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 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)_____
3. When did your pain problems begin? ___/___/___

   Day/Month/Year
4. 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)_____
5. Is your pain:
   - o Constant
   - o Intermittent
   - o Sharp
   - o Dull
   - o Achy
   - o Stinging
   - o Burning
   - o Throbbing
   - o Shooting

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

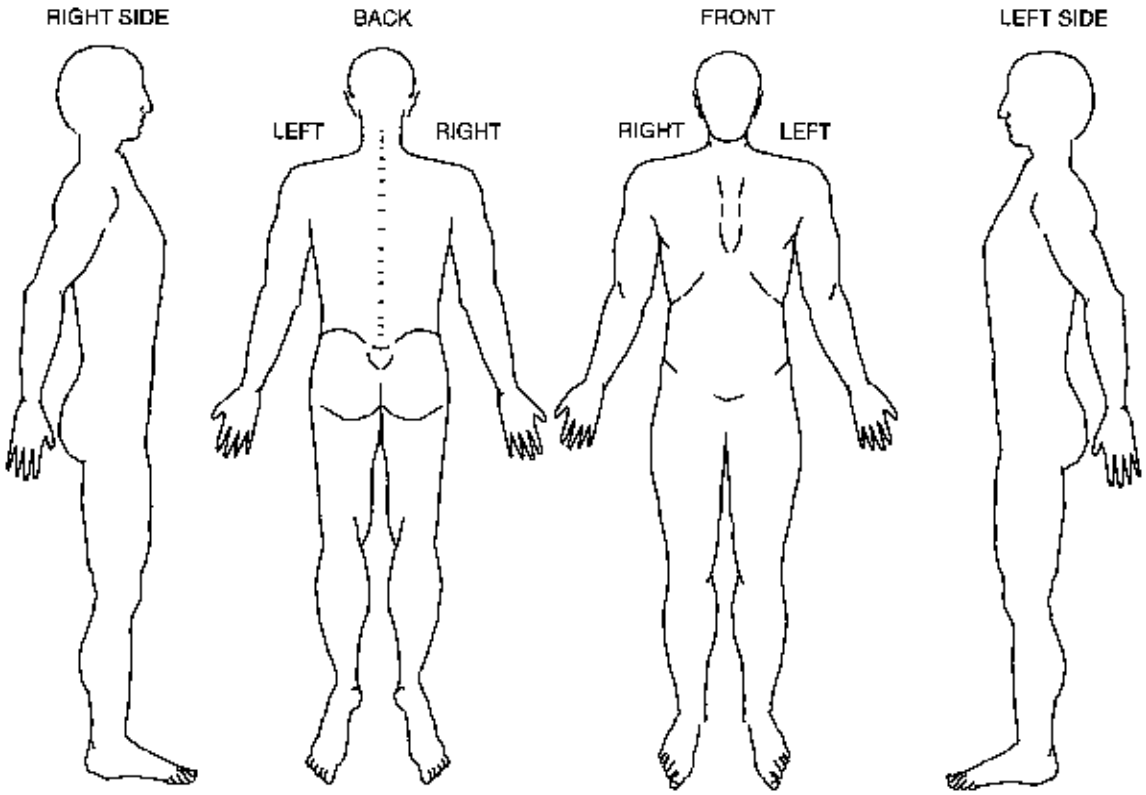
   Other: (describe) _____

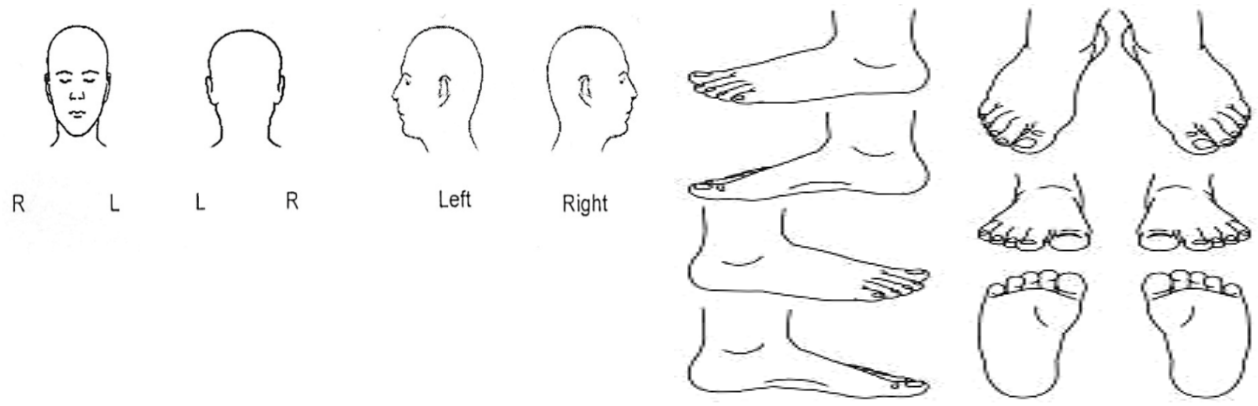
8. What relieves the pain? (circle all that apply)

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

   Other: (describe) _____

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





10. Please rank your main painful areas in order from 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

11. Circle the number 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

12. Have you ever been treated at another pain management center or program? o No o Yes
    If yes, where? _____ When? _____
    What did they do? _____
13. In the past 12 months, how many times have you been to the emergency room for your pain? _____
14. 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						

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

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

16. 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 Changes
- 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
- o None of the Above

Genitourinary:
- o Painful Urination
- o Urgency
- o Frequency
- o Blood in Urine
- o Flank Pain
- o Urinary - 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
- o

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

17. How much sleep do you average each night? _____ Hours.

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

PSYCHOLOGICAL AND SUBSTANCE USE

19. 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				

20. 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