INITIAL PAIN QUESTIONNAIRE

George Alhaj, MD
The Pain Management Solution PLLC
American board certified in Pain Medicine
American board certified in Anesthesiology
2124 Shadowlake Drive, Building O
Oklahoma City, Oklahoma 73159
Telephone: (405) 378-0600 Fax: (405) 576-3104
www.nopainoklahoma.com

Name: _____

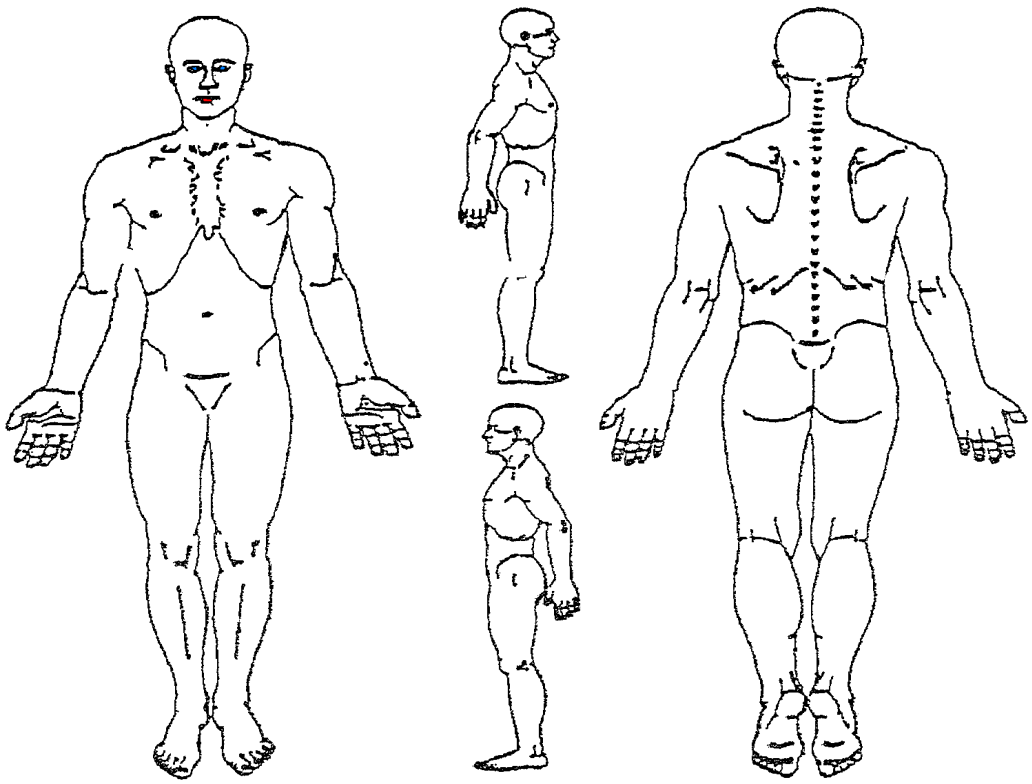
Date: _____ Age: _____ DOB: _____

Who referred you to the Center? _____

Ht. _____ Wt. _____ BP _____ HR _____

CHIEF COMPLAINT: Where are your main pain areas? _____

INDICATE PAIN LOCATIONS: Where does it hurt?



PAIN HISTORY

Circumstances of Onset

Accidental at work	____	Date of injury _____
Accidental at home	____	
Other accident	____	where were you working? _____
Following illness	____	
Following Surgery	____	
Pain "just began"	____	

Why do you think you have pain? What do you think is wrong? _____

_____

Do you have any numbness in your arms or legs? YES _____ NO _____ If yes, where? _____

Do you have any tingling sensation in your arms or legs? YES _____ NO _____ If yes, where? _____

Do you have any weakness in your arms or legs? YES _____ NO _____ If yes, where? _____

Do you have incontinence of bowel? YES _____ NO _____

Do you have incontinence of bladder? YES _____ NO _____

Have you had any of the following done concerning your pain area?

X-rays YES _____ NO _____ If Yes, WHEN _____ WHERE _____

CT-scan YES _____ NO _____ If Yes, WHEN _____ WHERE _____

MRI scan YES _____ NO _____ If Yes, WHEN _____ WHERE _____

Discography YES _____ NO _____ If Yes, WHEN _____ WHERE _____

Have you seen any of the following for you pain?

