ALASKA NATIVE MEDICAL CENTER

# Pain Management Questionnaire

In order to make the most of your visit, we require this form to be completed to the best of your ability and sent to the Pain Management Clinic – a copy should be shared with your Primary Care Provider as well. **You will not be scheduled for an evaluation until this questionnaire is submitted.**

Once complete, please mail or fax a copy of the completed questionnaire to:

Alaska Native Medical Center
Pain Management Clinic
4315 Diplomacy Drive
Anchorage, AK 99508

Fax: 907-729-2526

ANMC's Pain Management Clinic does not prescribe medications. If you are in need of prescriptions, you should discuss this with your primary care provider.

Patient Name: _____ DOB: _____ Date: _____

**Alaska Native Medical Center**
4315 Diplomacy Drive
Anchorage, AK 99508
907-563-2662
855-482-4382
anmc.org

Patient Name: _____ DOB: _____

**Pain Management Questionnaire**

1. What is the main reason for your referral to the Pain Management Clinic?

2. What type of care do you expect from your visit to the Pain Management Clinic?

- ☐ Consultation (advice for you and your primary care provider)
- ☐ Counseling
- ☐ Stress Management
- ☐ Physical Therapy
- ☐ Drug Treatment
- ☐ Acupuncture
- ☐ Surgery
- ☐ Relaxation Therapy
- ☐ Biofeedback
- ☐ Injections/Nerve Blocks
- ☐ Electrical Stimulation (TENS Unit)
- ☐ Spinal Cord Stimulator
- ☐ Implant Medication Pump
- ☐ Other (Describe)

_____

3. When did your pain begin?

4. Under what circumstances did your pain begin?

- ☐ Work accident
- ☐ Home accident
- ☐ After surgery
- ☐ Car accident
- ☐ ATV/Snow Machine accident
- ☐ After an illness
- ☐ No known cause
- ☐ Other (Describe)

_____

5. My pain is:

- ☐ Constant
- ☐ Intermittent
- ☐ Sharp
- ☐ Dull
- ☐ Achy
- ☐ Stinging
- ☐ Burning
- ☐ Throbbing
- ☐ Shooting

6. In general, my pain is worst:

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ No typical pattern

7. What makes your pain worse?

- ☐ Bending backward
- ☐ Bending forward
- ☐ Coughing/Sneezing
- ☐ Lifting
- ☐ Standing
- ☐ Driving
- ☐ Light Touch
- ☐ Stress
- ☐ Climbing stairs
- ☐ Exercise/Chopping Wood
- ☐ Sexual Activity
- ☐ Walking
- ☐ Cold
- ☐ Heat
- ☐ Sitting
- ☐ Work

