Tri-Valley Orthopedic Specialists, Inc.
SOLVING MUSCULOSKELETAL PROBLEMS SINCE 1985

INITIAL COMPREHENSIVE PAIN QUESTIONNAIRE

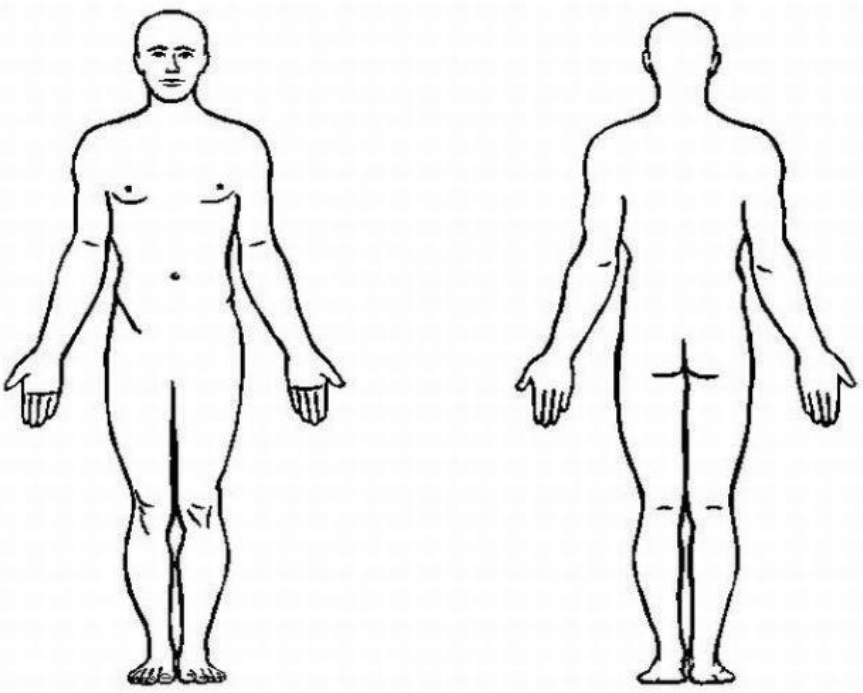
Name:_____DOB:_____
Address:_____
Phone number:_____
Referring Physician name: _____

PAIN HISTORY:
Was the pain a result of a particular incident (injury, accident, illness): □ No □ Yes (please explain)
_____
_____
If the pain started after an injury, did it occur while at work: □ No □ Yes, date:_____
Is there an active worker's compensation case related to the injury: □ No □ Yes
Is there any active litigation / lawsuits related to the injury: □ No □ Yes

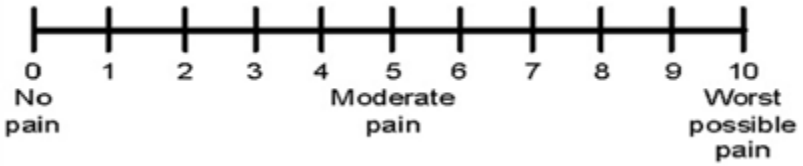
Do you have any existing pain diagnoses (fibromyalgia, CRPS): □ No □ Yes (please provide detail)
_____
_____

When did the pain start:_____

Where is your pain: on the diagram below, please shade the area where you feel pain and put an X on the area that hurts the most.



What level is your pain: please circle your **best**, **worst** and **average** pain scores.



What level of pain can you live and function at:_____

What is the timing of your pain: please check all that apply.
□ Constant □ Intermittent / Episodic □ Worse with / during_____

What does the pain feel like: please check all that apply.
□ Sharp □ Stabbing □ Stinging □ Electric □ Burning □ Radiating / shooting
□ Dull □ Aching □ Throbbing □ Cramping □ Gnawing □ Squeezing /crushing
□ Pressure □ Pinching □ Pulsing □ Numbing / Tingling □ Other_____

What symptoms do you have along with your pain: please check all that apply.
□ Numbness □ Tingling □ Weakness in arms □ Weakness in legs
□ Loss of urine control □ Loss of bowel control □ Balance problems □ Falls
□ Dropping things □ Muscle spasms □ Skin discoloration □ Hair changes
□ Nail changes □ Temperature changes □ Excessive sweating □ Extreme sensitivity to touch

Does the pain make it hard for you to: please check all that apply.
□ Enjoy life □ Work □ Take care of yourself / perform simple chores □ Sleep

PAIN MEDICATION HISTORY: please check all that apply.

