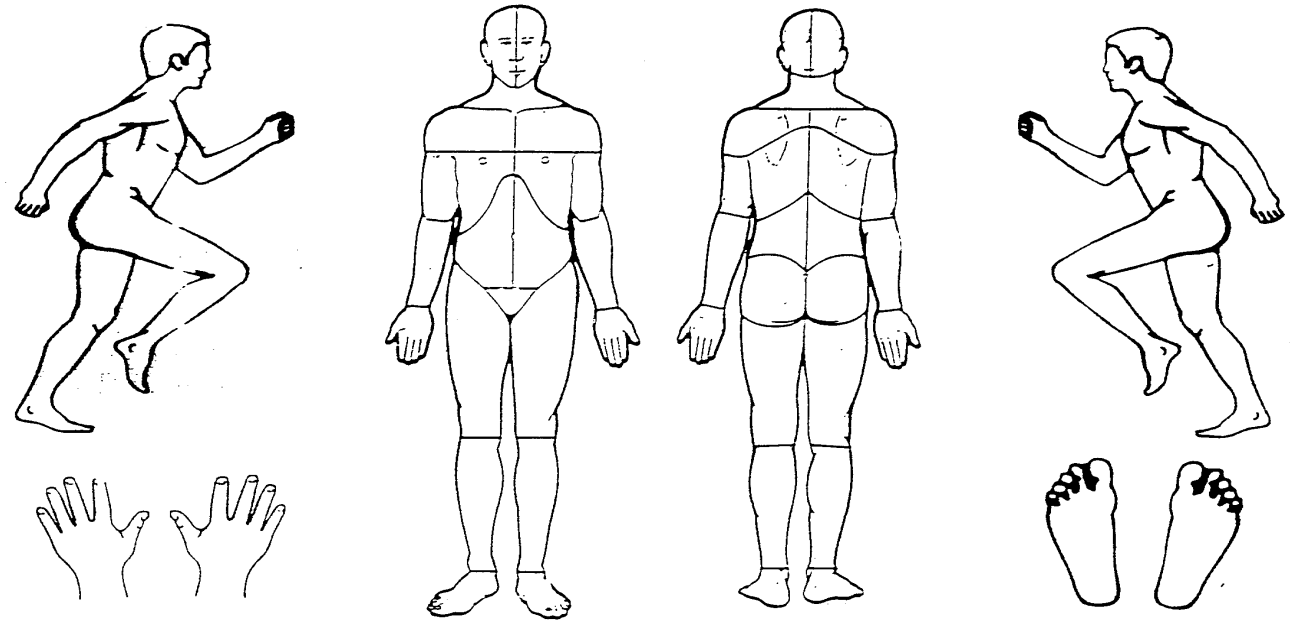
The NeuroCenter
Swedish Covenant Medical Group
6225 W. Touhy Ave, Chicago, Il 60646
Tel: 773-775-7540 Fax: 773-763-9792

PAIN MANAGEMENT SERVICES
New Patient Questionnaire

Date: _____ Primary MD: _____ Referring MD:_____

Pain

Shade all areas of pain or discomfort in your body with a red pen. Shade all areas of numbness in your body with a black pen. Mark #1 next to the most painful area in your body. Mark #2 next to the second most painful area in your body.



1. Rate your current pain on a scale of 0-10.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild	Discomforting			Distressing			Horrible		Excruciating Pain

2. What pain score is acceptable to you? _____

3. How would you describe your pain and in which location? (Circle one)

Burning	Stabbing	Throbbing	Numbness
Tingling	Shooting	Cramps	Aching
Dull	Diffuse	Sharp	Heaviness

Other: _____

4. When did your pain start? Month: _____ Year: _____

5. How and when did this pain start? _____

6. What part of the day is it worse? Morning Afternoon Evening
What part of the day is it better? Morning Afternoon Evening

7. Which statement best describes your pain? (Please circle)
Constant Frequent Occasional

8. What INCREASES you pain?

Standing	Sitting	Walking	Bending
Lying down	Lifting	Stress	Other

9. What DECREASES your pain?

Standing	Sitting	Walking	Bending
Lying down	Lifting	Stress	Other

10. Bladder or bowel control problems Yes No

11. Have you been treated at any pain clinic before? Yes No

Where: _____

12. Injections: Have you had any injections for your problem? Yes No (Please circle)
What kind of injection did you receive? _____
Where / Date: _____
Did you get pain relief? Yes No
How long did you feel pain relief? _____

13. Have you had any of the following for pain relief? (Please circle)
If yes, did it relieve the pain? Where, when, and how long?
Physical therapy Y N _____
Acupuncture Y N _____
Pain counseling Y N _____
Chiropractic Y N _____
Other _____

