ALASKA NATIVE MEDICAL CENTER

Comprehensive Pain Management Center

In order to make the most of your visit, we require this form be completed to the best of your ability and sent to the Comprehensive Pain Management Center. After completing, please mail, email or fax to the information listed below. Please note: appointments are prioritized and made according to the date that this questionnaire is returned to us, not by the date we receive the referral. Please return this form to the Comprehensive Pain Management Center as soon as possible so we can begin processing your referral.

ANMC Neurosurgery/
Comprehensive Pain Management Center
4315 Diplomacy Dr.
Anchorage AK 99508
Phone: 907-729-2525
Fax: 907-729-2526

If an appointment is made, please be sure to bring a sufficient amount of your medications. **Prescriptions or medications will not be given on the visit.**

Patient Name_____
Date of Birth_____

Comprehensive Pain Management Questionnaire

1. What is the main reason for your referral to the Comprehensive Pain Center?

   _____

   _____

2. What do you expect from our pain program? (select the one best answer)
   - o A diagnosis (to help find the cause of pain)
   - o Help in coping with the pain
   - o A reduction in pain
   - o A cure
   - o No expectations
   - o Don not know what to expect

3. What types of treatment do you expect from your visit to the Comprehensive Pain Center?
   - o Consultation only (advice only to you and your primary care physician)
   - o Counseling
   - o Stress Management
   - o Physical Therapy
   - o Drug treatment
   - o Acupuncture
   - o Surgery
   - o Relaxation therapy
   - o Biofeedback
   - o Injections or nerve blocks
   - o Electrical stimulation such as TENS unit
   - o Spinal cord stimulator
   - o Implant medication pump
   - o Don't know
   - o Other (describe)_____

4. When did your pain problems begin? ___/___/___

   Day/Month/Year

5. Under what circumstances did your pain begin?
   - o Accident at work
   - o Accident at home
   - o Following Surgery
   - o Pain just began with no known cause
   - o At work, but not an accident
   - o Motor Vehicle Accident
   - o Following illness
   - o Other (describe)_____

6. Is your pain:
   - Constant
   - Intermittent
   - Sharp
   - Dull
   - Achy
   - Stinging
   - Burning
   - Throbbing
   - Shooting

7. In general, when is your pain the worst?
   - Morning
   - Afternoon
   - Evening
   - No typical pattern

8. What makes your pain worse? (circle all that apply)

Bending backward	Bending forward	Climbing stairs	Cold
Cough/Sneeze	Driving	Exercise	Heat
Lifting	Light touch	Sexual activity	Sitting
Standing	Stressful situations	Walking	Work

