not have any thoughts of killing myself. (1) I have thoughts of killing myself, but I would not carry them out. (2) I would like to kill myself. (3) I would kill myself if I had the chance.
(0) I get as much satisfaction out of things as I used to. (1) I do not enjoy things the way I used to. (2) I do not get real satisfaction out of anything anymore. (3) I am dissatisfied of bored with everything.	(0) I do not cry any more than usual. (1) I cry more now than I used to. (2) I cry all the time now. (3) I used to be able to cry, but now I cannot even cry though I want to.
(0) I do not feel particularly guilty. (1) I feel guilty a good part of the time. (2) I feel quite guilty most of the time. (3) I feel guilty all of the time.	(0) I am no more irritated now than I ever am. (1) I get annoyed or irritated more easily than I used to. (2) I feel irritated all the time now. (3) I do not get irritated at all by the things that used to irritate me.
(0) I do not feel I am being punished. (1) I feel I may be punished. (2) I expect to be punished. (3) I feel I am being punished.	(0) I have not lost interest in other people. (1) I am less interested in other people than I used to be. (2) I have lost most of my interest in other people. (3) I have lost all interest in other people.
(0) I make decisions about as well as I ever could. (1) I put off making decisions more than I used to. (2) I have greater difficulty in making decisions than before. (3) I can't make decisions at all anymore.	(0) My appetite is no worse than usual. (1) My appetite is not as good as it used to be. (2) My appetite is much worse now. (3) I have no appetite at all anymore.
(0) I do not feel I look any worse than I used to. (1) I am worried that I am looking old or unattractive. (2) I feel that there are permanent changes in my appearance that make me look unattractive. (3) I believe that I look ugly.	(0) I have not lost much weight, if any, lately. (1) I have lost more than 5 pounds. (2) I have lost more than 10 pounds. (3) I have lost more than 15 pounds. I am purposely trying to lose weight by eating less. ❒ Yes ❒ No

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(0) I can work about as well as before. (1) It takes an extra effort to get started doing something. (2) I have to push myself very hard to do anything. (3) I can't do any work at all.	(0) I am no more worried about my health than usual. (1) I am worried about physical problem such as aches and pains; or upset stomach; or constipation. (2) I am very worried about physical problems and it's hard to think of much else. (3) I am so worried about my physical problems that I cannot think about anything else.
(0) I can sleep as well as usual. (1) I do not sleep as well as I used to. (2) I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. (3) I wake up several hours earlier than I used to and cannot get back to sleep.	(0) I have not noticed any recent change in my interest in sex. (1) I am less interested in sex than I used to be. (2) I am much less interested in sex now. (3) I have lost interest in sex completely.
(0) I do not get more tired than usual. (1) I get tired more easily than I used to. (2) I get tired from doing almost anything. (3) I am too tired to do anything.	**(To be completed by Office Staff)** _______ **Subtotal Page 1** _______ **Subtotal Page 2** _______ **Total Score**

Fall Risk Assessment

Have you fallen in the last six months? ❒ Yes ❒ No

Do you use a cane, walker, crutches, or other assistive device to walk? ❒ Yes ❒ No