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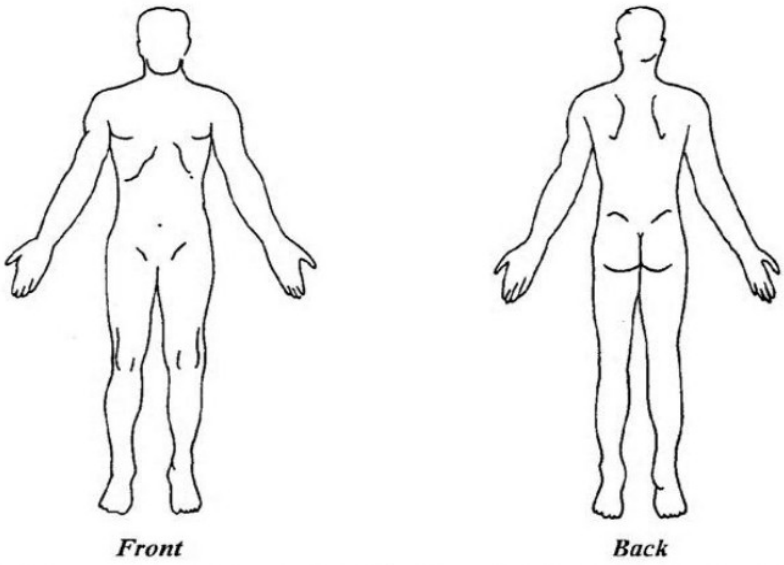
FOLLOW UP QUESTIONNAIRE

PAIN LOCATION

Please describe the location(s) of you pain:

_____



Front *Back*

Please mark the location(s) of your pain on the diagrams above. If whole areas are painful, please shade in the painful area.

RATE YOUR PAIN

(0-10 scale where 0 is no pain and a 10 is the worst possible pain)

I would rate my pain today a _____/10

I would rate my worst pain a _____/10.

I would rate my pain when under control as a _____/10.

I could accept or live with a level of pain at a _____/10.

PAIN QUALITY

How would you describe the pain?

☐ Burning ☐ Sharp ☐ Cutting ☐ Throbbing
☐ Cramping ☐ Numbness ☐ Dull
☐ Aching ☐ Pressure ☐ Soreness
☐ Pins and needles ☐ Shooting ☐ Other_____

In general, during the past month when has your pain been (please check one)?

☐ Worsening ☐ Improving ☐ Unchanged

TIMING OF PAIN

How often do you have your pain? (Please check one)

☐ Constantly (100% of the time)
☐ Nearly constantly (60% to 95% of the time)
☐ Intermittently (30% to 60% of the time)
☐ Occasionally (less than 30% of the time)

ACTIVITIES AND YOUR PAIN

During the past month, check the activities that you avoided because of pain:

☐ Going to work ☐ Performing household chores
☐ Doing yard work or shopping ☐ Socializing with friends
☐ Participating in recreation ☐ Having sexual relations
☐ Physically exercising

Does your pain cause any of the following?

☐ Loss of bowl control ☐ Loss of bladder control ☐ Loss of sleep

How many blocks can you walk before having to stop secondarily to pain?

☐ Less than a block _____blocks

How many minutes or hours can you sit before having to get up and move about?

_____Hours _____Minutes

How many minutes or hours can you stand before you have to sit down?

_____Hours _____Minutes

How often during the day do you lie down because of pain?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Constantly

RELIEVING AND AGGREVATING FACTORS

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

	Decrease	No Change	Increase
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercise (if applicable)	☐	☐	☐
Medications	☐	☐	☐
Relaxation	☐	☐	☐
Thinking about something else	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel movements	☐	☐	☐

Please list current medications- _____

_____

_____

_____

_____

_____

_____

_____

Do you take opioid medications? (circle) YES NO

As a result of taking opioid medications I can do the following-

_____

_____

_____

Since coming to Pacific Pain Care Consultants my **PAIN** has (circle one)

INCREASED STAYED THE SAME DECREASED

My current medications/pain management regime has resulted in the following changes in **ACTIVITY** level (circle one)

DECREASED STAYED THE SAME INCREASED

REVIEW OF SYSTEMS

Constitutional
- ☐ Weight change
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Insomnia
- ☐ Fever

Cardiovascular
- ☐ Heart trouble
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Swelling of the feet or ankles

Gastrointestinal
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Blood in the stool

Neurological
- ☐ Frequent headaches
- ☐ Light headed or dizzy
- ☐ Convulsions or seizures
- ☐ Numbness or tingling
- ☐ Tremors
- ☐ Paralysis
- ☐ Head injury
- ☐ Memory loss
- ☐ Fainting
- ☐ Poor balance

Eyes
- ☐ Eye disease
- ☐ Glasses or contacts
- ☐ Blurred or double vision
- ☐ Vision loss

Genitourinary
- ☐ Frequent urination
- ☐ Urgency of urination
- ☐ Painful urination
- ☐ Incontinence
- ☐ Sexual difficulty
- ☐ Kidney stones

Respiratory
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Wheezing

Ears/Nose/Mouth/Throat
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Swollen glands in the neck

Hematological
- ☐ Bleeding tendency
- ☐ Anemia
- ☐ Recurrent infections

Psychiatric
- ☐ Nervousness
- ☐ Depression
- ☐ Hallucination

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Weakness of muscles or joints
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Difficulty walking

Endocrine
- ☐ Excessive thirst
- ☐ Heat or cold intolerance
- ☐ Glandular or hormone problems

Skin
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
