LAHEY CLINIC
INTERVENTIONAL PAIN MANAGEMENT CENTER

PATIENT QUESTIONNAIRE

PLEASE FILL OUT THE ATTACHED QUESTIONNAIRE AND BRING WITH YOU TO YOUR SCHEDULED APPOINTMENT.

PLEASE BRING MEDICAL RECORDS IF NOT MAINTAINED AT LAHEY CLINIC.

APPT. DATE: _________________ TIME: _______ DR. __________________

Your Doctor has referred you to the Pain Center 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, even unnecessary. Pain is a very complex matter and we greatly appreciate your cooperation in filling out this document to the best of your ability. A physician will then evaluate you. No interventional procedures will be performed on the day of the initial evaluation. If the physician determines that you need a procedure, it will be scheduled for a subsequent day. The only pain prescriptions, which will be written, are following an interventional procedure. Thanks 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.

Thank you,

THE LAHEY CLINIC INTERVENTIONAL PAIN MANAGEMENT CENTER

41 Mall Road
Burlington, MA 01805
(781)-744-5090

One Essex Center Drive
Peabody, Ma 01960
(978)-538-4575

REV (03 JUN 2010)
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 _____________________HOW LONG? ____________

IF WORKING, IS IT: SEDENTARY? ____ LIGHT? ______ HEAVY?  

_______________

IF UNEMPLOYED, HOW LONG?  

___________________________________________

ARE YOU APPLYING FOR COMPENSATION/DISABILITY FOR YOU INJURY OR  

ILLNESS?  YES______ NO ______

HAVE YOU RECEIVED COMPENSATION/DISABILITY FOR YOU 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?
___________________________________________

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

Circle all of the words that describe your pain: sharp, dull, aching, burning, throbbing, shooting, stabbing, lightning shock, pressure, cutting, cramping, radiating, soreness terrifying, tight, hot, tingling

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 the Lahey Pain Management Center? ________________________
___________________________________________________

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?
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.

!---------!---------!---------!---------!---------!---------!---------!---------!---------!---------!
0        1        2        3        4        5        6        7        8        9        10

WHILE REFERRING TO THE “0” TO “10” SCALE ABOVE, WRITE THE NUMBER WHICH BEST DESCRIBES:

- The pain as it usually feels _____
- The pain at its absolute worst _____
- The pain at its lowest level _____
- Your pain level today _____
- The worst headache pain You’ve experienced _____
**FACTORS THAT AFFECT YOUR PAIN:**

**INDICATE THE EFFECT THAT EACH ITEM BELOW HAS ON YOUR PAIN.**
**MARK AN “X” FOR EACH ITEM:**

<table>
<thead>
<tr>
<th>ITEM</th>
<th>DECREASED PAIN</th>
<th>INCREASED PAIN</th>
<th>NO EFFECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Heat</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Cold</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Walking</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Standing</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Lying down</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Bending Backwards</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Sitting</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Bending Forwards</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Riding in a car</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Weather changes</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Intercourse</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Exercise (mild)</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Bowel movement</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Lifting</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Emotional stress</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Cough/sneeze</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>
THINGS YOU HAVE TRIED TO HELP MANAGE YOUR PAIN:
(Circle all that apply)


OTHERS: (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? _____________________________________________
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? List what ________________________________

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________

**LEVEL OF INTERFERENCE:**
When you have pain, which of the following activities does your pain affect? Place an X in the box which best describes to what extent these activities become difficult:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Always Difficult</th>
<th>Sometimes Difficult</th>
<th>Frequently Difficult</th>
<th>Never Difficult</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sports</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Job</td>
<td></td>
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<tr>
<td>Chores</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Driving</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hobbies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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REV (03 JUN 2010)
**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 NO or YES and elaborate)?

1. Weight gain or loss, fevers/chills? NO YES ________________________________________
2. Eyes/vision, ears, nose, throat? NO YES ________________________________________
3. Heart, arteries, blood pressure? NO YES ________________________________________
4. Lungs, breathing? NO YES ________________________________________
5. Stomach, intestines, liver? NO YES ________________________________________
6. Kidneys, bladder? NO YES ________________________________________
7. Bones, muscles, joints? NO YES ________________________________________
8. Strokes, seizures/epilepsy, nerve damage or disorder? NO YES ________________________________________
9. Depression, anxiety, other psychiatric conditions? NO YES ________________________________________
10. Bleeding disorders? NO YES ________________________________________
11. Diabetes, thyroid disease? NO YES ________________________________________

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REV (03 JUN 2010)
**FAMILY HISTORY:** (please list illnesses that run in your family, if any)

_____________________________________________________________

_____________________________________________________________

**PAST SURGICAL HISTORY:**
Please list all of the operations with the year that you have had done.

1. _________________________________________________
2. _________________________________________________
3. _________________________________________________
4. _________________________________________________
5. _________________________________________________

**MEDICATIONS:**

Please list *ALL* of the medications you are currently taking, with the dosage if you can.

1. _________________________________________________
2. _________________________________________________
3. _________________________________________________
4. _________________________________________________
5. _________________________________________________
6. _________________________________________________
7. _________________________________________________

What other medications can you remember trying for your pain?

_____________________________________________________________
ALLERGIES: (medications)

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

THE BODY PAIN MAP

On the next two pages, 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 (i.e. +++ 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.