



Pain Management Clinic
1102 S. Park Street, 3rd Floor
Madison, WI 53715
Phone: (608) 263-9550

Dear Patient:

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

Your appointment is on _____ with _____.

Please complete the enclosed questionnaire, PHQ-9 and GAD-7 for your first meeting with the psychologist. If you do not bring the completed paperwork or arrive early to allow yourself time to complete this paperwork, it may take interfere with some of your appointment time with the psychologist. This questionnaire will help the psychologist 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.

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

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 at 608-263-9550. Sincerely,

Shilagh A. Mirgain, Ph.D.
Licensed Psychologist

Norann Richard, Ph.D.
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:

<http://uwhealth.org/video/managing-chronic-spine-pain-with-health-psychology/26655>
and/or videos about our pain management and coping groups at:
<http://www.uwhealth.org/chronic-pain/pain-management-library/14081> (panels 3 – 6).

**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
- 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**

- Journaling**
- Laying in bed**
- Listening to music**
- Listening to relaxation tapes**
- Pacing my physical activities**
- Pain medication**
- Massage**
- Meditation**
- Reading**
- Rest**
- Sitting in a dark quiet room**
- Taking a warm shower**
- Talking to my family and friend**
- TENS Unit**
- Other:** _____

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.

Medication	Dosage	Reason	Prescribing Physician

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.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(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 too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or 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 way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

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

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

(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

(For office coding: Total Score T ____ = ____ + ____ + ____)

Patient Name

DOB:

MR #:

**University of Wisconsin Hospitals and Clinics
PAIN AGREEMENT FOR PSYCHOLOGICAL
SERVICES**

Date: _____

This document contains important information about Health Psychology Services to help you understand psychological treatment/services. After you have reviewed this document, discuss any concerns with your psychologist. If you consent to receiving psychology services, please sign the last page.

Testing/Assessment:

If your meeting involves testing, your psychologist may conduct a clinical interview along with any other psychological testing (s)he deems necessary. The purpose of psychological assessment is for your psychologist to learn about your knowledge, attitudes, capabilities, and/or motivation. Psychological testing provides a picture of your general psychological state and can help your psychologist identify whether there are significant psychological factors that might impact your ability to make permanent lifestyle changes, recover from medical and surgical treatments and cope with the emotional adjustments following medical and surgical treatments. The testing also provides your psychologist with information about your strengths, weaknesses, coping styles, self-care and ways of relating. This information can be used to tailor treatment plans and recommendations to your specific needs and to optimize the care you receive.

Throughout the assessment process, you have the right to inquire about the nature and purpose of the tests administered and to have your questions about the tests answered. You also have the right to a summary of the test results and recommendations. It is important that you know that the evaluation process and the discussion of life experiences may bring up uncomfortable feelings. Psychological responses to the evaluation process may include, but are not limited to: anxiety, depression, frustration, anger, distress or disappointment. Please discuss these with your psychologist if they occur.

If you are seeing a psychologist for pre-surgical assessment, more sessions may be needed in order to determine whether you are an appropriate candidate for surgery and/or to address certain issues prior to being approved for surgery. You will be responsible for the additional expenses if the psychologist feels that another session is necessary. If additional sessions are necessary and you have insurance, please be sure to get authorization for further sessions from your insurance company.

Treatment:

Psychotherapy and health and behavior intervention has been shown to be effective in treating a variety of problems that interfere with good psychological and physical health. In addressing a number of problems, it has also been shown to lead to better relationships and good outcomes for specific problems. These effects do not necessarily occur in all cases. You and your treatment provider will identify and discuss your goals for treatment and the potential for psychotherapy or health and behavior intervention to adequately achieve these goals. You will work together with your treatment provider to establish a treatment plan. Although treatment has many benefits, there may be times during your treatment that you experience uncomfortable feelings. Please discuss these with your treatment provider as they occur.

Confidentiality:

The information obtained in psychological services and evaluations is confidential. There are exceptions for situations in which we are required to release information without your permission. Examples are:

- 1) if there is evidence of physical, emotional, and/or sexual abuse of children or abuse of the elderly.
- 2) if we judge that you are in danger of harming yourself or others; and
- 3) if a court orders the release of the information.