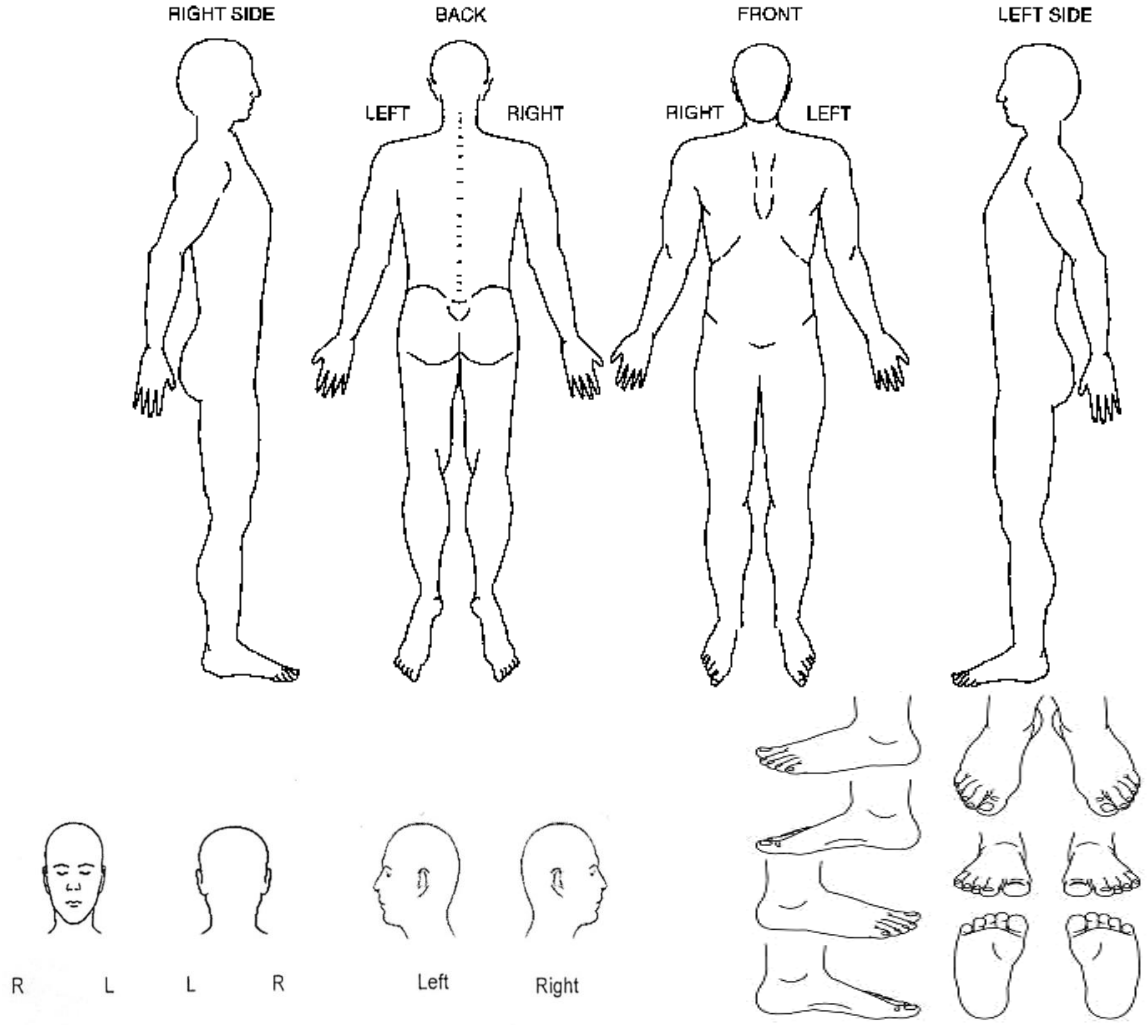
Patient Name: _____ DOB: _____

8. What relieves your pain?

- ☐ Bath/Shower
- ☐ Lying Down
- ☐ Relaxation
- ☐ Exercise
- ☐ Medications
- ☐ Sitting
- ☐ Heat
- ☐ Meditation
- ☐ Standing
- ☐ Cold
- ☐ Physical Therapy
- ☐ Walking
- ☐ Other (Describe)

_____

9. Please mark with an "X" where your pain is located:




10. Please rank your areas you have pain from 1 to 10 with 10 being the most painful:

___ Head, face, and mouth
___ Neck
___ Upper shoulders
___ Mid to upper back
___ Abdomen
___ Legs
___ Lower back/Tail bone
___ Anal, perineal, genital
___ Pelvis
___ Arms

Patient Name: _____ DOB: _____

11. Using a scale of 1 (does not interfere) to 10 (completely interferes) please assign a number describing how pain has interfered with these activities in the past 24 hours:

___ General activity
___ Mood
___ Walking
___ Work activities
___ Home activities
___ Interactions with others
___ Enjoyment of life
___ Sexual activity
___ Sleep

