ECPC PAIN SPECIALISTS
Division of East Carolina Anesthesia Associates, PLLC

ECPC Pain Specialists
2430 Emerald Place, Suite 103
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252-847-0601

Pain Questionnaire

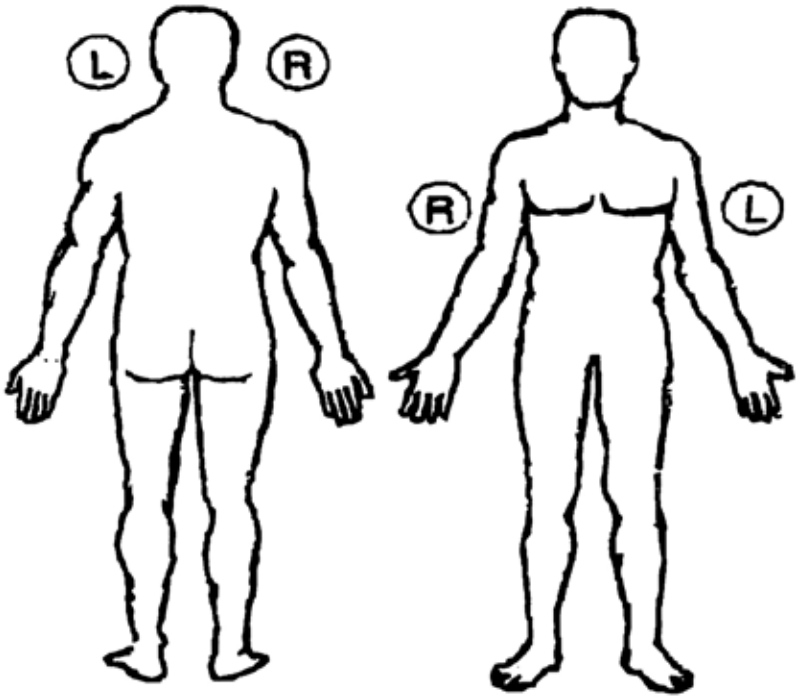
Please fill out this form before you come for your first appointment at the Pain Center. Your answers will help us understand your pain problem and plan the best treatment program for you.

Date of first appointment at the Pain Center: _____

1. Name: _____
   First MI Last
2. Date of Birth: _____
3. Family Physician: _____
   Address: _____
   Telephone: _____ Fax: _____
4. Pharmacy You Use: _____
   Telephone: _____
5. Education (Check highest grade/degree completed):
   a. ☐ Less than 8th grade
   b. ☐ Completed 8th grade
   c. ☐ Some high school
   d. ☐ High school graduate
   e. ☐ Some college
   f. ☐ College graduate
   g. ☐ Advanced degree
6. How long have you had this pain (months and years) before coming to the Pain Center?
   _____
7. In what situation did your present pain originally begin? Choose one:
   a. ☐ Accident or injury at home
   b. ☐ Accident or injury at work
   c. ☐ Accident or injury
   d. ☐ Related to illness
   e. ☐ Following surgery
   f. ☐ No apparent reason
8. Describe the feature of your pain. Check the letter that best describes your usual pain in the past month.
   a. ☐ Piercing
   b. ☐ Stabbing
   c. ☐ Shooting
   d. ☐ Burning
   e. ☐ Grinding
   f. ☐ Throbbing
   g. ☐ Cramping
   h. ☐ Aching
   i. ☐ Stinging
   j. ☐ Other: _____
   k. ☐ Numbing
   l. ☐ Itching
   m. ☐ Tingling
   n. ☐ Squeezing

9. On the diagram below, shade in the areas where you feel pain. Put an “X” on the area that hurts the most. Draw a line if the pain moves from one area to another area.

