

PREMIER HEALTH of PLACERVILLE Inc.
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www.premierhealthcareplacerville.com
JAMES DICKENS, M.D.

Patient Questionnaire

Please fill out the following questionnaire and bring it with you to your scheduled appointment. In addition, please bring your medical records.

Patient Name: _____

Appointment Date: ____/____/_____

Time: _____

Provider: _____

Your doctor has referred you to the PREMIER HEALTH of PLACERVILLE, Inc. for evaluation and assistance with your pain problem. In order to facilitate your care, it is essential that we learn as much about you as we can, and that we learn it directly from you. The following questionnaire asks many questions regarding your chronic pain problem. Some questions may seem unrelated to your problem, and even unnecessary.

Pain is a very complex matter, and we greatly appreciate your cooperation in completing this document to the best of your ability.

Upon your arrival, a member of our staff or the provider will review this questionnaire with you. You will then be evaluated by a physician or physician assistant **Please note: No interventional procedures will be performed on the day of your initial evaluation.** If the physician determines that you need a procedure, it will be scheduled for a later date. Pain prescriptions will only be written following an interventional procedure, as needed. Thank you for taking the time to help us help you!

The information you provide is strictly confidential and for clinic use only. The information cannot, and will not, be released to anyone else without your specific written permission.

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Identifying Data

Date: _____

Name: _____

Address: _____

Telephone (home): _____ (work): _____

Date of birth: _____ Place of birth: _____

Age: _____ Height: _____ Weight: _____ Sex: _____

Work

Are you presently employed? _____ Full time: _____ Part time: _____

Present occupation: _____

For how long have you held that job? _____

If you are currently working, is your job:
Sedentary? _____ Light? _____ Heavy? _____

If you are unemployed, for how long have you been so?

Are you applying for compensation/disability for your injury or illness?
YES _____ NO _____

Have you received compensation/disability for your injury or illness?
YES _____ NO _____

Is there any ongoing litigation concerning your chronic pain?
YES _____ NO _____

Pain History

When did the pain begin? Month: _____ Year: _____

In what part/parts of the body did the pain begin?

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What part/parts of the body now hurt when you experience pain?

CHECK all of the following words that describe your pain:

The pain:

- Only occurs under certain circumstances
- Is rarely present
- Is frequently present
- Is usually present
- Is always present

Since the beginning of the present problem, has the intensity of the pain:

- Been variable
- Remained the same
- Decreased
- Increased
- Unknown

What do you think is the cause of your pain?

What do you expect from your treatment at PREMIER HEALTH of PLACERVILLE?

If your pain cannot be relieved, what do you plan to do?

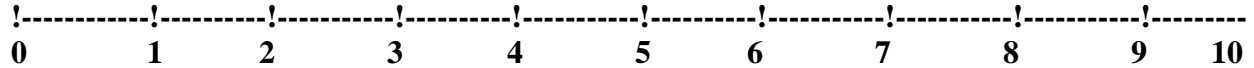
If your pain were to improve, what would you like to do again/more of?

PLEASE CIRCLE WHAT DESCRIBES YOUR PAIN THE MOST (YOU CAN CIRCLE MORE THAN ONE)

Aching, Lightning shock, Stabbing, Burning, Pressure, Terrifying, Cramping, Radiating
Throbbing, Cutting, Sharp, Tight, Dull, Shooting, Tingling, Hot, Soreness

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On the scale below, place a mark on the graph to represent the severity of your pain right now, where “0” is no pain and “10” is the worst possible pain imaginable.



While referring to the 0-10 scale above, write the number that best describes:

- The pain as it usually feels: _____
- The pain is at its absolute worst: _____
- The pain is at its lowest level: _____
- Your pain level today is: _____
- The worst headache pain you’ve experienced is: _____

Factors that Affect Your Pain

Indicate the effect that each item below has on your pain. Mark an “X” for each item:

	Decrease Pain	Increased Pain	No Effect
Alcohol	___	___	___
Heat	___	___	___
Cold	___	___	___
Walking	___	___	___
Standing	___	___	___
Lying down	___	___	___
Sitting	___	___	___
Bending forward	___	___	___
Riding in a car	___	___	___
Weather changes	___	___	___
Intercourse	___	___	___
Exercise (mild)	___	___	___
Bowel movement	___	___	___
Lifting	___	___	___
Emotional stress	___	___	___
Cough/sneeze	___	___	___

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Things You Have Tried to Help Manage Your Pain

Circle all that apply.

Acupuncture

TENS unit

Ice

Heat

Psychological

Nerve Blocks/Injections

Therapy/counseling

Traction

Biofeedback

Herbs

Massage

Physical Therapy

Surgery

Ultrasound

Chiropractor

Hypnosis

Narcotics

Prayer

Other (please list): _____

Of these, has anything helped relieve some or all of your pain? If so, for how long?