Anti-Inflammatories	**Active**	**Past**	**Helpful**	**Not Helpful**	**Side Effects**
□ Acetaminophen (TYLENOL)					
□ Aspirin					
□ Ibuprofen (ADVIL, MOTRIN)					
□ Naproxen (ALEVE, NAPROSYN)					
□ Diclofenac (ARTHROTEC)					
□ Indomethacin (INDOCIN)					
□ Etodolac (LODINE)					
□ Ketorolac (TORADOL)					
□ Meloxicam (MOBIC)					
□ Piroxicam (FELDENE)					
□ Nabumetone (Relafen)					
□ Other (specify)					
Anticonvulsants	**Active**	**Past**	**Helpful**	**Not Helpful**	**Side Effects**
□ Gabapentin (Neurontin)					
□ Pregabalin (LYRICA)					
□ Carbamazepine (TEGRETOL)					
□ Topiramate (TOPAMAX)					

□ Levetiracetam (KEPPRA)					
Antidepressants	**Active**	**Past**	**Helpful**	**Not Helpful**	**Side Effects**
□ Amitriptyline (ELAVIL)					
□ Nortriptyline (PAMELOR)					
□ Desipramine (NORPRAMIN)					
□ Imipramine (TOFRANIL)					
□ Doxepin					
□ Trazodone (OLEPTRO)					
Serotonin / Norepinephrine	**Active**	**Past**	**Helpful**	**Not Helpful**	**Side Effects**
□ Duloxetine (CYMBALTA)					
□ Venlafaxine (EFFEXOR)					
□ Milnacipran (SAVELLA)					
Antipsychotics	**Active**	**Past**	**Helpful**	**Not Helpful**	**Side Effects**
□ Olanzapine (ZYPREXA)					
□ Haloperidol (HALDOL)					
□ Ziprasidone (GEODON)					
Muscle Relaxants	**Active**	**Past**	**Helpful**	**Not Helpful**	**Side Effects**
□ Cyclobenzaprine (FLEXERIL)					
□ Carisoprodol (SOMA)					
□ Metaxalone (SKELAXIN)					
□ Methocarbamol (ROBAXIN)					
□ Tizanidine (ZANAFLEX)					
□ Orphenadrine (NORFLEX)					
□ Baclofen (LIORESAL)					
Benzodiazepines	**Active**	**Past**	**Helpful**	**Not Helpful**	**Side Effects**
□ Diazepam (VALIUM)					
□ Alprazolam (XANAX)					
□ Lorazepam (ATIVAN)					
□ Clonazepam (KLONOPIN)					
□ Chlordiazepoxide (LIBRIUM)					
Short Acting Opioids (list dose)	**Active**	**Past**	**Helpful**	**Not Helpful**	**Side Effects**
□ Tramadol (ULTRAM)					
□ Tapentadol (NUCYNTA)					
□ Meperidine (DEMEROL)					
□ Codeine (TYLENOL #3, #4)					
□ Hydrocodone (NORCO, VICODIN)					
□ Oxycodone (PERCOCET)					
□ Morphine					
□ Hydromorphone (DILAUDID)					
□ Oxymorphone (OPANA)					
□ Fentanyl (ACTIQ, FENTORA)					
□ Other (specify)					

Long Acting Opioids (list dose)	Active	Past	Helpful	Not Helpful	Side Effects
□ Hydrocodone (HYSINGLA, ZOHYDRO)					
□ Oxycodone (OXYCONTIN)					
□ Morphine (AVINZA, KADIAN, MS CONTIN, ORAMORPH)					
□ Hydromorphone (EXALGO)					
□ Oxymorphone (OPANA ER)					
□ Fentanyl Patch (DURAGESIC)					
□ Methadone (DOLOPHINE)					
□ Levorphanol (LEVODROMORAN)					
□ Buprenorphine (BUTRANS)					
□ Buprenorphine /Naloxone (SUBOXONE)					
□ Other (specify)					

PAIN TREATMENT HISTORY: please check all that apply.

