Dear Patient:

The UW Pain Treatment and Research Center takes a holistic approach to your pain care.

You will be meeting with a physician, physical therapist, and pain psychologist.

Your appointment is on ____________________________________________________

In addition, please read and sign the “Agreement for Psychological Treatment”, which is a standard form required prior to meeting individually with you.

Please complete the enclosed questionnaire for your meeting with the psychologist. The psychologist will gather information on how your pain condition has affected your life. The psychologist will evaluate how stress and other lifestyle factors add to your pain discomfort and offer suggestions to help you cope better.

We realize that you may have been asked the same information on other UW Pain clinic forms. We appreciate your cooperation in providing the information asked of you on this form as well. Please bring the completed form to the appointment and hand it directly to the psychologist.

If you have questions about this form, please contact an administrative assistant 608-263-9550.

Sincerely,

Shilagh A. Mirgain, Ph.D. Norann Richard, Ph.D.
Licensed Psychologist Licensed Psychologist

If you would like to learn more about health psychology and the treatment of chronic pain prior to your intake appointment, please view the following videos on UW website:

and/or videos about our pain management and coping groups at:
Health Psychology Pain Intake  
UW Pain Treatment and Research Center

Name: ___________________________  Today's Date: ____________

Gender: ____________, Age: ________, Date of Birth: _____________

Who referred you to the health psychologist? ______________________

PAIN and/or HEADACHE DESCRIPTION

1. **WHERE** is your pain? (example: lower back, neck, headache)

_____________________________________________________________________

2. **WHEN** did your pain start? (month and year)

_____________________________________________________________________

3. **HOW** did your pain start? (check all that apply)

- [ ] Following a work related injury (Date: _____)
- [ ] Following an automobile accident (Date: _____)
- [ ] Following a fall
- [ ] Following a physical assault
- [ ] Following a surgery
- [ ] I have always had pain.
- [ ] I don't know why I have pain.
- [ ] I have a medical condition that causes my pain (see next question)

4. **WHAT** medical diagnosis do you have that is causing your pain? (choices continues on next page)

- [ ] Arthritis
- [ ] Bulging disk
- [ ] Carpal Tunnel
- [ ] Cluster headaches
- [ ] Daily Tension Headaches
- [ ] Migraine headaches
- [ ] Complex Regional Pain Syndrome (RSD)
- [ ] Degenerative disk disease
- [ ] Degenerative joint disease
- [ ] Herniated or bulging disk
- [ ] Fibromyalgia
❖ Torn rotator cuff
❖ Other

5. Have you ever had BACK, SHOULDER, or KNEE SURGERY for your pain condition? (If yes, what kind of surgery and when?)

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

6. Please check the words that best describe your pain.
   ❖ Aching
   ❖ Burning
   ❖ Cramping
   ❖ Exhausting
   ❖ Exhauting
   ❖ Frightening
   ❖ Gnawing
   ❖ Heavy
   ❖ Hot
   ❖ Numbing
   ❖ Pounding
   ❖ Throbbing
   ❖ Sharp
   ❖ Shooting
   ❖ Splitting
   ❖ Stabbing
   ❖ Tender
   ❖ Other

_________________________________________________________________________________________

7. How would you rate the INTENSITY of your pain TODAY?

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Pain Severe Pain
8. What is the LEAST or BEST your pain has gotten over the past 2 weeks?

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Pain Severe Pain

9. What is the WORSE or MOST INTENSE your pain has gotten over the past 2 weeks?

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Pain Severe Pain

10. WHEN does your pain occur?
(Check all that apply. -items continue on the next page)

- Constantly (24 hours per day)
- Intermittently (off and on depending on the day)
- When I cough or sneeze
- When I move my bowels
- When I urinate or pee
- When I'm bending
- When I'm standing
- When I am at work
- When I am tense or anxious
- When I think about it
- When I'm lifting something
- When I am walking
- When I am sitting
- When I am resting
- When I am lying down
- When I do mild exercise
- When I am tired
- When I am stressed
- When I am doing any physical activity
When I am nervous or anxious
When I am down or depressed
When the weather is cold or damp
When the weather is hot or humid

11. **WHAT kind of TREATMENTS** have you tried for your pain?
(Check all that apply.)

- Acupuncture
- Acupressure
- Biofeedback Therapy
- Chiropractic care
- Cortisone Injection
- Dietary changes
- Epidural injection
- Facet injection
- Hypnosis
- Massage
- Occupational Therapy
- Pain Medication (pills you take by mouth)
- Pain Block injections
- Physical Therapy
- Radial frequency procedure
- Spinal Injections
- Surgery
- TENS unit
- Ultrasound
- Water therapy
- Others:

12. **WHAT helps Lessen or Relieve your pain (even if it is temporary)?**
(Items continue on the next page)

- Cold application
- Changing positions
- Exercise or stretching
- Distracting my attention away from the pain
- Heat application
13. What do you think is causing your pain?

