Patient Name

DOB:

MR #

UW Health **uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)
CONFIDENTIAL PAIN CLINIC QUESTIONNAIRE

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Date: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Mobile: (_____) _____ - _____

Referred by: _____ Primary Care Provider: _____

Describe the brief history of the pain problem you were sent here for._____

_____

_____

_____

_____

How long has pain been present: _____Work-related? ☐ Yes ☐ No Legal Case? ☐ Yes ☐ No
Describe the pain (burning, sharp, etc.) _____
What makes the pain worse? _____
What makes the pain better? _____
How do you spend your day? _____

Do you use a: ☐ Cane ☐ Crutches ☐ Walker ☐ Scooter ☐ Wheelchair Handedness: ☐ Left ☐ Right

Treatment If you have tried any of these treatments, **write ↑ if helpful, ↓ if made worse, – if no difference.**

	current	past		current	past		current	past
Physical Therapy (PT)			Heat			Trigger point injection		
Occupational Therapy (OT)			Cold			Spinal injection		
Exercises			Traction			Implanted pump		
Water exercise/aerobics			Acupuncture			Implanted stimulator		
Splints or braces			Chiropractic			Nerve blocks		
Psychological care for pain			Meditation/relaxation			Nerve ablation/burning		
Pain management classes			Massage			TENS unit		

Sleep Do you: ☐ Have trouble falling asleep? ☐ Snore? ☐ Have restless legs? ☐ Feel fatigued much of the time?
☐ Wake in the middle of the night? ☐ Have sleep apnea? ☐ Use CPAP? ☐ Nap during the day?

Exercise What do you do for exercise? _____
How often? _____ For how long each time? _____

Mood Describe your *current* emotional state (check all that apply): ☐ Happy ☐ Optimistic ☐ Well-adjusted ☐ Angry
☐ Depressed ☐ Suicidal ☐ Anxious ☐ Confused ☐ Hopeless ☐ Indifferent
Do you have a history of: ☐ Depression ☐ Anxiety ☐ Attention deficit ☐ Bipolar disorder ☐ Suicide attempt(s)
☐ Abuse experiences ☐ Other problems _____
Are you currently seeing a psychiatrist? ☐ Yes ☐ No If yes, name: _____
Are you currently seeing a counselor or psychologist? ☐ Yes ☐ No If yes, name: _____

Home / School Who lives with you? _____
Are you ☐ married ☐ single ☐ engaged ☐ divorced ☐ separated ☐ widowed
If you have children, how many and what are their ages? _____
How far did you go in school? _____ Have you spent time in the military? ☐ Yes ☐ No

Work Do/did you miss work because of pain? ☐ Yes ☐ No Do you work outside the home? ☐ Yes ☐ No
If yes, what is your job? _____ ☐ Full-time ☐ Part-time ☐ Light/limited duty
If no, when did you last work? _____ Why did you stop? _____
What is your source of income? _____ Do you intend to return to work? ☐ Yes ☐ No

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Medications: ***Please bring a complete list of your current medications to your clinic appointment. Bring current pill bottles, with pills, if possible.***

What medications have you tried to treat your pain condition? Please circle any you know you have taken.	*Helpful*	*Not helpful*
Vitamins, herbals, glucosamine, other supplements		
NSAIDs (Tylenol/acetaminophen, ibuprofen, Aleve, naproxen, aspirin, Celebrex, others)		
Opioids/narcotics (oxycodone, hydrocodone, Percocet, Vicodin, morphine, Dilaudid, fentanyl, methadone, Butrans, Suboxone, Kadian, tramadol, Nucynta, others)		
Muscle relaxants (carisoprodol, cyclobenzaprine, Skelaxin, baclofen, tizanidine, others)		
Anti-seizure medicines (gabapentin, Lyrica, pregabalin, Topamax, topiramate, others)		
Antidepressants (amitriptyline, nortriptyline, Cymbalta, duloxetine, sertraline, escitalopram, paroxetine, fluoxetine, Savella, milnacipran, others)		
Sedatives/anti-anxiety (diazepam, lorazepam, clonazepam, others)		
Sleeping aids (Benadryl, diphenhydramine, Ambien, zolpidem, Lunesta, Sonata, others)		
Topicals (Lidoderm patch, lidocaine cream, Ben-Gay, capsaicin, Qutenza, Tiger Balm, Voltaren gel others)		

Habits ☐ I have never smoked ☐ I currently smoke ☐ I have quit smoking ☐ I chew tobacco or inhale snuff

Average number of caffeinated beverages per day: _____

I have about _____ alcoholic drinks per day / week / month (circle the appropriate time period).