Patient Name

DOB:

MR #:

University of Wisconsin Hospitals and Clinics
PAIN AGREEMENT FOR PSYCHOLOGICAL SERVICES

If treatment involves more than one client (as in family or marital therapy), all involved parties have access to the records pertaining to that treatment. In addition, in the case of a minor or an adult deemed incompetent, usually the parent or legal guardian has the right to all treatment records.

Psychology trainees (practicum students, psychology interns, postdoctoral fellows) are required by law to be supervised by a licensed psychologist. If a psychology trainee is involved in your services, your case will be discussed with his/her psychologist supervisor.

Since psychology services are provided as a part of the multidisciplinary care at UWHC, it is important to know that your assessment will become a part of the UWHC medical record and will be available to others involved in your care.

Meetings:

Treatment sessions are generally 50 minutes long and are scheduled at a mutually agreed upon time and frequency. Your practitioner will notify you if it is expected that your session will run longer than this.

Appointment Check-In:

For your first appointment with a health psychologist, please present 20 minutes early. For all subsequent psychologist appointments, you can arrive at the time of your scheduled appointment. Please allow enough time to find parking and check-in.

Please check in with the check-in desk and/or receptionist at the start of each of your visits to see your health psychologist. After checking in, if you are waiting for more than ten minutes after your scheduled appointment time, please notify the receptionist. Please note that you should not bring children with you to your appointments unless (a) it is planned that they will participate in the session or (b) you bring another adult to supervise them during the session. You may not leave children unattended in the waiting area. Reception staff cannot supervise children in the waiting area.

Fees:

Fees for services vary and are determined by the University of Wisconsin Hospital and Clinics (UWHC). You may receive information about fees by calling 265-7090. You are responsible for payment of all fees for service. If you have insurance or another payer which pays for all or part of these services, your insurance company or payer will be billed by the UWHC billing center. Preauthorization for services may be required by your insurance company or payer. You are responsible for obtaining preauthorization for Health Psychology services with your insurance company or payer. We will be happy to assist you in this process as appropriate.

Note that most insurance companies and other payers require ongoing information regarding the nature and progress of your treatment. **By signing this document, you agree to allow disclosure of treatment information to your insurance company or other payer.**

Contacting your Treatment Provider:

Office hours are Monday-Friday, 8:30-5:00. If your treatment provider is not immediately available by telephone, please leave a message. We will seek to return your call on the same day, providing it is during normal business hours. If your call is urgent and your treatment provider is not available, you may call 262-2122 and ask for the psychiatrist on call or call your primary care physician, your local hospital emergency room (if you live outside Dane County) or your local Crisis Intervention Center. If you have an emergency, outside of normal business hours, please dial 911 or go to your local emergency room.

Patient Name

DOB:

MR #:

University of Wisconsin Hospitals and Clinics
PAIN AGREEMENT FOR PSYCHOLOGICAL SERVICES

Cancellations:

If you are unable to keep an appointment, you should notify us of your cancellation as early as possible. Please cancel at least 24 hours in advance. Giving less than one day's notice, without an excuse, will be a "Late Cancel." Late Cancellations may be taken into consideration for discharge from the clinic.

If you miss an appointment without cancellation, this is considered a "no show." It is your responsibility to reschedule these appointments. Three or more no shows may result in you being discharged from the clinic. This includes clinic appointments with medical providers, nurses, individual health psychology appointments, and group health psychology appointments. The clinic will notify you and your primary care provider if you are discharged. If you need a referral to a new psychologist or counselor, contact us and we can provide a list of providers.

Professional Records:

Treatment providers must keep treatment records. Your treatment records are a component of your UW Medical record. You may request a copy of your records from the Medical Record Department. We recommend that your treatment provider be present when you are reviewing your record in order to respond to any concerns or questions that you may have.

If you have any questions about the above information, please discuss them with your provider.

Your signature below indicates that you have read the above information, your questions have been answered and you agree to abide by its terms.

Signature of Patient/Representative _____ Date: _____ Time: _____ AM
PM

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

Patient is: Minor Incompetent / Incapacitated

Legal Authority: Legal Guardian Parent of Minor

Health Care Agent Other _____

Provider Signature: _____ Print Provider Name: _____

Date: _____ Time: _____ AM
PM Pager# _____

Interpreter or Reader Signature (if applicable)

Witness Signature*

Print Interpreter or Reader Name

Print Witness Name

Date Time AM
PM

Date Time AM
PM

* Only required if patient signature not obtained by provider or when telephone consent obtained