

Patient Name: _____

DOB: _____

MR # _____

Date _____



University of Wisconsin Hospital and Clinics
600 Highland Avenue • Madison, Wisconsin 53792
CONFIDENTIAL HEALTH QUESTIONNAIRE
PAIN TREATMENT AND RESEARCH CENTER

Thank you for arranging to visit one of our providers. Please complete this questionnaire before coming for your visit. It will be part of your medical history record. The form asks for information about your current problems and your past medical history. This form will give your doctor a better understanding of your problem, and will allow him or her to spend more time discussing treatment plans with you.

When you come for your first visit, please make sure we receive this completed form along with any other medical records, X-rays, CT or MRI scans, and other medical information related to your problem. Thank you very much!

UW Pain Treatment Clinicians

Name _____

Birth Date _____ Gender: Male Female Handedness: L R

Home Phone _____ Work Phone _____

Fax _____ Mobile Phone _____

Who referred you to see us? Please include mailing address and phone number _____

Who is your primary care physician? Please include mailing address and phone number. _____

A. About your pain problem

Do you have:

- neck pain
- shoulder pain
- arm pain
- headaches
- upper back pain
- lower back pain
- leg pain
- pain all over
- other pain complaints _____

Date pain began: _____ Was onset of pain: (check one) sudden gradual

Is pain the result of a work-related injury? Yes No unknown

Please describe your problem in detail.

If a motor vehicle accident was involved in the development of your pain, please check the items that apply.

- wearing seatbelt
- driving
- rear-end collision
- head-on collision
- broadside collision
- tailspin
- rollover
- other _____

When was the accident? _____

Is litigation (legal action) ongoing or pending? If so, please explain. _____

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B. Describe your pain

Check the boxes that describe your pain:

- | | | | | |
|---------------------------------------|------------------------------------|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Deep | <input type="checkbox"/> Dull | <input type="checkbox"/> Sharp | <input type="checkbox"/> Pulsing |
| <input type="checkbox"/> Intermittent | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Aching | <input type="checkbox"/> Shooting | <input type="checkbox"/> Pressure |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Burning | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Like a tight band |

Is your pain worse (check the box that best applies)...

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> At night | <input type="checkbox"/> In the morning | <input type="checkbox"/> End of shift/day | <input type="checkbox"/> Hot, humid days |
| <input type="checkbox"/> No difference day or night | <input type="checkbox"/> Wet/cloudy days | <input type="checkbox"/> Cold days | <input type="checkbox"/> Certain time of year |

If you have headaches:

How many days per month have you had them during the past three months?

- 0-5 6-10 11-15 16-20 21-25 26-30 more than one a day

other, please explain: _____

Do you have any of the following symptoms associated with your headache (check those that apply)?

- | | | | | |
|---|----------------------------------|--|-----------------------------------|--|
| <input type="checkbox"/> Aura | <input type="checkbox"/> Tearing | <input type="checkbox"/> Sensitive to noises | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Speech changes | <input type="checkbox"/> Nausea | <input type="checkbox"/> Sensitive to odors | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Sensitive to lights |

What brings on, triggers, or aggravates your headaches (check items that apply)?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Weather changes | <input type="checkbox"/> Exercise | <input type="checkbox"/> Missing meals | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Menstrual period | <input type="checkbox"/> Ovulation | <input type="checkbox"/> Changes in sleep pattern |

Foods (list): _____

Other: _____

Which of the following activities increase (I) or decrease (D) your pain?

