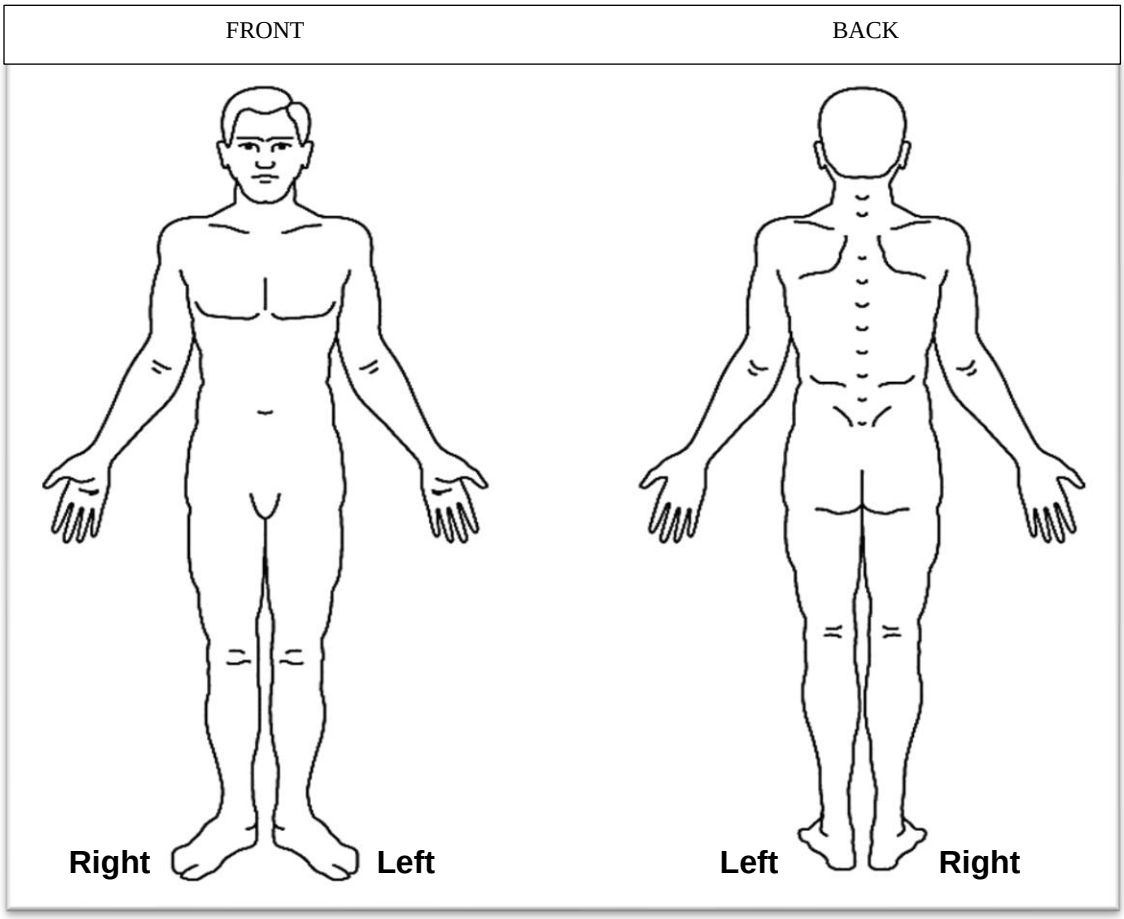
Legacy Pain Management Center

New Patient Questionnaire

Patient Sticker

Please complete this form prior to your visit to allow us to make the best use of our time together.

Please mark where the pain is at on the diagram below



Is the pain?

- ☐ Aching
- ☐ Burning
- ☐ Constant
- ☐ Pulsing
- ☐ Shooting
- ☐ Sharp
- ☐ Stabbing

Pain History

1. What is the diagnosis of your pain? (If known) _____
2. When did your pain problems begin? (Date of injury or age at the time) _____
3. How did the pain begin? _____
4. Do you have any numbness? **YES** **NO** If yes, where? _____
5. Do you have any weakness? **YES** **NO** If yes, where? _____
6. What makes the pain worse? _____
7. What makes the pain better? _____