BACK **FRONT**



10. Please rate your pain by placing an “X” on the line to best describe your pain on average in the past month.

No Pain _____ Pain as bad as it could be

1 2 3 4 5 6 7 8 9 10

11. How often do you have your pain?

a. ☐ All the time (80% - 100% of the time)

b. ☐ Nearly all the time (50% - 80% of the time)

c. ☐ Comes and goes (25% - 50% of the time)

d. ☐ Sometimes (less than 25% of the time)

12. What other symptoms do you have with your pain?

a. ☐ Numbness

b. ☐ Weakness

c. ☐ Urinary incontinence (not able to hold your urine)

d. ☐ Bowel incontinence (not able to hold your bowel movements)

e. ☐ Tenderness of the painful area

f. ☐ Cool, pale skin

g. ☐ Swelling

h. ☐ Redness

i. ☐ Other: _____

13. When is your pain the worst?

a. ☐ Morning b. ☐ Afternoon c. ☐ Evening

d. ☐ Night e. ☐ No regular pattern

14. How many times during the day do you lie down because of the pain?_____

15. How many hours each day do you spend lying down due to pain? _____

16. Have any of your family members ever had a pain problem? ☐ Yes ☐ No

If yes, who? _____ What kind of pain?_____

17. Does your pain wake you at night? ☐ Usually ☐ Sometimes ☐ Never

18. How many hours do you sleep each night? _____

19. Do you feel rested during the day? ☐ Yes ☐ No

20. How do the following affect your pain? (Please check one for each item).

	DECREASES	HAS NO EFFECT	INCREASES
a. Lying down	☐	☐	☐
b. Standing	☐	☐	☐
c. Sitting	☐	☐	☐
d. Walking	☐	☐	☐
e. Exercising	☐	☐	☐
f. Sexual activity	☐	☐	☐
g. Pain medication	☐	☐	☐
h. Relaxing	☐	☐	☐
i. Coughing or sneezing	☐	☐	☐
j. Passing urine	☐	☐	☐
k. Having a bowel movement	☐	☐	☐
l. Anxiety or “nervousness”	☐	☐	☐
m. Lifting	☐	☐	☐
n. Bending over	☐	☐	☐
o. Climbing stairs	☐	☐	☐
p. Weather changes	☐	☐	☐
q. Changing positions	☐	☐	☐
r. Bright lights	☐	☐	☐
s. Loud noises	☐	☐	☐
t. Other: _____	☐	☐	☐

21. Check each treatment listed below that you have tried, and the effect it has had on your present pain.

	DECREASES	HAS NO EFFECT	INCREASES
1. Acupuncture	☐	☐	☐
2. Biofeedback	☐	☐	☐
3. Chiropractor	☐	☐	☐
4. Epidural steroid injections	☐	☐	☐
5. Exercise	☐	☐	☐
6. Heat or cold treatments	☐	☐	☐
7. Hospital bedrest	☐	☐	☐
8. Medication	☐	☐	☐
9. Nerve block injections	☐	☐	☐
10. Orthotics	☐	☐	☐
11. Physical therapy	☐	☐	☐
12. Psychotherapy/Counseling	☐	☐	☐
13. Pool/Aqua therapy	☐	☐	☐
14. Prosthetics (braces, supports)	☐	☐	☐
15. Spinal cord stimulation	☐	☐	☐
16. Surgery	☐	☐	☐
17. TENS unit	☐	☐	☐
18. Traction	☐	☐	☐
19. Trigger point injections	☐	☐	☐
20. Ultrasound	☐	☐	☐
21. Work hardening/work stimulation	☐	☐	☐

22. Have you ever had thoughts of wanting to die? ☐ Yes ☐ No
If you answered yes, please describe your thoughts. _____

_____

23. Do you feel tense and worried all the time? ☐ Yes ☐ No
If yes, please describe. _____

24. Have you had any panic attacks? ☐ Yes ☐ No
If yes, please describe. _____

25. Do you presently have any thoughts of harming or hurting anyone? ☐ Yes ☐ No
If yes, please describe. _____

26. Have you ever been seen by a psychiatrist, psychologist, or other mental health professional? ☐ Yes ☐ No
If yes, please describe. _____

27. <u>CIRCLE ALL</u> THE MEDICATIONS YOU HAVE TRIED FOR YOUR CURRENT PAIN PROBLEM

NARCOTIC PAIN MEDICATIONS

	Generic Name	***Trade Name***
a.	buprenorphine	Buprenex®
b.	butorphanol	Stadol®
c.	codeine	Codeine
d.	fentanyl	Duragesic® patch, Actiq®
e.	hydrocodone	Lorcet®, Norco®, Vicodin®, Vicoprofen®, Zydone®
f.	hydromorphone	Dilaudid®
g.	levorphanol	Levo-Dromoran®
h.	meperidine	Demerol®, Mepergan Fortis
i.	methadone	Dolophine®
j.	morphine	Astramorph/PF®, Duramorph®, MS Contin®, MS IR®, Roxanol®, Oramorph®, Kadian®, Avinza®
k.	nallbuphine	Nubain®
l.	pentazocine	Talacen®, Talwin®
m.	oxycodone	Percocet®, Roxicet™, Roxicodone®, Tylox®, Percodan®, Oxycontin®
n.	sufentanil	Sufenta®, Sublimaze®