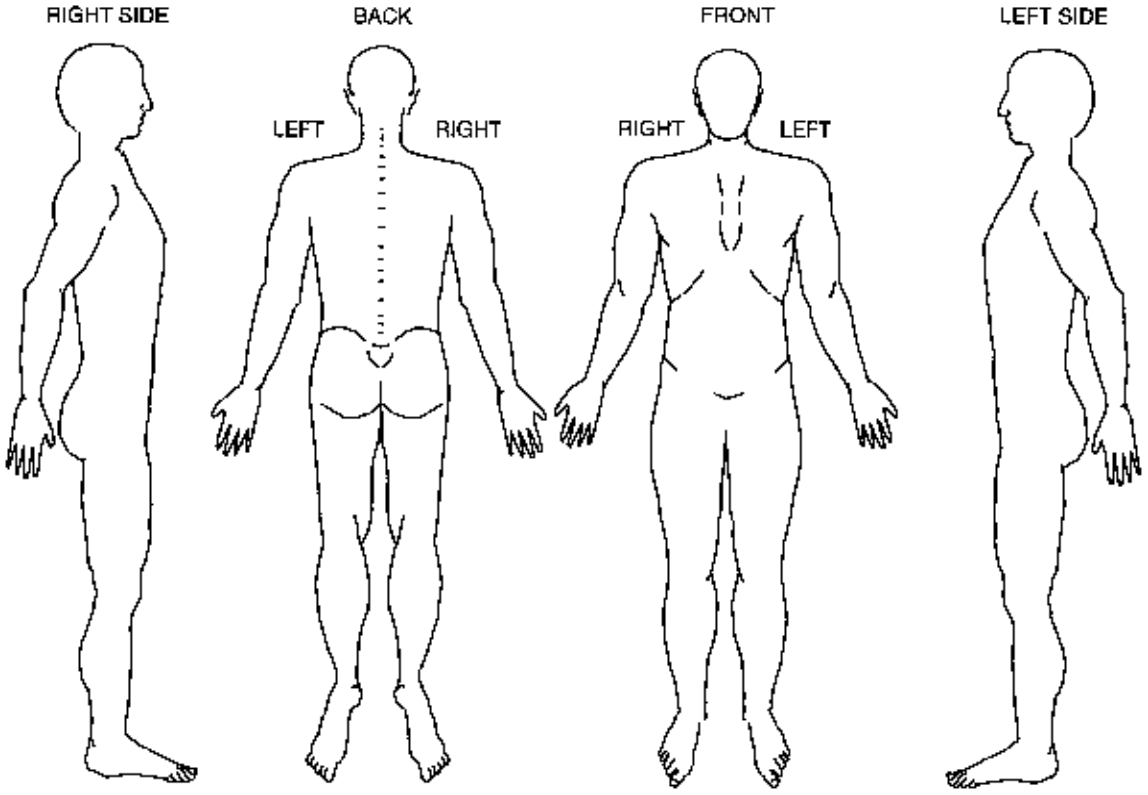
Other: (describe)_____

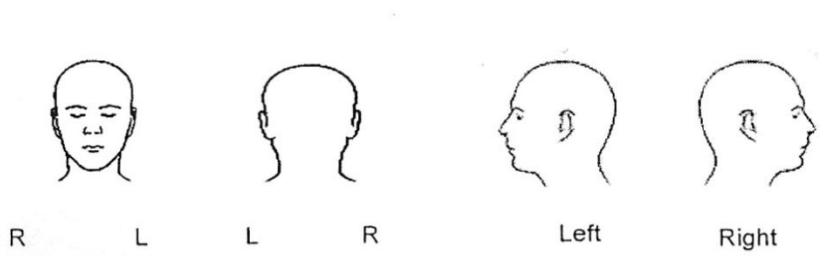
9. What relieves the pain? (circle all that apply)

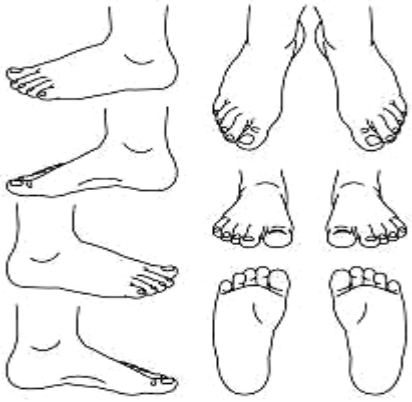
Bath/shower	Exercise	Heat	Cold
Lying Down	Medications	Meditation	Physical Therapy
Relaxation	Sitting	Standing	Walking

Other: (describe) _____

10. Where is your pain? Please be as specific as possible.







11. Please rank your main painful areas in order form 1 to 10 with 1 being the most painful.
    - ___ Head, face, mouth
    - ___ Cervical (neck) region
    - ___ Upper shoulder and upper limbs
    - ___ Thoracic (mid to upper back) region
    - ___ Abdominal Region
    - ___ Lower back, lumbar spine, sacrum
    - ___ Pelvic region
    - ___ Anal, perineal, genital
    - ___ Generalized pain

12. Please rate your pain by filling in the circle that describes how much pain you have **right now**:

    No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

13. Please rate your pain by filling in the circle that describes your pain at its least in the last 24 hours:

    No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

14. Please rate your pain by filling in the circle that describes your pain at its worst in the last 24 hours:

    No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

15. Please rate your pain by filling in the circle that describes your pain on average:

    No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

16. In the last 24 hours, how much pain relief have pain treatments or medications provided? Please fill in the circle of the one percentage that most shows how much relief you have received:

None 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% best possible relief

17. Fill in the circle that describes how, during the last 24 hours, pain has interfered with your:
    A. General Activity:

