Legacy Pain Management Center

New Patient Questionnaire

Please complete this form prior to your visit to allow us to make the best use of our time together.
Primary Care Provider:
Referring Physician:
Other providers you currently see:

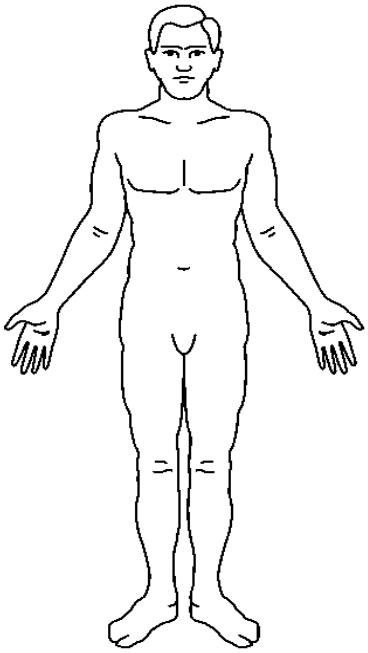
Pain History

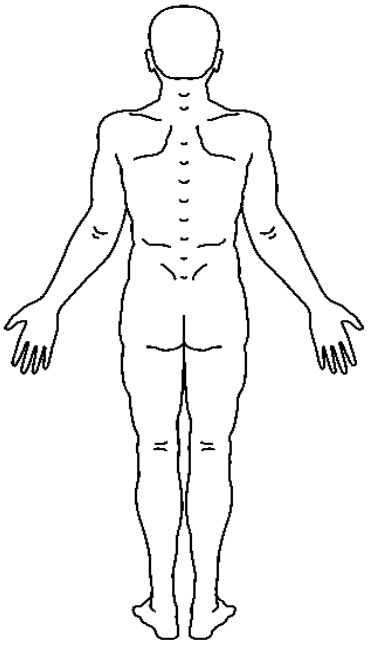
1. What is the diagnosis of your pain? (If known)

2. How did your pain begin?

3. When did your pain problems begin? (date of injury or your age when pain began)

4. Where is the pain? (Shade pain areas on the diagram below). Draw an arrow to the WORST area.





Is the pain: (please check those that apply):

[ ] aching

[ ] burning

[ ] constant

[ ] pulsing

[ ] shooting

[ ] sharp

[ ] stabbing

5. Do you have pain at all times? Y N (circle one)

6. What time of day does your pain bother you most?

7. On average, how severe is your pain from 0 to 10, with 0 being NO pain and 10 being WORST pain imaginable?	
8. Do you have any weakness?	[ ] Yes [ ] No Where?
9. Do you have any numbness?	[ ] Yes [ ] No Where?
10. What makes your pain worse?	
11. What makes your pain better?	
12. What medications do you currently use for pain? (Please include dosage and frequency).	

Pain Treatment History

1. Circle all **pain medications** you have tried in the past:

Name of Medication (Brand Name)	Still Taking?	Reason for stopping
hydrocodone (Vicodin, Norco)		
oxycodone (Percocet, Oxycontin)		
methadone		
hydromorphone (Dilaudid)		
tramadol (Ultram)		
codeine (Tylenol #3)		
fentanyl patch (Duragesic)		
morphine (MSContin, Kadian)		
oxymorphone (Opana)		
cyclobenzaprine (Flexeril)		
methocarbamol (Robaxin)		
tizanadine (Zanaflex)		
metaxalone (Skelaxin)		
carisoprodol (Soma)		
gapapentin (Neurontin)		
pregabalin (Lyrica)		
duloxetine (Cymbalta)		
venlafaxine (Effexor)		
amitriptyline (Elavil)		
buprenorphine/naloxone (Suboxone)		

2. Circle all other therapies you have tried:

Pain therapies tried:	Past?	Current?	Were they helpful? (Yes/No)
Physical therapy			
Counseling			
Injections			
Other:			

Review of Systems

Check any of the following symptoms you have experienced in the past month:

Constitutional
- ☐ Fatigue
- ☐ Fevers

Eyes
- ☐ Itching
- ☐ Light sensitivity
- ☐ Vision changes

Respiratory
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiac
- ☐ Chest pain
- ☐ Swelling

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Problems urinating
- ☐ Incontinence
- ☐ Frequent urination

Musculoskeletal
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Joint swelling
- ☐ Muscle Pain

Skin
- ☐ Color change
- ☐ Rash
- ☐ Wounds

Neurological
- ☐ Headaches
- ☐ Numbness

Neurological, cont.
- ☐ Seizures
- ☐ Tremors
- ☐ Weakness

Mood
- ☐ Decreased concentration
- ☐ Depression
- ☐ Hallucinations
- ☐ Anxiety
- ☐ Sleep difficulty
- ☐ Considered suicide

Medical History

1. List **ALL** other MEDICATIONS and dosage (VERY IMPORTANT):

2. List any allergies to medications:

3. List all surgeries and their dates, if known:

4. Have you ever been diagnosed with sleep apnea? [ ] Yes [ ] No
   If yes, do you use a CPAP mask at night? [ ] Yes [ ] No

Do you use oxygen at night?	[ ] Yes [ ] No

Social History

1. Do you use tobacco? If yes, how much and when did you start? If no, have you in the past?	[ ] Yes [ ] No
2. Do you drink alcohol? If yes, how much and how often?	[ ] Yes [ ] No
3. Do you currently use any illicit substances?	[ ] Yes [ ] No
4. Do you have a history of substance abuse? If yes, what substance and when was last use?	[ ] Yes [ ] No
5. Marital status: [ ] Married [ ] Never married [ ] Live with spouse/partner [ ] Widowed [ ] Divorce/separated	
6. Do you live alone or with others?	[ ] Alone [ ] With others
7. Are you currently employed? [ ] Yes, how many hours per week and where? [ ] No, when did you last work?	
8. Are you currently on disability?	[ ] Yes [ ] No
9. Are you currently involved in a disability or legal claim?	[ ] Yes [ ] No

Psychological History

1. Have you even been diagnosed with anxiety, depression, panic attacks, or any other psychological condition? If yes, what/when?	[ ] Yes [ ] No
2. Are you under the care of a mental health professional? If yes, who?	[ ] Yes [ ] No
3. Do you have a history of prior physical or sexual abuse or other traumatic experiences?	[ ] Yes [ ] No
4. Are you bothered by little interest or pleasure in doing things?	[ ] Yes [ ] No
5. Have you been feeling down, depressed, or hopeless?	[ ] Yes [ ] No

Family History

Relationship	Status	Arthritis	Cancer	Chronic Pain	Depression	Diabetes	High Blood Pressure	High Cholesterol	Obesity	Substance Abuse	Migraine
Mother	□ Alive □ Deceased										
Father	□ Alive □ Deceased										
Sister	□ Alive □ Deceased										
Sister	□ Alive □ Deceased										
Sister	□ Alive □ Deceased										
Brother	□ Alive □ Deceased										
Brother	□ Alive □ Deceased										
Brother	□ Alive □ Deceased										
Maternal Grandmother	□ Alive □ Deceased										
Maternal Grandfather	□ Alive □ Deceased										
Paternal Grandmother	□ Alive □ Deceased										
Paternal Grandfather	□ Alive □ Deceased										
Other:	□ Alive □ Deceased										

Thank you for taking the time to fill out this questionnaire!