I have used non-prescribed drugs (check the appropriate boxes):

	Marijuana	Cocaine	Heroin	Amphetamines	Narcotic pills	Others
Now						
In the past						

☐ I have been treated for alcohol or drug addiction ☐ I am in treatment now ☐ I need treatment

Health History Please check the items that apply to you. Provide details at right.

System	**Problems**	**Details, or other problems**
General	☐ Fatigue ☐ Fevers/Chills ☐ Weight loss or gain ☐ Night sweats ☐ "Hot flashes"	
Head/Neck	☐ Poor vision ☐ Poor hearing ☐ TMJ syndrome ☐ Head/neck cancer ☐ Swollen glands/nodes	
Blood/ Immune	☐ Easy bruising or bleeding ☐ Anemia ☐ Lymphoma or leukemia ☐ Transfusions ☐ Transplant	
Bones/ Joints	☐ Broken bones ☐ Joint swelling ☐ Stiff joints ☐ Osteoarthritis ☐ Very flexible joints ☐ Morning stiffness ☐ Lupus ☐ Rheumatoid	
Skin	☐ Rashes ☐ Sores/ulcers ☐ Scars ☐ Eczema ☐ Skin cancer	
Lungs/Chest	☐ Shortness of breath ☐ Cough ☐ Asthma ☐ Emphysema/COPD ☐ Pneumonia ☐ Lung cancer ☐ Lung surgery	
Heart	☐ Chest pain (from heart)/Angina ☐ High blood pressure ☐ Heart attack ☐ Low blood pressure ☐ Irregular heartbeat ☐ Valvular disease ☐ Swollen legs/arms ☐ Aneurysm ☐ Cold hands/feet	
Spine	☐ Scoliosis ☐ Disc problems ☐ Fracture ☐ Neck injury ☐ Back injury ☐ Spinal arthritis ☐ Spine surgery ☐ Spinal tumor	
Endocrine	☐ Diabetes ☐ Goiter ☐ Thyroid disease ☐ Low testosterone/estrogen ☐ Pancreatic disease	
Genital/ Urinary and Pelvic	☐ Kidney stones ☐ Kidney failure ☐ Kidney cancer ☐ Prostate problem ☐ Urinary infection ☐ Problems controlling urine ☐ "Fallen bladder" ☐ Painful intercourse ☐ Erectile dysfunction ☐ Prostate/bladder cancer ☐ Menstrual problems ☐ Pelvic pain ☐ Ovarian/uterine/cervical cancer	

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System	Problems	Details, or other problems
Abdomen/GI	☐ Heartburn, GERD, hiatal hernia ☐ Peptic ulcer ☐ Gallstones ☐ Hepatitis ☐ Diarrhea ☐ Constipation ☐ Irritable bowel ☐ Ostomy ☐ Crohn's ☐ Ulcerative colitis ☐ Cancer ☐ Gastric bypass ☐ Problems controlling bowels ☐ Blood in stool	
Neuro-muscular	☐ Headache ☐ Vertigo (spinning) ☐ Lightheadedness ☐ Stroke ☐ Seizures/epilepsy ☐ Tremor ☐ Falls ☐ Balance problems ☐ Weakness ☐ Muscle pain ☐ Fibromyalgia ☐ CRPS/RSD ☐ Brain tumor ☐ Parkinson's ☐ Multiple sclerosis ☐ Double vision ☐ Peripheral neuropathy ☐ Chronic fatigue ☐ Spinal *cord* injury ☐ Muscular dystrophy or myopathy ☐ Head injury/concussion	
Other	☐ Now pregnant ☐ Now breastfeeding ☐ Planning pregnancy ☐ HIV infection ☐ Artificial joint or disc ☐ Pacemaker, defibrillator, stents, artificial heart valve	

Other medical history: _____

_____

_____

_____

_____

Surgical history: _____

_____

_____

Family Medical History:

Family Member	Medical Problem(s)	Family Member	Medical Problem(s)
Father		Child	
Mother		Child	
Brother/Sister		Others	

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 _____

Reviewed by: _____ Date: _____ Time: _____ AM/PM