       Does not interfere 1 2 3 4 5 6 7 8 9 10 Completely interferes

    B. Mood:

       Does not interfere 1 2 3 4 5 6 7 8 9 10 Completely interferes

    C. Walking Ability:

       Does not interfere 1 2 3 4 5 6 7 8 9 10 Completely interferes

    D. Normal Work: (includes both work outside the home and housework)

       Does not interfere 1 2 3 4 5 6 7 8 9 10 Completely interferes

    E. Relations with other people:

       Does not interfere 1 2 3 4 5 6 7 8 9 10 Completely interferes

    F. Enjoyment of life:

       Does not interfere 1 2 3 4 5 6 7 8 9 10 Completely interferes

    G. Sexual Activity:

       Does not interfere 1 2 3 4 5 6 7 8 9 10 Completely interferes

    H. Sleep:

       Does not interfere 1 2 3 4 5 6 7 8 9 10 Completely interferes

18. Have you ever been treated at another pain management center or program? o No o Yes
    If yes, where?_____ When?_____
    What did they do?_____

19. In the past 12 months (year), how many times have you been to the emergency room for your pain? _____

20. Have you ever had the following types of treatment for your pain problem, and what was the result?

Indicate pain therapies tried	Yes	No	Better	Worse	No Change	Comments
Medications						
Drug Detoxifications						
Surgery						
Epidural Steroid Injections						
Facet Joint Injections						
Trigger Point Injection						
Nerve (lumbar, sympathetic, stellate ganglion, etc) blocks						
Other injections Specify:_____						
Spinal Cord Stimulation						
Medication pump						
Radiation Treatment						
Physical Therapy						
Exercise						
Manipulations/Mobilization						
Tractions Exercise/Aerobic Conditioning						
Passive (heat, ice, gentle massage, ultrasound)						
Aqua/water/pool therapy						
Trigger point therapy/deep tissue massage/ acupressure						
Occupational Therapy						
Acupuncture						
Chiropractic						
Orthotics (corrective shoe insert)						
Prosthetics(braces, supports. etc)						
TENS or other Electric Stimulation						
Biofeedback/Relaxation						
Yoga						
Hypnosis						
Group Therapies						
Psychological Counseling for pain						
Other:_____						

21. What medical tests have been done to evaluate your pain?

Test	Date (approximate)	Results (if known)
○ X-Ray	___/___/___	_____
○ CT Scan	___/___/___	_____
○ Myelogram	___/___/___	_____
○ MRI	___/___/___	_____
○ Bone Scan	___/___/___	_____
○ EMG	___/___/___	_____
○ EKG	___/___/___	_____
○ Other	___/___/___	_____

OTHER MEDICAL HISTORY

22. Current Medications;

Please list **all** medications that you are taking **now** or attach your own medication list.

Include over the counter, herbal, vitamins, and other supplemental medications.

Medication	Dose Mg or # of pills	How Often # times per day	What for?	Prescribing Doctor

23. List all other pain medications that you have tried in the past.

Name of Medication	Tried	Maximum Dose	Length of Therapy	If stopped, why?	Side Effects	No side effects
Pain Medicines/Opioids						
Buprenorphine(Subutex, Suboxone)						
Codeine, Tylenol #3, #4, 222						
Fentanyl Lollipops (Actiq)						
Fentanyl Patches (Duragesic)						
Fentanyl Tablet (Fentora)						
Hydrocodone (Vicodin, Lortab, Norco)						
Hydromorphone (Dilaudid)						
Methadone (Dolophine)						
Morphine (Avinza, Kadian, MS Contin, MSIR)						
Meperidine (Demerol)						
Oxycodone (Percocet, Oxycontin)						
Oxymorphone (Opana)						
Propoxyphene (Darvon)						
Tapentadol (Nucynta)						
Tramadol (Ultram, Ultram ER, Ulracet, Ryzotl)						
Other_____						
Anti-Seizure Medicines						
Carbamazepine (Tegretol)						
Gabapentin (Neurontin)						
Lacosamide (Vimpat)						
Lamotrigine (Lamictal)						
Oxycarbazepine (Trileptal)						
Tiagabine (Gabatril)						
Topiramate (Topamax)						
Zonisamide (Zonegram)						
Pregabalin (Lyrica)						
Valproic Acid (Depakole)						
Other_____						
Muscle Relaxants						
Baclofen (Lioresal)						
Carisoprodol (Soma)						
Clonazepam (Klonopin)						
Cyclobenzaprine (Flexeril)						
Diazepam (Valium)						
Metaxolone (Skelaxin)						
Methocarbamol (Robaxin)						
Tizanidine (Zanaflex)						
Other_____						

