



## Interventional Pain Management Center Patient Questionnaire

Please fill out the following questionnaire and bring it with you to your scheduled appointment. In addition, please bring your medical records, if not maintained at Lahey Clinic.

Appointment Date: \_\_\_\_\_  
Time: \_\_\_\_\_  
Physician: \_\_\_\_\_

Your doctor has referred you to the Interventional Pain Management 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, 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 nursing staff will review this questionnaire with you. You will then be evaluated by a physician. **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.

## 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?

\_\_\_\_\_

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

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Circle all of the following words that describe your pain:

Aching  
Burning  
Cramping  
Cutting  
Dull  
Hot

Lightning shock  
Pressure  
Radiating  
Sharp  
Shooting  
Soreness

Stabbing  
Terrifying  
Throbbing  
Tight  
Tingling

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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?

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What do you expect from your treatment at Lahey's Interventional Pain Management Center? \_\_\_\_\_

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

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

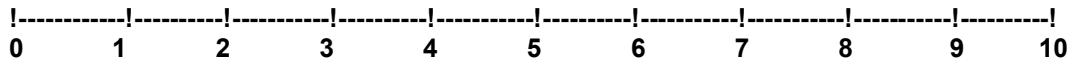
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On the scale below, place a mark on the graph to represent the severity of your pain right now, where “0” is no pain and “10” is the worst possible pain imaginable.



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

The pain as it usually feels \_\_\_\_\_

The pain 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:

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

## Things You Have Tried to Help Manage Your Pain

Circle all that apply.

Acupuncture	Ice	Psychological therapy/counseling
Biofeedback	Massage	Surgery
Chiropractor	Narcotics	TENS unit
Heat	Nerve Blocks/Injections	Traction
Herbs	Physical Therapy	Ultrasound
Hypnosis	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. \_\_\_\_\_

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 \_\_\_\_\_

## Level of Interference

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

Place an "X" below the phrase that best describes to what extent these activities become difficult:

	<b>Always Difficult</b>	<b>Sometimes Difficult</b>	<b>Frequently Difficult</b>	<b>Never Difficult</b>	<b>N/A</b>
Sleeping	_____	_____	_____	_____	_____
Eating	_____	_____	_____	_____	_____
Sports	_____	_____	_____	_____	_____
Job	_____	_____	_____	_____	_____
Chores	_____	_____	_____	_____	_____
Driving	_____	_____	_____	_____	_____
Walking	_____	_____	_____	_____	_____
Sex	_____	_____	_____	_____	_____
Hobbies	_____	_____	_____	_____	_____

## 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 | _____ |
| 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,<br>nerve damage or disorder? | NO | YES | _____ |
| 9. Depression, anxiety, other<br>psychiatric conditions?    | NO | YES | _____ |
| 10. Bleeding disorders?                                     | NO | YES | _____ |
| 11. Diabetes, thyroid disease?                              | NO | YES | _____ |

## Family History

Please list illnesses that run 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?