- | | | |
|--|---|---|
| <input type="checkbox"/> Getting out of bed in morning | <input type="checkbox"/> Standing up | <input type="checkbox"/> Continuous standing |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Bending backward | <input type="checkbox"/> Lying on back/side |
| <input type="checkbox"/> Leaning forward | <input type="checkbox"/> Coughing/sneezing | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Straining | <input type="checkbox"/> Reaching over |
| <input type="checkbox"/> Looking up or sideways | <input type="checkbox"/> Washing/combing hair | <input type="checkbox"/> Going down stairs/ramp |
| <input type="checkbox"/> Long car rides | <input type="checkbox"/> Exercising | <input type="checkbox"/> Computer work |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Walking | <input type="checkbox"/> Running |

Other: _____

Do you experience:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Weakness | <input type="checkbox"/> Clumsiness |
| <input type="checkbox"/> Falls | <input type="checkbox"/> Walking problems | <input type="checkbox"/> Balance problems | <input type="checkbox"/> Spasms |
| <input type="checkbox"/> Limited motion | <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Bladder/urinary problems | <input type="checkbox"/> Sweating changes |
| <input type="checkbox"/> Temperature changes | <input type="checkbox"/> Color changes | <input type="checkbox"/> Hair/nail growth changes | |



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C. About your function

What aspects of your life can you not perform normally because of your pain? _____

For how long (in minutes or hours) can you continuously: Sit _____ Stand _____ Walk _____

How much, and for how long, can you: Carry - time _____ weight _____
 Lift - time _____ weight _____

Do you:

	Yes	No		Yes	No
Sleep soundly	<input type="checkbox"/>	<input type="checkbox"/>	Wake up rested	<input type="checkbox"/>	<input type="checkbox"/>
Have trouble falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	Wake in middle of night	<input type="checkbox"/>	<input type="checkbox"/>
Feel fatigued much of the time	<input type="checkbox"/>	<input type="checkbox"/>	Take sleeping medication	<input type="checkbox"/>	<input type="checkbox"/>

How would you describe your emotional health (check all that apply to you)?

<input type="checkbox"/> happy/cheerful	<input type="checkbox"/> optimistic	<input type="checkbox"/> anxious	<input type="checkbox"/> worried	<input type="checkbox"/> angry
<input type="checkbox"/> depressed	<input type="checkbox"/> suicidal	<input type="checkbox"/> compulsive	<input type="checkbox"/> indifferent	<input type="checkbox"/> hopeless
<input type="checkbox"/> frustrated	<input type="checkbox"/> panicked			

D. Previous evaluation and treatment

What tests have been done to investigate your current problems?

Test	Dates	Where (what clinic, hospital)?
<input type="checkbox"/> Plain x-rays	_____	_____
<input type="checkbox"/> Bone scan	_____	_____
<input type="checkbox"/> CT scan (CAT scan)	_____	_____
<input type="checkbox"/> MRI scan	_____	_____
<input type="checkbox"/> Myelogram	_____	_____
<input type="checkbox"/> EMG/nerve conduction studies	_____	_____
<input type="checkbox"/> PET or SPECT scan	_____	_____
<input type="checkbox"/> Functional capacity evaluation (FCE)	_____	_____
<input type="checkbox"/> EEG (electroencephalogram)	_____	_____
<input type="checkbox"/> Spinal tap or lumbar puncture	_____	_____
<input type="checkbox"/> Blood tests	_____	_____
<input type="checkbox"/> Other	_____	_____

Please list your prior pain-related surgeries. If there is not enough room, attach a separate sheet of paper.

Date	Surgery	Reason (symptoms)	Surgeon

Did your symptoms improve after your most recent surgery? Yes No Which symptoms got better? _____

Did you get worse after surgery? Yes No If yes, please explain. _____

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What nonsurgical treatments have you received for this condition? Write ↑ if helped, ↓ if made you worse, – if no difference. (check here)

- | Treatment | Helped? |
|---|---------|
| <input type="checkbox"/> Heat, ice, ultrasound | _____ |
| <input type="checkbox"/> Traction | _____ |
| <input type="checkbox"/> Braces, splints, taping | _____ |
| <input type="checkbox"/> TENS unit | _____ |
| <input type="checkbox"/> Stretching exercises | _____ |
| <input type="checkbox"/> Treadmill or other exercise machine | _____ |
| <input type="checkbox"/> Pool / aquatic therapy | _____ |
| <input type="checkbox"/> Work hardening / conditioning | _____ |
| <input type="checkbox"/> Back school | _____ |
| <input type="checkbox"/> Craniosacral therapy | _____ |
| <input type="checkbox"/> Massage | _____ |
| <input type="checkbox"/> Herbal supplements | _____ |
| <input type="checkbox"/> Dietary changes | _____ |
| <input type="checkbox"/> Do you do a regular exercise program now: _____ Yes _____ No | |