	Name	Treatment Received	Date(s)	Helpful?
Acupuncturist	_____	_____	_____	_____
Anesthesiologist	_____	_____	_____	_____
Chiropractor	_____	_____	_____	_____
Neurologist	_____	_____	_____	_____
Neurosurgeon	_____	_____	_____	_____
Pain Management Physician	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____
Primary Care Physician	_____	_____	_____	_____
Psychologist / Psychiatrist	_____	_____	_____	_____
Rheumatologist	_____	_____	_____	_____
Other	_____	_____	_____	_____

What medications or other therapies (such as heat, TENS unit, Biofeedback, Ultrasound, etc.) have you ever tried for your pain? (Please indicate how helpful each has been and if there were any associated side effects)

Medication / Therapy	**Helpful?**	**Side Effects**

If you have ever taken narcotics for your pain, please indicate approximate dates:

Type of narcotic _____ From: _____ To: _____

Type of narcotic _____ From: _____ To: _____

PAIN DESCRIPTION

On a scale of 0-10 with 0= no pain and 10= worst pain imaginable, please rate:

	Your pain right Now (0-10)
	Your pain at its Worst (0-10)
	Your pain at its least (0-10)

Does the severity of your pain vary according to time of day? _____

List specific activities, which increase your pain:

a.) _____ c.) _____

b.) _____ d.) _____

List specific activities or thing you can do which decrease your pain

a.) _____ c.) _____

b.) _____ d.) _____

McGill Short Form Pain Questionnaire
Please indicate degree that each of the following word descriptors apply to you pain.

	None	Mild	Moderate	Severe
Throbbing	0)_____	1)_____	2)_____	3)_____
Shooting	0)_____	1)_____	2)_____	3)_____
Stabbing	0)_____	1)_____	2)_____	3)_____
Sharp	0)_____	1)_____	2)_____	3)_____
Cramping	0)_____	1)_____	2)_____	3)_____
Gnawing	0)_____	1)_____	2)_____	3)_____
Hot-Burning	0)_____	1)_____	2)_____	3)_____
Aching	0)_____	1)_____	2)_____	3)_____
Heavy	0)_____	1)_____	2)_____	3)_____
Tender	0)_____	1)_____	2)_____	3)_____
Splitting	0)_____	1)_____	2)_____	3)_____
Tiring-exhausting	0)_____	1)_____	2)_____	3)_____
Sickening	0)_____	1)_____	2)_____	3)_____
Fearful	0)_____	1)_____	2)_____	3)_____
Punishing-cruel	0)_____	1)_____	2)_____	3)_____

Does your pain interfere with your ability to carry / handle everyday objects such as a bag of groceries or books?

0 1 2 3 4 5 6 7 8 9 10
not at all all of the time

Does your pain interfere with your ability to manage your personal grooming (bathing, dressing, combing your hair, etc.)?

0 1 2 3 4 5 6 7 8 9 10
not at all all of the time

Does your pain interfere with your ability to drive a car?

0 1 2 3 4 5 6 7 8 9 10

not at all all of the time

Does your pain interfere with your ability to travel in a car as a passenger?

0 1 2 3 4 5 6 7 8 9 10

not at all all of the time

Does your pain interfere with your ability to work or complete your usual activities such as housework or school?

0 1 2 3 4 5 6 7 8 9 10

not at all all of the time

Does your pain interfere with your ability to visit and enjoy family and friends?

0 1 2 3 4 5 6 7 8 9 10

not at all all of the time

Doe your pain interfere with your ability to participate in recreational activities?

0 1 2 3 4 5 6 7 8 9 10

not at all all of the time

Does your pain require you to use a cane, walker, or wheelchair? If yes, please circle which: Cane Walker Wheelchair

0 1 2 3 4 5 6 7 8 9 10

not at all all of the time

How many hours are you reclining or in bed each day because of your pain? _____

Have you been considered suicide because of your pain? YES _____ NO _____

Does your pain interfere with your ability to sleep?

0 1 2 3 4 5 6 7 8 9 10

not at all all of the time

MEDICAL HISTORY

What medicines are you taking regularly right now (please include Vitamins, Herbs & Supplements)?

Medicines	Does	How often?

Do you have allergies to any medications? YES _____ NO _____ If Yes, please write below

Medication	Type of reaction

Please list all past and present medical problems. (Example – Diabetes, High Blood Pressure, etc.)

Medical Problem	Details

Please list previous surgeries

Surgery	Date	Details

FAMILY MEDICAL HISTORY

Family	Age	Diseases	If disabled, cause	If deceased, cause of death

Are there any pain problems that run in your family? YES _____ NO _____

Are there other family members on disability for pain related problems? YES _____ NO _____

PATIENT SOCIAL HISTORY

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Children: Ages: _____. Living at home with you? YES _____ NO _____
Who else lives with you at home? _____
Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of tobacco: Never: _____ Previously, but quit: _____ Current packs per day: _____
Use of non-prescription drugs: Never: _____ Type / Frequency _____
Use of caffeine: Never: _____ Type / Frequency _____
Have you ever had a problem with dependency or abuse of prescription or Non-prescription drugs? YES _____ NO _____
Have you ever been physically abused? YES _____ NO _____
Have you ever been sexually abused? YES _____ NO _____
Excessive exposure at home or work to: Fumes _____ Dust _____ Solvents _____ Particles _____ Noise _____
Occupation: _____ Hours per day: _____
Retired: YES _____ NO _____ Disabled: YES _____ NO _____ Since when? _____
Are you involved in any litigation, workers' compensation claim or disability claim? YES _____ NO _____