14. Do you exercise regularly? Yes No

15. Sleep: Do you have difficulty sleeping at night? Yes No
How many times at night are you waking up? _____
On average, how many hours do you sleep at night? _____
Do you feel this awakening is due to: (Circle all that apply)
Pain Anxiety Insomnia Having to urinate Other: _____
Are you taking any medication to help you sleep at night? Yes No
If Yes, what is it? _____

16. Nutrition: In the past month, have you lost or gained weight without trying to?
Yes No

17. Have you had any recent dental work/ surgery in the last 2 weeks?
Yes No

Health Habits

18. Smoking: Do you smoke? Yes No
If so, how many packs per day? _____

19. Do you drink alcohol? Yes No
How often? _____ How much? _____

20. Do you use recreational drugs? (Marijuana, heroine, cocaine, etc.)
Yes No if yes, which do you use? _____

21. Are you a recovering alcoholic or recovering drug user? Yes No

Other

22. Do you live alone? Yes No

23. Do you have a support system such as family or friends? Yes No

24. What is the highest grade of education completed? Grade School/ High School/College

Employment History

25. Are you working? Yes No
Full time / Part time / Retired / Unemployed / Disabled (circle one)

26. What is your job title? _____

27. Are you on work restrictions? Yes No if yes, what are the restrictions?
_____

28. Which Doctor placed you on work restrictions/ disability? _____

29. Do you consider your work: Sedentary Active Heavy (Circle one)

30. Does your job involve any of the following?

Sitting	Standing	Walking	Bending	Pushing	Pulling	Driving	Squatting
Climbing	Overhead work		Repetitive Movement		Lifting- 10/20/50/100lbs/more		

31. Is there any litigation or a lawyer involved in your case? Yes No If yes- please complete last page.

<u>Past Medical History</u>

32. Past Medical Conditions: Please circle the medical conditions that you have

Angina/chest pain
Skin problems
Irregular heart beat
Irritable bowel syndrome
High blood pressure
Fibromyalgia
Heart attack / Coronary
artery disease Diabetes
Stroke
Thyroid problems
Asthma/ emphysema/COPD

Kidney problems
Prostate problems
Arthritis
Liver problems or Hepatitis
A / B / C Cancer
Bleeding / Clotting Disorder
Stomach ulcer
GI bleeding
HIV / AIDS
Lupus

Depression
Anxiety
Migraines/ Headaches
Seizures
Parkinson's
Multiple Sclerosis
Immune disorders
Herpes / Shingles
Other: _____

33. Surgical History: (Please circle and write date)

Back/ Neck surgery ____ Abdominal surgery ____
Hip /Knee replacement ____ Aneurysm surgery ____
Hysterectomy ____ Angioplasty/Open heart Surgery ____
Pacemaker ____ Implanted stimulator/ pump ____
Hernia surgery ____ Breast surgery ____
Fractures ____ Anesthesia complications: Yes No
Other: _____

34. GOALS: goals for treatment here. What do you want to be able to do?

_____

_____

Have **YOU RECENTLY** had any of the following symptoms or conditions? Please check those that apply

Constitutional
[ ] Chills
[ ] high fever
[ ] low fever
[ ] insomnia
[ ] loss of appetite
[ ] sedation
[ ] unusual tiredness
[ ] unexplained weight loss

Eyes
[ ] abnormal vision
[ ] blurred vision
[ ] contact lenses
[ ] double vision
[ ] glasses

Ears,Nose,Mouth,Throat
[ ] dizziness
[ ] mouth sores
[ ] ringing in ears
[ ] room spinning
[ ] sinus drainage
[ ] sinus pain
[ ] sore throat

Cardiovascular
[ ] angina (chest pain)
[ ] ankle swelling
[ ] coronary disease
[ ] heart failure

Cardiovascular-cont
[ ] heart attack
[ ] high blood pressure
[ ] heart murmur
[ ] high cholesterol
[ ] trouble breathing
[ ] trouble breathing when flat

Respiratory
[ ] asthma
[ ] cough up blood
[ ] cough up sputum
[ ] heavy cough
[ ] pneumonia

Neurological
[ ] epilepsy (seizures)
[ ] fainting
[ ] memory problems
[ ] stroke

Gastrointestinal
[ ] change in bowel habits
[ ] blood in stool
[ ] black, tarry stools
[ ] constipation
[ ] diarrhea
[ ] gastroesophageal reflux/heartburn
[ ] hiatal hernia