12. Have you been treated at other Pain Management Clinics?

- ☐ Yes; where/when? _____
- ☐ No

13. In the past 12 months, how many times have you been to the emergency room for your pain?

14. Please indicate treatments you have had and the outcomes of those treatments:

| Pain Therapies | Completed | Not completed | Decreased Pain | Increased Pain | No change in pain | Comments |
|---|---|---|---|---|---|---|
| Medications | | | | | | |
| Drug Detoxifications | | | | | | |
| Surgery | | | | | | |
| Epidural Steroid Injections | | | | | | |
| Facet Joint Injections | | | | | | |
| Trigger Point Injections | | | | | | |
| Nerve Blocks | | | | | | |
| Spinal Cord Stimulation | | | | | | |
| Medication Pump | | | | | | |
| Radiation Therapy | | | | | | |
| Physical Therapy | | | | | | |
| Exercise | | | | | | |
| Manipulation/Mobilization | | | | | | |
| Traction Exercise | | | | | | |
| Passive (heat, ice, gentle massage, ultrasound) | | | | | | |
| Pool Therapy | | | | | | |
| Occupational Therapy | | | | | | |
| Orthotics (shoe inserts) | | | | | | |
| Prosthetics (braces/supports) | | | | | | |
| Electric Stimulations (TENS unit) | | | | | | |
| Yoga | | | | | | |
| Hypnosis | | | | | | |
| Group Therapy | | | | | | |
| Psychological counseling for pain | | | | | | |

15. What medical tests have you been completed to evaluate your pain?

- ☐ X-ray Date: _____
- ☐ CT Scan Date: _____
- ☐ Myelogram Date: _____
- ☐ MRI Date: _____
- ☐ Bone Scan Date: _____
- ☐ EMG/NCV Date: _____
- ☐ EKG Date: _____
- ☐ Other _____ Date: _____

Patient Name: _____ DOB: _____

16. Please check all that apply:

**Constitutional:**
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Sweaty
- ☐ Weak
- ☐ None

**Gastrointestinal:**
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody Stool
- ☐ Melena
- ☐ None

**Endo/Heme/Allergy:**
- ☐ Easy bruising / bleeding
- ☐ Allergies
- ☐ Frequent urination
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Clotting Disorder
- ☐ None

**Skin:**
- ☐ Rash
- ☐ Itching
- ☐ Nail Changes
- ☐ Skin disorder
- ☐ None

**Cardiovascular:**
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Gasping for breath
- ☐ Claudication
- ☐ Leg Swelling
- ☐ High blood pressure
- ☐ Difficulty breathing at night
- ☐ None

**Genitourinary:**
- ☐ Painful urination
- ☐ Urgent urination
- ☐ Frequent urination
- ☐ Bloody urine
- ☐ Flank pain
- ☐ Urinary incontinence
- ☐ None

**Eyes:**
- ☐ Blurred
- ☐ Double vision
- ☐ Photophobia
- ☐ Pain
- ☐ Discharge
- ☐ Redness
- ☐ None

**Neurological:**
- ☐ Dizziness
- ☐ Tingling
- ☐ Tremor
- ☐ Sensory change
- ☐ Speech change
- ☐ Focal weakness
- ☐ Seizures
- ☐ Loss of consciousness
- ☐ None

**HENT**:
- ☐ Headaches
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Congestion
- ☐ Sore Throat
- ☐ None

**Respiratory:**
- ☐ Cough
- ☐ Bloody cough
- ☐ Sputum production
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Asthma
- ☐ Sleep apnea
- ☐ None

**Musculoskeletal:**
- ☐ Muscle pain
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain
- ☐ Falls
- ☐ Fractures
- ☐ Herniated discs
- ☐ None

**Psychiatric:**
- ☐ Depression
- ☐ Suicidal ideas
- ☐ Substance abuse
- ☐ Hallucinations
- ☐ Nervous / Anxious
- ☐ Insomnia
- ☐ Memory loss
- ☐ None

17. On average, how many hours of sleep do you get a night?

18. Is your sleep disturbed at night?

☐ Yes ☐ No

19. Please indicate your use of the following substances:

| Substance | Currently Using | Previously Used | Never Used | Comments |
|---|---|---|---|---|
| Marijuana | | | | |
| Cocaine | | | | |
| Methamphetamine | | | | |
| Heroin | | | | |
| Other | | | | |

20. Please check the box that best describes your employment:

- ☐ Full-time
- ☐ Part-time
- ☐ Retired
- ☐ Not working due to pain
- ☐ Retired due to pain
- ☐ On leave from work
- ☐ Homeworker
- ☐ Other _____