Name of Medication	Tried	Maximum Dose	Length of Therapy	If stopped, Why?	Side Effects	No side Effects
Anti-Depressants						
Amitriptyline (Evavil)						
Bupropion (Wellbutrin)						
Citalopram (Celexa)						
Desipramine (Norpramin)						
Desvenlafaxine (Pristiq)						
Duloxetine (Cymbalta)						
Escitalopram (Lexapro)						
Fluoxetine (Prozac)						
Fluvoxamine (Luvox)						
Hyp. Perforatum (St John's Wort)						
Milnacipran (Savella)						
Mirtazepine (Remeron)						
Nefazodone (Serzone)						
Nortriptyline (Pamelor)						
Paroxetine (Paxil)						
Sertraline (Zoloft)						
Trazadone (Deseryl)						
Venlafaxine (Effexor)						
Other_____						
Anti-Anxiety/ Other Mood Stabilizers						
Alprazolam (Xanax)						
Chlordiazepoxide (Librium)						
Clonazepam (Klonopin)						
Lithium (Eskalith)						
Olazepine (Zyprexa)						
Phenelzine (Nardil)						
Quetiapine (Seroquel)						
Resperidone (Risperdal)						
Other_____						
Sleep						
Melatonin						
Eszopiclone (Lunesta)						
Ramelton (Rozerem)						
Temazepam (Restoril)						
Triazolam (Halcion)						
Tylenol-PM						
Zolpidem (Ambien)						
Other_____						

Name of Medication	Tried	Maximum Dose	Length of Therapy	If stopped, Why?	Side Effects	No side Effects
Anti-Inflammatories						
Celecoxib (Celebrex)						
Ibuprofen (Advil, Motrin)						
Meloxicam (Mobic)						
Naproxen (Aleve, Naprosyn)						
Nabumetone (Relafen)						
Rofecoxib (Vioxx)						
Valdecoxib (Bextra)						
Other_____						
Other						
Acetaminophen (Tylenol)						
Ketamine						
Pramipexole (Mirapex)						
Pyridostigmine (Mestinon)						
Lidocaine Patch (Lidoderm)						
Other_____						

24. .Review of Systems: PLEASE CHECK ALL THAT APPLY

Constitutional:
- o Fever
- o Chills
- o Weight Loss
- o Malaise/Fatigue
- o Diaphoresis (Sweaty)
- o Weakness
- o None of the Above

Eyes:
- o Blurred
- o Double Vision
- o Photophobia
- o Eye Pain
- o Eye Discharge
- o Eye Redness
- o None of the Above

Gastrointestinal:
- o Heartburn
- o Nausea
- o Vomiting
- o Abdominal Pain
- o Diarrhea
- o Constipation
- o Blood in Stool
- o Melena
- o None of the Above

Endo/Heme/Allergy:
- o Easy Bruise/Bleed
- o Environment Allergies
- o Frequent Urination
- o Diabetes
- o Thyroid Disorder
- o Clotting Disorder
- o None of the Above

Skin:
- o Rash
- o Itching
- o Nail Chang
- o Skin Disorder
- o None of the Above

Cardiovascular:
- o Chest Pain
- o Palpitations
- o Gasping for Breath
- o Claudication
- o Leg Swelling
- o High Blood Pressure
- o Difficulty breathing at night

Genitourinary:
- o Painful Urination
- o Urgency
- o Frequency
- o Blood in Urine
- o Flank Pain
- o Urinary
- o Incontinence
- o None of the Above

Neurological:
- o Dizziness
- o Tingling
- o Tremor
- o Sensory Change
- o Speech Change
- o Focal Weakness
- o Seizures
- o Loss of Consciousness
- o None of the Above

Hent:
- o Headaches
- o Hearing Loss
- o Ringing in Ears
- o Ear Pain
- o Ear Discharge
- o Nose Bleeds
- o Congestion
- o Difficulty Breathing
- o Sore Throat
- o None of the Above

Respiratory:
- o Cough
- o Bloody Cough
- o Sputum Production
- o Shortness of Breath
- o Wheezing
- o Asthma
- o Sleep Apnea
- o None of the Above

Musculoskeletal:
- o Muscle Pain
- o Neck Pain
- o Back Pain
- o Joint Pain
- o Falls
- o Fractures
- o Herniated Disc
- o None of the Above

Psychiatric:
- o Depression
- o Suicidal Ideas
- o Substance Abuse
- o Hallucinations
- o Nerve/Anxious
- o Insomnia
- o Memory Loss
- o None of the Above