- | Treatment | Helped? |
|---|---------|
| <input type="checkbox"/> Physical therapy | _____ |
| <input type="checkbox"/> Pain medication | _____ |
| <input type="checkbox"/> Biofeedback, relaxation training | _____ |
| <input type="checkbox"/> Chronic pain program | _____ |
| <input type="checkbox"/> Acupuncture | _____ |
| <input type="checkbox"/> Trigger point injections | _____ |
| <input type="checkbox"/> Nerve blocks / spinal injections | _____ |
| <input type="checkbox"/> Spinal stimulator | _____ |
| <input type="checkbox"/> Implanted pump | _____ |
| <input type="checkbox"/> Prolotherapy | _____ |
| <input type="checkbox"/> Other injections | _____ |
| <input type="checkbox"/> Other treatments | _____ |
| <input type="checkbox"/> Chiropractic | _____ |

E. About your past medical history Please check the box for all areas where you have (or once had) problems.

Head/Neck

- Glaucoma
- Eye/vision problems
- Hearing problems
- Nose/Sinus problems
- Throat problems
- Jaw/Teeth problems
- Other: _____

Skin

- Rashes
- Sores/ulcers
- Eczema/allergic dermatitis
- Poor wound healing
- Other: _____

Muscles/Bones/Joints

- Broken bones
- Arthritis
- Amputation
- Ehlers-Danlos syndrome
- Joint swelling or stiffness
- Very flexible joints
- Lupus
- Muscle pain
- Fatigue
- Morning stiffness
- Other: _____

OB/GYN

- Pelvic pain
- First menstrual period at age _____
- Last menstrual period began _____
- Menstrual problems
- Menopause

Lungs/Chest

- Shortness of breath
- Cough
- Chest pains
- Asthma/emphysema
- Throat problems
- Hay fever/allergies
- Pneumonia
- Other: _____

Nerves/Brain

- Headache
- Vertigo/spinning sensation
- Lightheadedness
- Seizures
- Stroke
- Brain injury
- Spinal cord injury
- Nerve pain
- Balance problems
- Tremor
- Double vision
- Chiari malformation
- Loss of consciousness
- Brain Tumor
- Multiple Sclerosis
- Other: _____

Constitutional

- Fevers
- Chills
- Night sweats
- Weight loss
- Weight gain
- Other: _____

Urinary/Genital

- Kidney stones
- Urinary infections
- Kidney failure/dialysis
- Trouble urinating
- Loss of urine control
- Pain with intercourse
- Erectile dysfunction
- Other sexual difficulties
- Other: _____

Cardiovascular

- High blood pressure
- Low blood pressure
- Varicose veins
- Chest pains/angina
- Heart attack
- Heart murmur
- Irregular heartbeat
- Low blood pressure
- Heart surgery
- Blood clots in legs or arms
- Mitral valve prolapse
- Nonhealing sores
- Poor Circulation
- Leg or arm swelling
- Other: _____

Spine

- Neck injury or pain
- Back injury or pain
- Disc disease
- Fracture
- Scoliosis
- Other: _____



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Psychological

- Depression
- Anxiety
- Panic attacks
- Suicide attempt or gesture
- Psychiatric hospitalization
- Schizophrenia
- Bipolar disorder
- Obsessive-compulsive disorder
- Attention deficit disorder
- Counseling
- Victim of abuse
- Other: _____

Stomach / Abdomen

- Heartburn
- Ulcers
- Reflux / GERD
- Gallstones
- Hepatitis infection
- Diarrhea
- Constipation
- Trouble swallowing
- Loss of bowel control
- Red or black in stools
- Nausea or vomiting
- Stomach upset from medicine
- Irritable bowel syndrome
- Other: _____