PEG: A Three-Item Scale Assessing Pain Intensity and Interference

1. What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

3. What number best describes how, during the past week, pain has interfered with your general activity

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

Review of Systems

Check any of the following symptoms you have experienced in the **LAST MONTH**

Constitutional
- ☐ Chills
- ☐ Excessive Fatigue
- ☐ Fever
- ☐ Increased Sweating
- ☐ Unexpected Weight Changes

Eyes/Ears/Mouth
- ☐ Light Sensitivity
- ☐ Vision Changes
- ☐ Ringing in Ears
- ☐ Dental Problems

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Cardiac
- ☐ Anti-Coagulation Therapy
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations

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

Genitourinary
- ☐ Incontinence
- ☐ Urinary Urgency
- ☐ Frequency

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Swelling
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Neck Pain
- ☐ Neck Stiffness

Skin
- ☐ Rash
- ☐ Skin Changes
- ☐ Wound
- ☐ Bruises/Bleeding Easily

Neurological
- ☐ Dizziness
- ☐ Seizures
- ☐ Headaches/Migraines
- ☐ Tremors
- ☐ Numbness(Where) _____
- ☐ Weakness(Where) _____

Mood
- ☐ Depression
- ☐ Anxiety
- ☐ Decreased Concentration
- ☐ Sleep Difficulty
- ☐ Hallucinations
- ☐ Considered suicide

Psychological & Social History

Over the past 2 WEEKS, how often have you been bothered by these problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

1. Have you ever been diagnosed with:
   ☐ Anxiety ☐ Depression ☐ PTSD ☐ Bipolar ☐ Personality Disorder

2. Are you under the care of a mental health provider? **YES** **NO** (provider name) _____

Marital status:
☐ Married ☐ Divorced ☐ Widowed
☐ Live with spouse/Partner ☐ Never married

Do you live with others? **YES** **NO**

Are you currently employed? **YES NO**
If yes, how many hours weekly _____
If not, when did you last work _____

Currently on disability? **YES** **NO**
Or a disability/legal claim? **YES** **NO**

Do you drink alcohol? **YES** **NO**
If yes, how much on average? _____

Do you currently use tobacco? **YES** **NO**
If yes, how many packs per day? _____
If you have smoked in the past when did you quit? _____

Do you use smokeless tobacco? **YES** **NO**

Past drug use? **YES** **NO**
If no, when did you stop? _____

Currently using any drugs? **YES** **NO**
Which drug(s)? (Circle those that apply)

Marijuana Cocaine Ecstasy LSD
PCP Heroin Methamphetamine

Medication Information

What medications do you *CURRENTLY* use for the PAIN? (more room on back of page)

Medication Name	Dose (MG or MCG)	When/how much do you take

Check here if **YES**	**Have you used this medication?**	**Reason for stopping**
	Hydrocodone (Vicodin, Norco)	
	Oxycodone (Percocet, Oxycontin)	
	Methadone	
	Hydromorphone (Dilaudid)	
	Tramadol (Ultram)	
	Codeine (Tylenol #3)	
	Fentanyl patch (Duragesic)	
	Morphine (MS Contin)	
	Levorphanol	
	Oxymorphone (Opana)	
	Baclofen	
	Cyclobenzaprine (Flexeril)	
	Methocarbamol (Robaxin)	
	Tizanidine (Zanaflex)	
	Metaxalone (Skelaxin)	
	Carisoprodol (Soma)	
	Gabapentin (Neurontin)	
	Pregabalin (Lyrica)	
	Duloxetine (Cymbalta)	
	Venlafaxine (Effexor)	
	Amitriptyline(Elavil), nortriptyline, desipramine	
	Buprenorphine (Subutex, Belbuca, Butrans)	
	Buprenorphine/naloxone (Suboxone)	
	Nucynta (tapentadol)	
	Naltrexone- low dose	
	Anti-inflammatory	

Current/Previous Treatments

Treatment Type	Currently or When	Was it helpful? Yes/ No
Physical Therapy		
Counseling		
Injections		
Acupuncture, massage, chiropractor		
Other		

Family History

Adopted ☐ Yes ☐ No

If yes or you do **not** know your family history skip this section.

	Mom	Dad	Sister	Brother	Grandparents
No Significant History Known					
Alcoholism					
Anxiety					
Arthritis					
Autoimmune Disease					
Cancer					
Chronic Pain					
Depression					
Diabetes					
Drug Abuse					
Migraine					