__________________________________________________________________________

14. DO you experience HEADACHES?

- Yes
- NO (If ‘NO” then skip to the next section –Medical History, question #21)

15. HOW long have you been experiencing headaches?

_____years _____ months

16. HOW often you get headaches?

- Every day
- 4-6 times per week
- 2-3 times per week
- Less than 15 times per month
- More than 15 times per month
- 1 time per month
- a few times per year
17. **WHERE** do you feel your headache pain?

- All over your head
- Back of the head
- Forehead
- Temples
- One side of the head (which side? ________)

18. **HOW** long do your headaches last?

- Several hours
- An hour or less
- A full day
- Several days
- Constant

19. Do your **HEADACHES** have any of the following **FEATURES**?

- Blurred vision before the start of the headache
- Nausea
- Pain worse on one side of the head
- Pain worsens with physical activity
- Sensitivity to light
- Sensitivity to noise
- Vomiting

20. **WHAT** medications do you take for headache?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

21. **BESIDES MEDICATION**, do you do anything else to relieve your headache? (such as relaxation, cold compress, self-massage)

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
MEDICAL HISTORY

22. Do you have any of the following conditions?

- Arthritis
- Asthma
- Aneurysm
- Bleeding Disorder
- Crohn's Disease
- Fibromyalgia
- Irritable Bowel Syndrome
- Cancer
- Diabetes
- Heart Problems
- Heart Attack
- High Blood Pressure
- GI (stomach indigestion) Problems
- Seizure Disorder
- Stroke
- Thyroid Problems
- Kidney Problems
- Other:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

23. Does anyone in your family have problems with pain or headache? (If yes, please explain)

_______________________________________________________________________
_______________________________________________________________________

____________________________________________________________

____________________________________________________________
24. *What other medical or psychological problems run in your family?*

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

25. *What MEDICATIONS are you prescribed?*
   *Please include any vitamins or herbs you are taking.*

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<th>Medication</th>
<th>Dosage</th>
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<th>Prescribing Physician</th>
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</table>
26. Please list your **ALLERGIES** to **MEDICINES** or **FOODS**.

______________________________________________________________________________

______________________________________________________________________________

27. Please list any other major **SURGERY** you have had and when?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

PERSONAL HISTORY

28. Are you:
   - Single (never married)
   - Married
   - Partnered (same-sex partner)
   - Widowed
   - Divorced
   - Separated
   - In a relationship

29. Who do you live with? ________________________________________________

30. How many Children do you have? ________________________________

31. What are the ages and genders of your children?

______________________________________________________________________________

32. Are you currently working?
   - Yes
   - No
33. If you are working, what do you do?
____________________________________________________

34. Are you receiving Social Security Disability?

☐ Yes, SINCE WHEN? _________________________________
☐ No

35. How far did you go in school?

☐ Less than high school
☐ High school diploma or GED
☐ Some College
☐ College degree
☐ Graduate degree

OTHER HEALTH QUESTIONS

36. Have you ever had problems with anxiety, panic attacks or depression in the past? (If yes, please describe)

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
37. **What outpatient services have you received for any emotional or psychiatric problem such as anxiety or depression?**

   *Service means receiving counseling or medication by a physician, psychiatrist, psychologist, social worker, or counselor.*

   If yes, please provide the name of the health professional and time period you saw the professional.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

38. **Are you currently seeing a psychiatrist, psychologist, social worker, or other type of counselor?**

   *If yes, who? Please provide an address and phone number.*

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

39. **Have you ever been hospitalized for a psychiatric reason?**

   *(continued on next page)*

   *Hospitalization means being admitted to the psychiatric unit of a hospital to receive mental health services? If yes, please describe the situation briefly.*
40. Have you received treatment for a drug or alcohol problem in the past?  (If yes, for what drug, when and where?)

41. Has anyone ever told you that you had a problem with alcohol or drugs?

- Yes
- No

42. How often do you consume alcohol?

43. Please check all the drugs you are CURRENTLY using.

- Marijuana (weed)
- Cocaine
- Heroin
- Speed
- Crack
- Injection drugs
- Ecstasy (“Vitamin E”)
- Other _____________________
- I am not using any drugs

44. Please check any drugs you used in the PAST.  
(continued on next page)

- Marijuana (weed)
- Cocaine
- Heroin
- Speed
☐ Crack
☐ Injection drug use
☐ Ecstasy ("Vitamin E")
☐ Other _________________________
☐ I never used drugs.

45. **Do you smoke cigarettes?**
   - Yes
   - No

   *If yes, how many cigarettes or packs per day are you smoking?*

   ____________________________________________________________________

46. **How much caffeine do you consume per day (such as coffee, soda)?**

   ____________________________________________________________________

47. **On average, how many hours of sleep are you getting a night? ____**

48. **How often do you exercise per week (PT exercises, walking, etc)?**
   _____________ times, for _________ minutes.

   *Types of exercise you do regularly: ______________________________________
   ____________________________________________________________________

49. **Is there any additional information you think would be helpful for us to know?**

   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

**PLEASE BRING THIS FORM WITH YOU WHEN YOU SEE THE PSYCHOLOGIST.**

You will not be able to be seen without having this form complete.