Blood / Immune

- Anemia ("low blood")
- Swollen glands or nodes
- Cancer
- Easy bleeding/bruising
- Transfusions
- Nasal Polyps
- Transplant patient
- Other: _____

Endocrine

- Diabetes
- Thyroid problems

Other

- Anesthesia problems in past
- Taking seizure medication
- Need prophylactic antibiotics before procedures
- Pregnant or breastfeeding
- Taking Coumadin, warfarin, Plavix, Ticlid, aspirin, heparin
- Immunosuppressed
- HIV infection
- Artificial heart valve, pacemaker, defibrillator, coronary stents

If involved in counseling, please list your psychiatrist, psychologist, and/or therapist and their addresses.

Please list any other major illnesses you have not mentioned earlier. Give dates. _____

Please list any operations or surgeries you have not mentioned earlier. Give dates. _____

F. About your medications

ALLERGIES: Please list any medications you cannot take because of allergies or other problems. Please tell us what reaction you had to each drug. _____

Are you allergic to iodine or contrast dye (for IVP, myelogram, etc.)? Yes No

Please write down **all medications** you are currently taking. Include over-the-counter medications, vitamins, herbs, and supplements as well as prescription medications.

Name	Strength (milligrams, etc.)	How many, how often	Does it help?			Side effects, if any
			No	Some	A Lot	
<i>Example: Ibuprofen</i>	<i>800 mg</i>	<i>2 tabs, 3 times a day</i>			<i>X</i>	<i>Upset stomach</i>

(continued on next page)

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Medications: (continued)

Name	Strength (milligrams, etc.)	How many, how often	Does it help?			Side effects, if any
			No	Some	A Lot	

G. About your family's medical history

If any of your family members have major medical problems, please list them here. Include headaches, pain problems, arthritis, unusual joint flexibility. Please also include cancer, heart disease, stroke, high blood pressure, diabetes, seizures, substance abuse problems, psychological illnesses, and others.

H. About your life

What is your present or previous occupation? _____

Do you work: Full time? Part time? Light or limited duty? Explain: _____

How long have/had you been at this job? _____ How much do/did you like it? _____

Have you been off work because of your pain in the past? Yes No If so, how many times and for how long? _____

How many hours per day does your job require you to:

- Sit? _____ Stand? _____ Walk? _____ Bend/stoop? _____
- Drive? _____ Reach? _____ Use power tools? _____ Which ones? _____
- Work at computer _____ Work under fluorescent lights _____
- Carry, push, pull? _____ How heavy? _____ Lift? _____ How heavy? _____
- Work with chemicals or fumes

Please answer these questions if you are not working outside the home.

When did you last work, and why did you stop? _____

How do you spend your day? _____

What is your source of income? _____



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Do you plan to: [] Return to your old job? [] Take a different job? [] Not return to work?

How far did you go in school? Were you in the military? [] Yes [] No

Are you: [] married [] single [] divorced [] separated [] widowed

Have you any children? If so, how many and what ages?

Who lives at home with you?

Table with 5 columns: Do you currently:, If yes, how much and for how long?, If no, did you in the past?, If yes, how much and for how long?, If no, did you in the past?. Rows include Smoke?, Use alcohol?, Use illegal drugs?, Use caffeine?

Have you ever had a problem with alcohol or drug use? [] Yes [] No If yes, please explain.

Have you ever been treated for alcohol or drug addiction? [] Yes [] No If yes, when and where?

I. Final Questions

What do you think is causing your pain?

What do you want to accomplish with your visit to us?

Is there anything else you would like to tell us?

Thank you! Please sign below.

Patient's Signature Date Time

If unable to sign, please have a parent, guardian, or other responsible party sign below and give the reason you are unable to sign.

Signature Date Time

Reason patient unable to sign:

For provider's use only

PROVIDER DECLARATION: I have reviewed this document in detail and have discussed its contents with the patient. (Provider sign and date below)

Signature Date Time

5-Hole 1/4 1 3/8 c-to-c

