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

INITIAL COMPREHENSIVE PAIN QUESTIONNAIRE

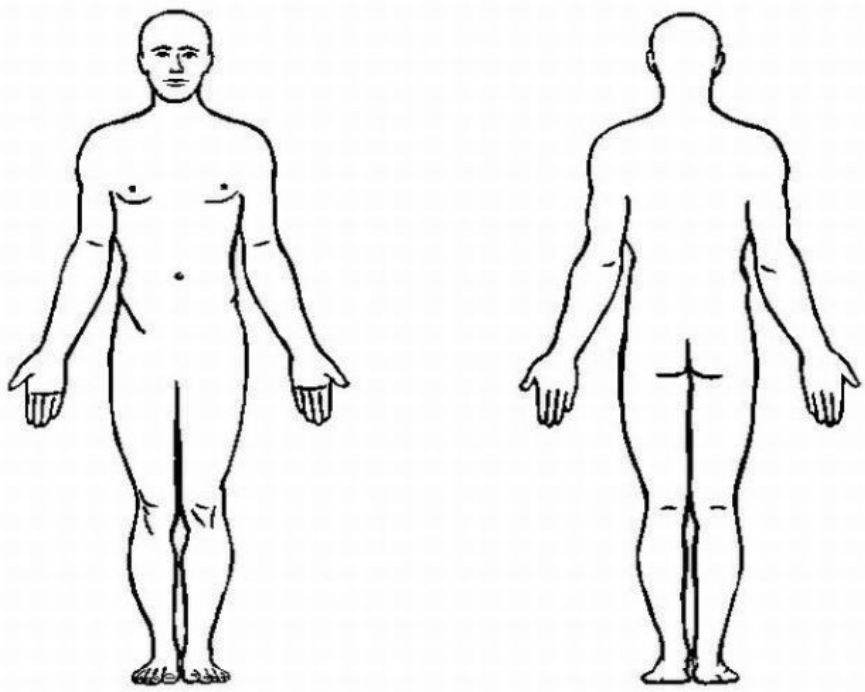
Name:_____DOB:_____
Address:_____
Phone number:_____
Referring Physician name: _____

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

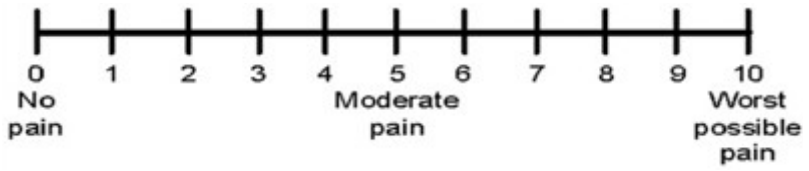
Do you have any existing pain diagnoses (fibromyalgia, CRPS): □ No □ Yes (please provide detail)
_____
_____

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 the pain medications that you have used to treat your pain currently or in the past.

Medication Generic Name (BRAND NAME)	Dose	Check If Current Use	Check If Helpful	Check If Not Helpful	Please List Any Side Effects
Anti-Inflammatories					
□ Acetaminophen (TYLENOL)					
□ Aspirin					
□ Ibuprofen (ADVIL,					
□ Naproxen (ALEVE,					
□ Diclofenac (ARTHROTEC)					
□ Indomethacin (INDOCIN)					
□ Etodolac (LODINE)					
□ Ketoralac (TORADOL)					
□ Meloxicam (MOBIC)					
□ Piroxicam (FELDENE)					
□ Nabumetone (Relafen)					
□ Other:					
Anticonvulsants					
□ Gabapentin (Neurontin)					
□ Pregabalin (LYRICA)					
□ Carbamazepine					
□ Topiramate (TOPAMAX)					
□ Levetiracetam (KEPPRA)					
Antidepressants					
□ Amitriptyline (ELAVIL)					
□ Nortriptyline (PAMELOR)					
□ Desipramine (NORPRAMIN)					

□ Imipramine (TOFRANIL)					
□ Doxepin					
□ Trazodone (OLEPTRO)					
Serotonin / Norepinephrine					
□ Duloxetine (CYMBALTA)					
□ Venlafaxine (EFFEXOR)					
□ Milnacipran (SAVELLA)					
Antipsychotics					
□ Olanzapine (ZYPREXA)					
□ Haloperidol (HALDOL)					
□ Ziprasidone (GEODON)					
Muscle Relaxants					
□ Clyclobenzaprine					
□ Carisoprodol (SOMA)					
□ Metaxalone (SKELAXIN)					
□ Methocarbamol (ROBAXIN)					
□ Tizanidine (ZANAFLEX)					
□ Orphenadrine (NORFLEX)					
□ Baclofen (LIORESAL)					
Benzodiazepines					
□ Diazepam (VALIUM)					
□ Alprazolam (XANAX)					
□ Lorazepam (ATIVAN)					
□ Clonazepam (KLONOPIN)					
□ Chlordiazepoxide					
Short Acting Opioids					
□ Tramadol (ULTRAM,					
□ Tapentadol (NUCYNTA)					
□ Hydrocodone (VICODIN,					
□ Oxycodone (PERCOCET,					
□ Meperidine (DEMEROL)					
□ Hydromorphone					
□ Fentanyl (ACTIQ,					
□ Codeine (TYLENOL #3, #4)					
Long Acting Opioids					
□ CR Oxycodone					
□ LA Morphine (MS CONTIN,					
□ Methadone (DOLOPHINE)					
□ Fentanyl Patch					
□ LA Oxmorphone (OPANA					
□ Levorphanol					
□ Buprenorphine (BUTRANS)					
□ Buprenorphine /Naloxone					

Pain Interventions History: please check all that apply.

Name Of Intervention	Check If Helpful	Check If Not Helpful
Procedures		
□ Trigger point injections		
□ Botox injections		
□ Nerve blocks		

□ Facet injections		
□ Radiofrequency ablation		
□ SI joint injections		
□ Piriformis injections		
□ Epidural injections		
□ Shoulder injections		
□ Hip injections		
□ Knee injections		
□ Foot injections		
□ Spinal cord stimulator trial		
□ Spinal cord stimulator		
□ Intrathecal (spinal) pump		
□ Spine sugery		
Conservative Therapies		
□ Physical therapy		
□ Occupational therapy		
□ Aqua therapy		
□ Yoga, Tai Chi, Pilates		
□ Chiropractic treatment		
□ Osteopathic treatment		
□ Homeopathic treatment		
□ Heat		
□ Cold		
□ Braces / Orthotics		
□ TENS Unit		
□ Massage		
□ Acupuncture		
□ Biofeedback		
□ Cognitive behavioral		
□ Meditation		
□ Psychological programs		
□ Other:		

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