Conservative Therapies	Dates	Helpful	Not Helpful
□ Physical therapy			
□ Occupational therapy			
□ Aqua therapy			
□ Chiropractic treatment			
□ Acupuncture			
□ Osteopathic treatment			
□ Homeopathic treatment			
□ Massage			
□ Home exercise program			
□ TENS Unit			
□ Braces / Orthotics			
□ Heat			
□ Cold			
□ Biofeedback			
□ Cognitive behavioral therapy			
□ Meditation			
□ Psychological programs			
□ Other:			
Interventions	**Dates**	**Helpful**	**Not Helpful**
□ Trigger point injections			
□ Botox injections			
□ Nerve blocks			
□ Facet injections			
□ Radiofrequency ablation			
□ SI joint injections			
□ Piriformis injections			

□ Epidural injections			
□ Shoulder injections			
□ Hip injections			
□ Knee injections			
□ Elbow/wrist/hand/foot injections (specify type)			
□ Spinal cord stimulator trial			
□ Spinal cord stimulator implant			
□ Intrathecal (spinal) pump			
□ Spine sugery			

REMAINING MEDICAL HISTORY:

Past Medical History: please list active medical conditions currently being monitored or treated.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Past Surgical History: please list in chronological order.

Year	Type of Surgery

Social History:

Occupation:_____

□ Working full time □ Working part time □ Unemployed □ Disabled □ Retired

Highest degree of education earned:_____

Marital status:_____

Who do you live with:_____

Exercise: what kind and how often:_____

Tobacco use: □ No □ Yes □ In the past How many pack-years:_____

Alcohol ABUSE: □ No □ Yes □ In the past □ In the family; how much:_____

Recreational drug use: □ No □ Yes □ In the past □ In the family; type(s):_____

Prescription drug abuse: □ No □ Yes □ In the past □ In the family; type(s):_____

Physical abuse history: □ No □ Yes □ In the past
Sexual abuse history: □ No □ Yes □ In the past
Suicide history: □ No □ Considered □ Planned □ Attempted

Family History: please list medical conditions among first-degree relatives.

_____
_____
_____
_____
_____
_____
_____

Other Medications: please list other non-pain related medications you currently use.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Blood Thinning Medications: please check all that you are currently taking or have taken recently.

□ Aspirin
□ Heparin
□ Warfarin (COUMADIN)
□ Edoxaban (SAVAYSA)
□ Dabigatran (PRADAXA)
□ Clopidogrel (PLAVIX)
□ Eptifibatide (INTEGRILIN)
□ Prasugrel (EFFIENT)
□ Cilostazol (PLETAL)
□ tPa, urokinase, alteplase, streptokinase
□ Aspirin/Dipyridamole (AGGRENOX)
□ Low Molecular Weight Heparin (LOVENOX)
□ Apixaban (ELIQUIS)
□ Rivaroxaban (XARELTO)
□ Fondaparinux (ARIXTRA)
□ Abciximab (REOPRO)
□ Ticrofiban (AGGRASTAT)
□ Ticagrelor (BRILINTA)
□ Abciximab (REOPRO)
□ Other:

Allergies: please list medication and corresponding reactions. □ No known drug allergy

Medication	Reaction

Are you allergic to contrast dye: □ No □ Yes, please describe reaction_____

REVIEW OF SYSTEMS: please check all that currently applies to you.

General:
□ Fever, chills, night sweats
□ Excessive sweating
□ Fatigue
□ Poor sleep
□ Loss of appetite / weight loss
□ Weight gain

Head, Eyes, Ear, Nose, Throat:
□ Headaches
□ Dizziness
□ Blurred vision
□ Ringing in ears
□ Hoarseness
□ Difficulty swallowing

Cardiovascular:
□ Chest pain
□ Palpitations
□ Fainting
□ Difficulty breathing while lying down
□ Swelling of the legs

Respiratory:
□ Shortness of breath
□ Cough
□ Wheezing
□ Pauses in breathing during sleep
□ Excessive daytime sleepiness

Gastrointestinal:
□ Abdominal pain
□ Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Blood in stool
□ Bowel incontinence

Urinary:
□ Pelvic pain
□ Flank pain
□ Pain or burning on urination
□ Inability to urinate
□ Urgency to urinate
□ Urinary incontinence

Genital-Reproductive:
□ Pelvic pain
□ Groin pain
□ Decreased sexual desire
□ Decrease ability to achieve erection
□ Irregular / heavy menstrual periods

Hematologic / Endocrine:
□ Easy bruising / bleeding
□ History of blood clots
□ Cold intolerance
□ Heat intolerance

Musculoskeletal:
□ Join pain
□ Joint instability
□ Joint swelling
□ Joint redness / warmth
□ Muscle spasms / pain

Neurologic:
□ Seizures
□ Strokes
□ Numbness / tingling
□ Weakness or paralysis in arms or legs
□ Loss of balance / loss of coordination

Psychiatric:
□ Depression
□ Anxiety
□ Difficulty with thinking / problem solving
□ Suicidal / homicidal thoughts

Skin:
□ Rash
□ Discoloration
□ Itching
□ Hair loss