Gastrointestinal- Cont
[ ] nausea
[ ] stomach pain
[ ] ulcers
[ ] vomiting
[ ] vomiting "coffee grounds"

Genitourinary
[ ] blood in urine
[ ] change in bladder habits
[ ] discharge from penis
[ ] dialysis
[ ] hesitancy
[ ] kidney problems
[ ] kidney transplant
[ ] loss of sexual desire
[ ] one kidney
[ ] painful urination
[ ] painful sex
[ ] urgency
[ ] vaginal discharge
[ ] venereal disease

Musculoskeletal
[ ] bone infection
[ ] gout
[ ] joint infection
[ ] muscle spasms
[ ] osteomalacia
[ ] painful joints
[ ] sore muscles

Musculoskeletal-Cont.
[ ] redness of joints
[ ] swollen joints

Integumentary (Skin)
[ ] skin cancer
[ ] itching
[ ] skin rash
[ ] skin sores

Psychiatric
[ ] anxiety
[ ] depression
[ ] mental/nervous disorders
[ ] suicidal thoughts

Endocrine
[ ] diabetes
[ ] thyroid (too little)
[ ] thyroid (too much)

Hematologic/Lymphatic
[ ] anemia
[ ] AIDS
[ ] unusual bleeding
[ ] breast lump
[ ] easy bruising
[ ] swollen glands
[ ] HIV
[ ] hepatitis

Patient Questionnaire

PAIN MEDICATIONS: Please list ALL CURRENT PAIN MEDICATIONS

MEDICATION	DOSE	FREQUENCY	PROVIDER

MEDICATION: Please list ALL current medications & supplements

ALLERGIES: Please list ALL known allergies

Permission to call or leave messages: Is it OK for us to leave verbal messages for you regarding your care or future appointments either on voice mail or with others at your phone number?

Yes No Preferred phone number: _____ **Patient Signature:** _____

Completed by: (circle one)

Patient Staff Other: _____

Information reviewed by Dr. _____

Accident/Injury/Legal Information

Please complete ONLY if your current problem is associated with an accident or injury

If NO what activities were you engaged in when the pain began? _____

[Please check **ONE**.] How did the injury occur?

[ ] Motor Vehicle Accident; [ ] Sports Activity; [ ] Recreational Activity; [ ] Fall; [ ] Job related;
[ ] Other (Please specify) _____

Date of the injury [month/year]:_____

Describe the injury:

_____

_____

Did the pain start immediately or was there a delayed onset? [Please check **ONE**.] [ ] Immediate
[ ] delayed 1-7 days; [ ] delayed 1-2 weeks; [ ] delayed 2-4 weeks; [ ] delayed 4-8 weeks

When did you first go to the ER or seek medical care for injury? [Month/Year]:_____

[Please check **ONE**.] If this was a motor vehicle accident were you:

[ ] driver; [ ] front seat passenger; [ ] motorcycle driver; [ ] motorcycle passenger; [ ] rear seat passenger;
[ ] truck/SUV driver; [ ] truck/SUV passenger; [ ] Other (Please specify) _____

[Please check **ONE**.] Were you wearing a seatbelt at the time of the accident? [ ] Yes [ ] No

[Please check **ALL THAT APPLY.]** Did you sustain injuries **in addition** to your back?

[ ] abdominal area	[ ] left arm (fracture)	[ ] left leg (fracture)
[ ] chest	[ ] left arm (no fracture)	[ ] left leg (no fracture)
[ ] head	[ ] right arm (fracture)	[ ] right leg (fracture)
	[ ] right arm (no fracture)	[ ] right leg (no fracture)

[Please check **ONE**.] Are you currently involved in any legal proceedings related to **THIS** injury? [ ] YES; [ ] No
- [ ] Disability/Social Security – [ ] litigation pending; [ ] litigation completed
- [ ] Medical Malpractice – [ ] litigation pending; [ ] litigation completed
- [ ] Workman's Compensation –[ ] litigation pending; [ ] litigation completed
- [ ] Physical Injury/Liability – [ ] litigation pending; [ ] litigation completed
- [ ] Motor Vehicle Accident – [ ] litigation pending; [ ] litigation completed

104. [Please check **ONE**.] Have you ever been involved in any legal proceedings related to **PREVIOUS** health matters?
[ ] Disability; [ ] medical malpractice; [ ] motor vehicle accident; [ ] physical injury/liability; [ ] Social Security
[ ] Workman's Compensation [ ] Other (please specify)_____

ATTORNEY INFORMATION

Attorney Name: _____ Law Firm: _____

Address:_____

City: _____ State: __ Zip: _____ Phone: ____ Fax: ____ E-mail: _____