ASPIRIN TYPE MEDICATIONS

	Generic Name	***Trade Name***
a.	aspirin	Anacin®, Ascriptin®, Aspergum®, Bufferin®, Ecotrin®, Empirin®, Salsitab®, Salsalate, BC® or Goody's® powders
b.	choline salicylate	Arthropan®
c.	diflunisal	Dolobid®
d.	magnesium salicylate	Backache, Doan's® pills, Magan®, Mobidin®
e.	sodium salicylate	sodium salicylate
f.	Salicylate combinations	Choline Magnesium Trisalicylate, Tricosal®, Trilisate®

NON-STEROIDAL ANTI-INFLAMMATORY MEDICATIONS

	Generic Name	***Trade Name***
a.	celecoxib	Celebrex®
b.	diclofenac	Cataflam®, Voltaren®
c.	etodolac	Lodine®
d.	fenoprofen	Nalfon®
e.	ibuprofen	Advil®, Bayer Select®, Excedrin® IB, Ibu-Tab®, Midol® 200, Midol IB®, Motrin IB®, Nuprin®, Pamprin-IB®

NON-STEROIDAL ANTI-INFLAMMATORY MEDICATIONS (cont'd)

	Generic Name	*Trade Name*
f.	indomethacin	Indocin®
g.	ketoprofen	Orudis®,
h.	ketorolac	Toradol®
i.	meclofenamate	Meclomen®
j.	nabumetone	Relafen®
k.	naproxen	Naprosyn®
l.	naproxen sodium	Aleve®, Anaprox®
m.	oxaprozin	Daypro®
n.	piroxicam	Feldene®
o.	rofecoxib	Vioxx®
p.	sulindac	Clinoril®
q.	Tolmetin	Tolectin®
r.	Valdecoxib	Bextra®
s.	_____	_____

ANTI-CONVULSANT PAIN MEDICATIONS

	Generic Name	*Trade Name*
a.	carbamazepine	Epitol®, Tegretol®
b.	gabapentin	Neurontin®
c.	phenytoin	Dilantin®
d.	lamotrigine	Lamictal®
e.	tiagabine	Gabitril®
f.	topirate	Topamax®
g.	levetiracetam	Keppra®
h.	zonisamide	Zonegran®
f.	pregabalin	Lyrica®

ANTI-MIGRAINE MEDICATIONS

	Generic Name	*Trade Name*
a.	dihydroergotamine	D.H.E. 45®, Migrand
b.	ergotamine	Cafatine, Cafergot®, Ercaf, Ergostat®, Wigraine
c.	isometheptene	Isopap, Midchlor, Midrin®, Migratine™
d.	methysergide maleate	Sansert®
e.	naratriptan	Amerge®

ANTI-MIGRAINE MEDICATIONS (cont'd)

f.	sumatriptan	Imitrex®
g.	zolmitriptan	Zomig®

ANTI-DEPRESSANT PAIN MEDICATIONS

	Generic Name	***Trade Name***
a.	amitriptyline	Elavil®, Endep®
b.	amoxapine	Asendin
c.	bupropion	Wellbutrin®
d.	citalopram	Celexa®
e.	clomipramine	Anafranil®
f.	duloxetine	Cymbalta®
g.	desipramine	Norpramin®, Pertofrane®
h.	doxepin	Adapin®, Sinequan®
i.	fluoxetine	Prozac®
j.	imipramine	Janimine, Tofranil®
k.	nortriptyline	Aventyl®, Pamelor®
l.	paroxetine	Paxil®
m.	protriptyline	Vivactil®
n.	sertraline	Zoloft®
o.	trazadone	Desyrel®
p.	trimipramine	Surmontil®
q.	venlafaxine	Effexor®

MUSCLE RELAXANTS/SEDATIVES

	Generic Name	***Trade Name***
a.	alprazolam	Xanax®
b.	lioresal	Baclofen
c.	carisprodol	Soma®
d.	cyclobenzaprine	Flexeril®
e.	diazepam	Valium®
f.	lorazepam	Ativan®
g.	metaxolone	Skelaxin®
h.	methocarbamol	Robaxin®
i.	oxazepam	Serax®
j.	tizanidine	Zanaflex®