25. How much sleep do you average each night? _____ hours.

26. Is your sleep disturbed at night? o No o Yes

27. Do you have any medical devices implanted in your body?

Infusion Pump	o No	o Yes
Spinal Cord Simulator	o No	o Yes
Rids	o No	o Yes
Prosthesis	o No	o Yes
Pacemaker	o No	o Yes
Portacath	o No	o Yes

Other_____

28. List all hospitalizations and/or surgeries:

Neurological/Orthopedic	Dates (approximate)	Level(s)	Left Side	Right Side
Craniotomy/Brain Surgery				
Cervical Fusion				
Cervical Laminectomy				
Lumbar Fusion				
Lumbar Laminectomy				
Surgical Treatment of Fracture				
Hip Replacement				
Knee Arthroscopy				
Knee Replacement				
Abdominal	**Dates (approximate)**	**Location**		
Hernia Repair				
Abdominal Wall Defect Repair				
Gastric Bypass				
Colectomy				
Colostomy				
Lysis of Adhesions				
Genitourinary	**Dates (approximate)**			
Nephrectomy				
Hysterectomy				
Cesarean Section				
TURP/Transurethral Resection of Prostate				
Prostatectomy				
Vascular/Lung				
Femoral Bypass				
Abdominal Aortic Aneurysm Repair				
Heart Valve Surgery				
Coronary Artery Bypass Graft				
Thoracotomy/Lung Surgery				

29. Please list any medical conditions in your immediate family such as diabetes, arthritis, substance abuse, psychiatric, etc._____
_____
_____
_____

PSYCHOLOGICAL AND SUBSTANCE USE

30. Have there been any other stressful life experiences recently? o No o Yes
If yes, explain: _____
_____
_____

31. Have you ever had thoughts of suicide or harming yourself? o No o Yes
Harming someone else? o No o Yes

32. Please mark the appropriate answer to the following questions:
During the past month, have you been tense or anxious?
o Never o Seldom oSometimes oFrequently o Always
During the past month, have you been depressed or discouraged?
o Never o Seldom oSometimes oFrequently o Always

33. Have you been under the care of a mental health professional? o No o Yes
If yes, how often _____

34. Would you like to have access to a mental health professional? o No o Yes

35. Are you, or have you ever been, involved with any of the following:

Item	Currently Use	Used in the Past	Never	Comments
Marijuana				
Cocaine				
Methamphetamine				
Heroin				
Other illicit/street drug				

36. Do you smoke? o No o Yes
If yes, How many packs a day?_____How long have you smoked?_____
If no, have you ever smoked? _____ o No o Yes
If yes, when did you smoke? _____ How many packs per day did you smoke? _____

37. Please answer all that apply:
Have you felt you ought to cut down on your drinking or drug use?
o No o Yes o Does not apply
Have people annoyed you by criticizing your drinking or drug use?
o No o Yes o Does not apply
Have you felt bad or guilty about your drinking or drug use?
o No o Yes o Does not apply
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?
o No o Yes o Does not apply
Do you drink alcohol to decrease or relieve the pain?
o No o Yes o Does not apply

38. Education Level:

o 8th grade or less o Some High School o High School Graduate or GED

o Some College o Associate's Degree o Bachelor's Degree

o Technical or Trade School Graduate

o Completed Graduate or Professional School Degree (e.g. Master's, Ph.D. M.D., Etc)

39. Currently Employed? o No o Yes (select the best description for you)

o Homework o Not working due to pain o Not working due to other reasons

o On leave from work o Retired due to pain o Retired not due to pain

o Working full time o Working part time

39. Describe your current (or most recent) occupation and duties: _____

_____

When did you last work?_____

40. In the past six months, how many full days of work have you missed because of pain?

o <5 days o 6-14 days o 3-4 weeks o> 1 moths

41. What exercise of recreational activities do you enjoy? _____

_____

42. Please mark the statements that apply to you:

Disability:

o Not receiving or seeking disability

o Not receiving but seeking or planning to seek disability

o Receiving disability

Litigation/Lawsuit: (s)

o No (and not intending) pain-related litigation/lawsuit or legal involvements

o Currently in pain-related litigation/lawsuit or pain-related legal involvement

o Past litigation/lawsuit or legal involvement related to pain condition

Motor Vehicle Accidents:

o Pain not related to motor vehicle accident

o Pain related to motor vehicle accident and settlement pending

o Pain related to motor vehicle accident but no settlement pending or necessary

Do you have any other litigation or lawsuits ongoing, pending, or under consideration? o No o Yes

If yes, explain:_____

_____

_____