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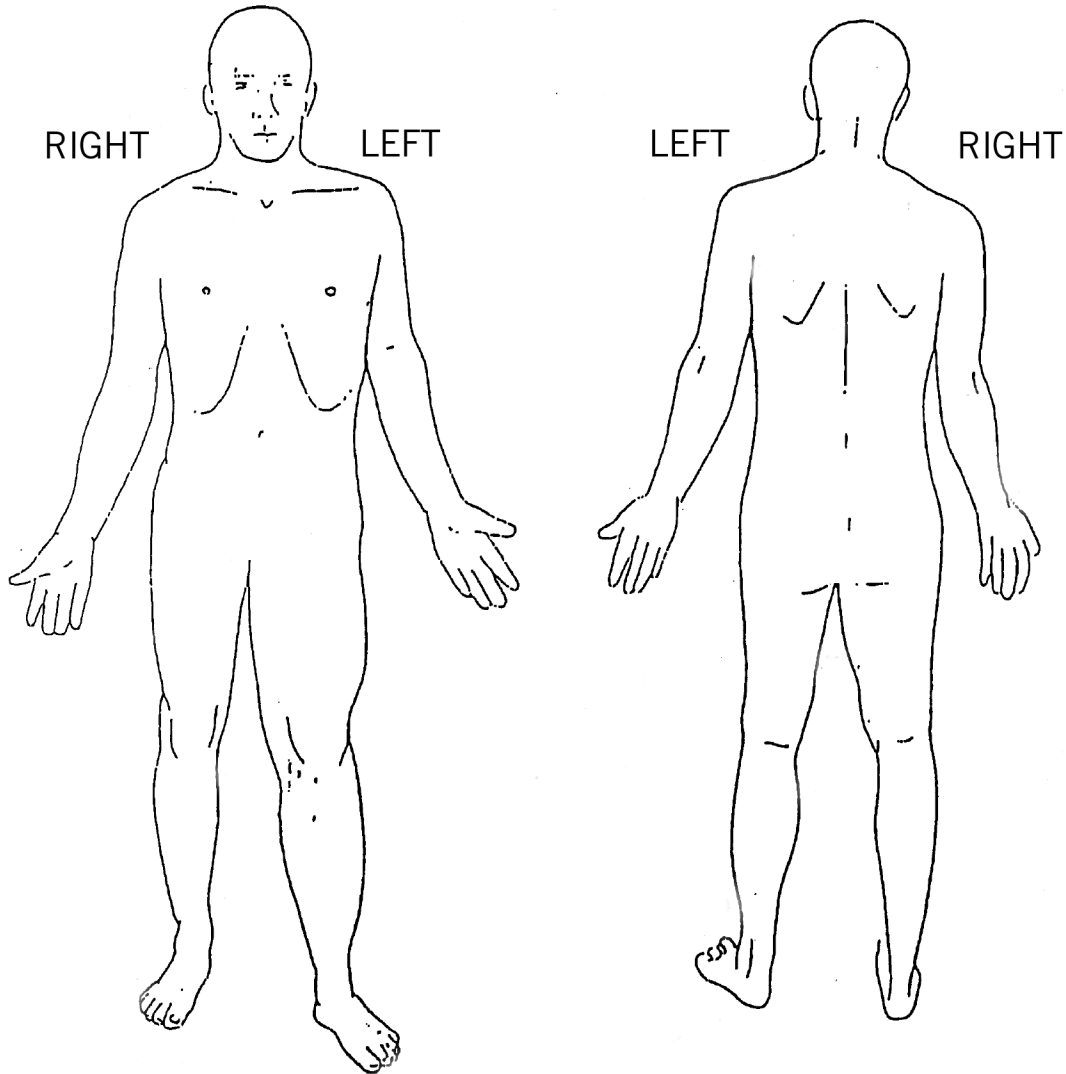
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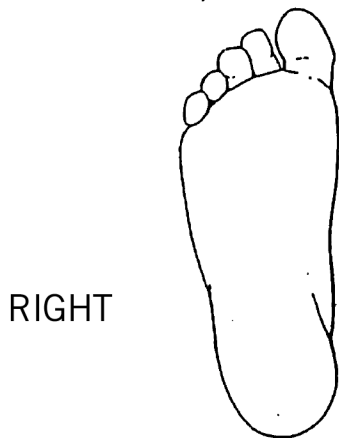
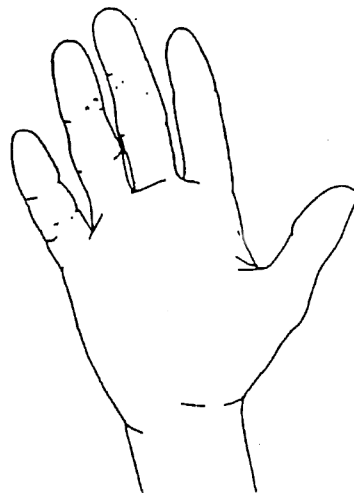
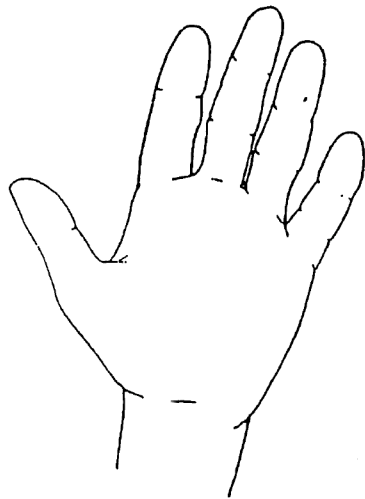
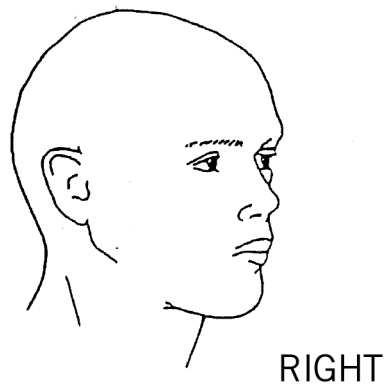
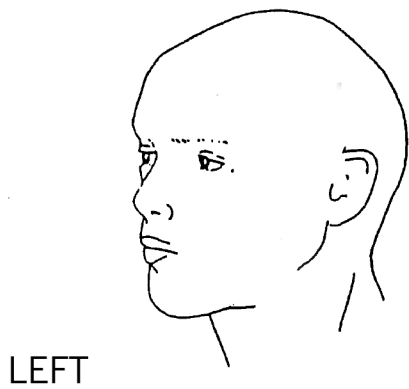
## Medication Allergies

- |          |          |
|----------|----------|
| 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 (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.  
\_\_\_\_\_, MD