OTHER PAIN RELATED MEDICATIONS

	Generic Name	*Trade Name*
a.	acetaminophen	Anacin-3®, aspirin-free Anacin®, Arthritis Pain Formula Aspirin-Free, Bromo Seltzer®
b.	butalbital	Esgic®, Esgic-Plus®, Fioricet®, Fiorinal®
c.	clonidine	Clonidine
d.	colchicine	Colchicine
e.	clonazepam	Klonopin®
f.	mexiletine	Mexitil®
g.	Oxygen	Oxygen
h.	tramadol	Ultram®, ultracet®
i.	zolpidem	Ambien®
j.	zaleplon	Sonata®
k.	eszopicione	Lunesta®
l.	_____	_____

28. What medications are you currently taking? Please list them below and include the dose and times you take the medication.

Medication	Dose	Times Taken per Day

29. Are you allergic to any medications? Please list them below, and tell us what happened to you when you took the medication.

Medication	Reaction

EFFECT OF PAIN ON YOUR LIFE

30. Please rate the effect your pain has on these activities in the past month by placing an “X” on the line

A. General activities of living:

No effect _____ Completely interferes

1 2 3 4 5 6 7 8 9 10

B. Your mood:

No effect _____ Completely interferes

1 2 3 4 5 6 7 8 9 10

C. Ability to walk:

No effect _____ Completely interferes

1 2 3 4 5 6 7 8 9 10

D. Ability to work (including both in and outside the home):

No effect _____ Completely interferes

1 2 3 4 5 6 7 8 9 10

E. Relationships with other people:

No effect _____ Completely interferes

1 2 3 4 5 6 7 8 9 10

F. Sleep:

No effect _____ Completely interferes

1 2 3 4 5 6 7 8 9 10

G. Enjoyment of life:

No effect _____ Completely interferes

1 2 3 4 5 6 7 8 9 10

31. Please tell us your top three goals in entering the Pain Center. Mark the most important as number 1, the next most important as number 2, and the least important goal as number 3.

___ Complete pain relief

___ Partial pain relief

___ Reduced medication use

___ Increased job activities

___ Increased general activities

___ Better relationships

___ Improved mood

___ Reduced tension

___ Not sure about your goals

___ Other:_____

32. What is your current work or your last job if you are not currently working?

_____

33. Present job situation:

☐ Full time ☐ Unemployed ☐ Leave of Absence ☐ Student

☐ Part time ☐ Retired ☐ Homemaker ☐ Disabled

If you are working full or part time, when did you return to work? (Date)_____ .

34. If you are not working, what was your last day of work? _____ .

35. Would you return to work if you had less pain? ☐ Yes ☐ No

36. Have you tried to return to work? ☐ Yes ☐ No

37. Please check your current disability / compensation status:

☐ Receiving full compensation / disability

☐ Receiving compensation / disability but not full benefits that are due

☐ Receiving compensation / disability but benefits will run out soon

☐ Receiving compensation / disability but re-evaluation is required by the provider

☐ Was on compensation / disability but it has stopped

☐ Have filed for compensation / disability payments but have not received any payments

☐ Received compensation / disability in past but not presently

38. If you are receiving disability payments, please circle the percentage of your total family income that is from your disability payments:

a. 0% - 25% b. 26% - 50% c. 51% - 75% d. 76% - 100%

39. Have you hired an attorney to help with your pain issues? ☐ Yes ☐ No

Is your case settled? ☐ Yes ☐ No

40. Substance intake per day:

a. Caffeine (coffee, tea, cola, mountain dew, etc.) _____

b. Nicotine (cigarettes, cigar, pipe, chewing tobacco, etc.) _____

41. Have you ever felt the need to cut back on your drinking or drug use? ☐ Yes ☐ No

42. Have you ever been annoyed by someone questioning your use or alcohol of other drugs? ☐ Yes ☐ No

43. Have you ever felt guilty about something you did while drinking or using drugs? ☐ Yes ☐ No

44. Have you ever had to have an eye opener (A drink or drug first thing in the morning)? ☐ Yes ☐ No

45. Have you recently used any of the following drugs? (Choose all that apply):

☐ Marijuana ☐ Amphetamines ☐ Cocaine ☐ Heroin

☐ None of these ☐ Other:_____

46. Marriage Status (choose one):

☐ Single ☐ Separated ☐ Married ☐ Widowed ☐ Divorced ☐ Remarried

47. Number of children: _____ Please list their ages: _____

48. Present living arrangements (Please check all that apply):

☐ Alone ☐ Spouse ☐ Friend ☐ Children

☐ Parents ☐ Other family members

49. MEDICAL HISTORY Please check any of the problems below that you have experienced:

Constitutional (General) Symptoms:

☐ No Problems

☐ Weight loss ____ lbs ☐ Weight gain____ lbs ☐ Fatigue (tiredness)

☐ Fever/Chills ☐ General weakness

☐ Other _____

Eyes:

☐ No Problems

☐ Wear contacts or glasses ☐ Glaucoma

☐ Cataracts ☐ Double or blurred vision

☐ Other eye problems_____

Ears/Nose/Mouth/Throat:

☐ No Problems

☐ Hearing problems ☐ Nose Bleeds/Drainage

☐ Ringing in ears ☐ Mouth sores

☐ Sore throat ☐ Dental problems

☐ Other problems _____

Respiratory (Lung & Breathing):

☐ No Problems

☐ Chronic cough ☐ Asthma

☐ Shortness of breath ☐ Emphysema

☐ Other problems _____

Cardiovascular (Heart & Circulation):

☐ No Problems

☐ Heart trouble ☐ Swelling of feet and/or ankles ☐ Heart murmur

☐ High blood pressure ☐ Chest pain ☐ Mitral valve prolapse

☐ Heart attack ☐ Shortness of breath ☐ Heart palpitations

☐ Heart surgery ☐ Heart failure ☐ Blood clots

☐ Varicose veins ☐ Poor circulation in your arms and/or legs

☐ Changes in skin color and/or temperature

☐ Other problems _____

Gastrointestinal system (Stomach and bowels):

- ☐ No Problems
- ☐ Abdominal pain
- ☐ Ulcers
- ☐ Heartburn or reflux disease
- ☐ Recurrent nausea and vomiting
- ☐ Recurrent diarrhea
- ☐ Irritable bowel syndrome
- ☐ Crohns' disease
- ☐ Constipation
- ☐ Liver disease
- ☐ Hepatitis/Cirrhosis
- ☐ Other problems _____

Genitourinary system (Bladder or Kidneys):

- ☐ No Problems
- ☐ Kidney infections
- ☐ Loss of bladder control
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Bladder infections
- ☐ Difficulty urinating
- ☐ Impotence
- ☐ Other problems _____

Neurological (Brain and nervous system):

- ☐ No Problems
- ☐ Headaches
- ☐ Past head injury
- ☐ Memory problems
- ☐ Fainting
- ☐ Blackouts
- ☐ Stroke
- ☐ Dizziness
- ☐ Seizures
- ☐ Problems walking
- ☐ Tremors
- ☐ Numbness
- ☐ Problems with coordination (walking, writing)
- ☐ Other problems _____

Skin:

- ☐ No Problems
- ☐ Changes in color
- ☐ Changes in temperature
- ☐ Rashes
- ☐ Ulcers
- ☐ Other problems _____

Hematologic system (Blood system):

- ☐ No Problems
- ☐ Easy bleeding and/or bruising
- ☐ Slow to heal after cuts
- ☐ History of blood clots
- ☐ Anemia (low blood count)
- ☐ Swollen or enlarged glands
- ☐ Phlebitis
- ☐ On blood thinners
- ☐ Cancer _____
- ☐ Sickle cell disease

Other problems _____

Musculoskeletal system (Muscles and Joints):

- ☐ No Problems
- ☐ Muscle cramps
- ☐ Stiff joints _____
- ☐ Swollen joints
- ☐ Sore muscles
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Broken bones:_____
- ☐ Gout

Other:

- ☐ No Problems
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Depression
- ☐ Anxiety or panic attacks

50. PREVIOUS SURGERIES:

Surgery type	**Year**

51. What is the easiest way for you to learn new things?

- ☐ Written material
- ☐ Someone showing you how to do something; then you repeat back to them what you've learned
- ☐ Videos/DVD
- ☐ Other _____

52. Did you have help filing out this form? ☐ Yes ☐ No

If yes, who helped you? _____

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 252-847-0601.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 252-847-0601.