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.

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

Pain Management Questionnaire

1. What is your name?

2. What is your date of birth?

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

4. 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

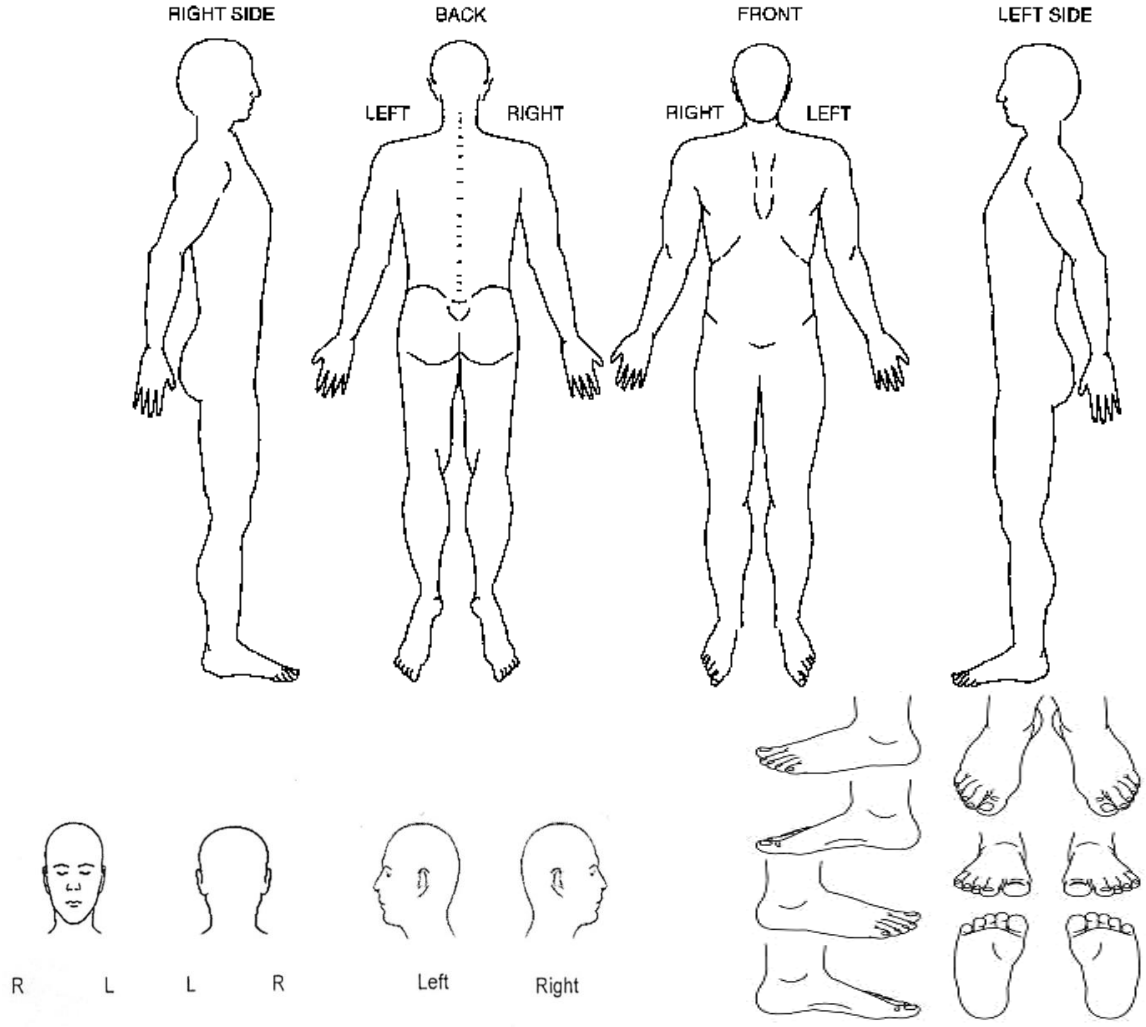
7. What makes your pain worse?

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

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

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 Date: _____
- ☐ EKG Date: _____
- ☐ Other _____ Date: _____

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				
Meth				
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