REVIEW OF SYSTEMS:

CONSTITUTIONAL SYMPTOMS

Good general health lately	YES ___ NO ___
Recent weight change	YES ___ NO ___
Fever	YES ___ NO ___
Fatigue	YES ___ NO ___

EYES

Eye disease or injury	YES ___ NO ___
Wear glasses / contact lenses	YES ___ NO ___
Blurred vision	YES ___ NO ___
Glaucoma	YES ___ NO ___

EAR / NOSE / MOUTH / THROAT

Hearing loss or ringing	YES ___ NO ___
Earaches or drainage	YES ___ NO ___
Chronic sinus problem or rhinitis	YES ___ NO ___
Nose bleeds	YES ___ NO ___
Mouth sores	YES ___ NO ___
Bleeding gums	YES ___ NO ___
Sore throat or voice change	YES ___ NO ___

CARDIOVASCULAR

Heart trouble	YES ___ NO ___
Chest pain or angina pectoris	YES ___ NO ___
Palpitations	YES ___ NO ___
Exposure to TB?	YES ___ NO ___
Swelling of feet, ankles or hands	YES ___ NO ___
Murmurs	YES ___ NO ___

RESPIRATORY

Chronic or frequent coughs	YES ___ NO ___
Spitting up blood	YES ___ NO ___
Shortness of breath	YES ___ NO ___
Asthma or Wheezing	YES ___ NO ___

GASTROINTESTINAL

Loss of appetite	YES ___ NO ___
Nausea or vomiting	YES ___ NO ___
Frequent diarrhea	YES ___ NO ___
Painful bowel movements or constipation	YES ___ NO ___
Rectal bleeding or blood in stool	YES ___ NO ___
Abdominal pain	YES ___ NO ___
Peptic ulcer (stomach or duodenal)	YES ___ NO ___
Hepatitis	YES ___ NO ___
Pancreatitis	YES ___ NO ___

GENITOURINARY

Frequent urination	YES ___ NO ___
Burning or painful urination	YES ___ NO ___
Blood in urine	YES ___ NO ___
Incontinence	YES ___ NO ___
Kidney stones	YES ___ NO ___
Sexual difficulty	YES ___ NO ___
Male – testicle pain	YES ___ NO ___
Female – pain with periods	YES ___ NO ___
Irregular periods	YES ___ NO ___
Could you be pregnant now?	YES ___ NO ___
Are you breast feeding?	YES ___ NO ___
Do you experience pain with intercourse	YES ___ NO ___

MUSCULOSKELETAL

Joint pain	YES ___ NO ___
Joint stiffness or swelling	YES ___ NO ___
Weakness of muscles or joints	YES ___ NO ___
Muscle pain or cramps	YES ___ NO ___
Back pain	YES ___ NO ___
Difficulty in walking	YES ___ NO ___

INTEGUMENTARY (Skin, Breast)

Rash or itching	YES ___ NO ___
Change in skin color	YES ___ NO ___
Change in hair or nails	YES ___ NO ___
Change in temperature of extremities	YES ___ NO ___
Varicose veins	YES ___ NO ___
Breast pain	YES ___ NO ___

NEUROLOGICAL

Frequent or recurring headaches	YES ___ NO ___
Light headed or dizzy	YES ___ NO ___
Convulsions or seizures	YES ___ NO ___
Numbness or tingling sensations	YES ___ NO ___
Tremors	YES ___ NO ___
Paralysis	YES ___ NO ___
Stroke	YES ___ NO ___
Head injury	YES ___ NO ___

PSYCHIATRIC

Memory loss or confusion	YES ___ NO ___
Anxiety	YES ___ NO ___
Depression	YES ___ NO ___
Insomnia	YES ___ NO ___

ENDOCRINE

Glandular or hormone problem	YES ___ NO ___
Thyroid disease	YES ___ NO ___
Diabetes (insulin or Non-insulin circle one)	YES ___ NO ___
Excessive thirst or urination	YES ___ NO ___
Heat or cold intolerance	YES ___ NO ___
Skin becoming dryer	YES ___ NO ___
Change in hat or glove size	YES ___ NO ___

HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts	YES ___ NO ___
Bleeding or bruising tendency	YES ___ NO ___
Anemia	YES ___ NO ___
Phlebitis	YES ___ NO ___
Past transfusion	YES ___ NO ___
Enlarged glands	YES ___ NO ___

ALLERGIC / IMMUNOLOGIC YES ___ NO ___

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	YES ___ NO ___
Morphine, Demerol or other narcotics	YES ___ NO ___
Novocain or other anesthetics	YES ___ NO ___
Aspirin or other pain remedies	YES ___ NO ___
Tetanus antitoxin or other serums	YES ___ NO ___
Iodine or other antiseptic	YES ___ NO ___