Have you ever been seen by a pain clinic/specialist before, and if so, what types of procedures/injections did they do for you?

Social History

What hobbies or recreational activities do you enjoy? _____

Did you do these before your pain started? _____

Do you enjoy them as much as before? _____

What is your marital status?

With whom do you live? _____

Number of children? _____ Ages? _____

Ages of children living at home. _____

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What major concerns are you and your family experiencing as a result of your pain?

Compared to the way you were before your pain started, are you now

- More stressed
- Less stressed
- About the same

Which of the following is bothering you now?

- Change of job
- Financial difficulty
- Marital concerns
- Family concerns
- Death of significant other
- Something else? (please list) _____

Do you have trouble falling asleep at night? Yes _____ No _____

If yes, how often? _____ How many times a week? _____

Do you currently see a psychologist/counselor on a regular basis? _____

Does the pain frequently wake you up at night? Yes _____ No _____

Do you take medicine for sleep? Yes _____ What? _____ No _____

Do you smoke? Yes _____ How much? _____ No _____

Do you drink alcohol? Yes _____ How much? _____ No _____

Any illicit drug use? Yes _____ No _____ If yes what drug(s)? _____

Level of Interference

When you have pain, which of the following activities does your pain affect?

Fill in the blank with, using one of the words below, which best describes to what extent these activities become difficult:

Always

Never

Sometimes

N/A

Frequently

Difficult

Sleeping _____

Eating _____

Sports _____

Job _____

Chores _____

Driving _____

Walking _____

Sex _____

Hobbies _____

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Medical History

Besides your pain problem, what medical conditions do you currently have?

1. _____
2. _____
3. _____
4. _____
5. _____

Review of Systems: Do you have any problems/history with:
(Circle your answer; if YES, elaborate)

1. Weight gain or loss, fevers/chills?
NO / YES

7. Bones, muscles, joints?
NO / YES

2. Eyes/vision, ears, nose, throat?
NO / YES

8. Strokes, seizures/epilepsy, nerve damage
or disorder?
NO / YES

3. Heart, arteries, blood pressure?
NO / YES

9. Depression, anxiety, other psychiatric
conditions?
NO / YES

4. Lungs, breathing?
NO / YES

10. Bleeding disorders?
NO / YES

5. Stomach, intestines, liver?
NO / YES

11. Diabetes, thyroid disease?
NO / YES

6. Kidneys, bladder?
NO / YES

Family History

Please list illnesses that runs in your family, if any.

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Past Surgical History

Please list all of the operations you have undergone, including the year they were performed.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Medications

Please list all of the medications you are currently taking, with the dosage, if possible.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

What other medications can you remember trying for your pain?

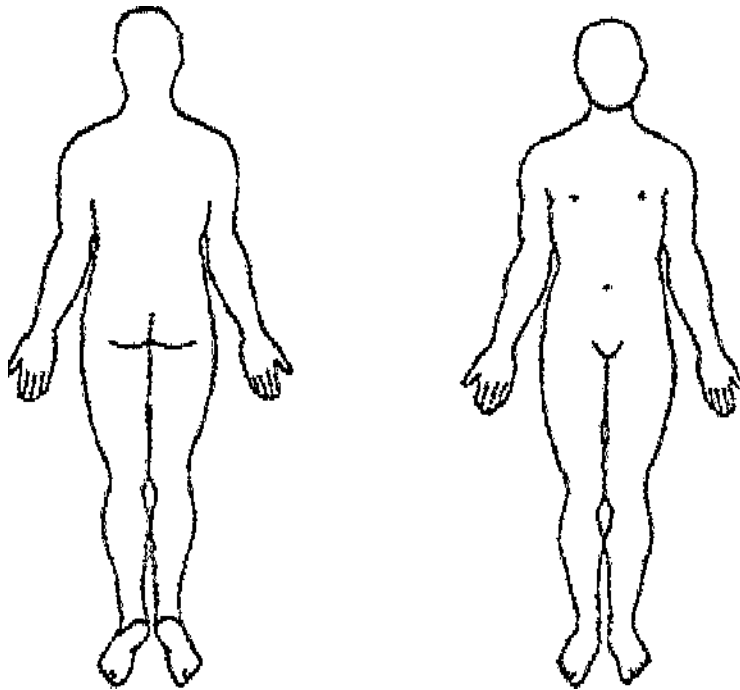
Medication Allergies

- 1. _____ 3. _____
- 2. _____ 4. _____

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The Body Pain Map

On this page please shade in the areas of the body where pain is bothering you. You may use arrows to show where the pain shoots/spreads. You also may use symbols to represent different types of pain (e.g., +++ is burning pain). Please identify symbols if you choose to use them.



This questionnaire was discussed with the patient and reviewed by me.

_____, M.D. Date _____

_____, P.A. Date _____