CHRONIC PAIN TREATMENT CENTRE - PAIN MANAGEMENT

PAIN INVENTORY

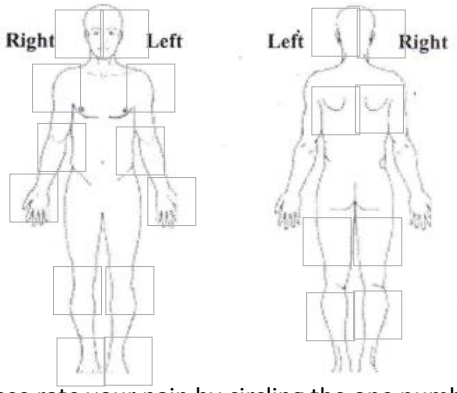
Date: _____/_____/_____

Name: _____

OHIP#_____

1. Throughout most of our lives, most of us have had pain from time to time (such as major headaches, sprains, and toothaches). Have you ever had any pain other than these everyday kinds of pain in the last 6 months?
   1. Yes 2. No

2. On the diagram shade in the areas where you have felt pain in the last 6 months. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its WORST in the last two weeks.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its LEAST in the last two weeks.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the AVERAGE in the last two weeks.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

7. What allied health treatments have you received (Physiotherapy, chiropractic, osteopathy, massage, acupuncture, etc.)?

   _____
   _____
   _____

8. What medications have you taken, or are receiving, **for your pain**?

   _____
   _____
   _____
   _____
   _____

9. Have you had any surgeries or injections to help with your pain?

   _____
   _____
   _____
   _____

10. In the last two weeks how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

11. Circle the one number that describes how, during the past two weeks, pain has interfered with your:
    a. General activity

0	1	2	3	4	5	6	7	8	9	10
No Interference										Complete interference

    b. Mood

0	1	2	3	4	5	6	7	8	9	10
No Interference										Complete interference

c. Walking ability

0	1	2	3	4	5	6	7	8	9	10
No Interference										Complete interference

d. Normal work (work both in and outside the home)

0	1	2	3	4	5	6	7	8	9	10
No Interference										Complete interference

e. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
No Interference										Complete interference

f. Sleep

0	1	2	3	4	5	6	7	8	9	10
No Interference										Complete interference

g. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
No Interference										Complete interference

12. What does your pain feel like? Circle those words that best describe your pain.

□ Aching	□ Throbbing	□ Shooting
□ Stabbing	□ Gnawing	□ Prickling
□ Sharp	□ Tender	□ Burning
□ Exhausting	□ Tiring	□ Penetrating
□ Nagging	□ Numb	□ Miserable
□ Unbearable	□ Dull	□ Radiating
□ Squeezing	□ Cramping	□ Deep

13. How long have you had chronic pain? Choose one.

□ Less than 3 months 3 to 6 months

□ 6 to 12 months 12 or more months

_____years

14. Do you have any other symptoms? Choose any that apply.

□ Nausea	□ Vomiting
□ Constipation	□ Diarrhea
□ Lack of appetite	□ Indigestion
□ Difficulty sleeping	□ Feeling drowsy
□ Nightmares	□ Dizziness
□ Urinary problems	□ Sweating
□ Weakness	□ Headaches

15. What kinds of things make your pain feel better (For example, heat, medication, rest, movement)?

_____
_____
_____
_____

16. What kinds of things make your pain worse (For example, walking, standing, lifting, weather, stress)?

_____
_____
_____
_____

Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience cannot be compared to another person's pain. ONLY YOU know how and when you hurt, and how the pain affects your life.

It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Why Is Pain Relief So Important?

Proper treatment for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of sleep, depression, loss of appetite, weakness, and other problems. Pain can also affect your life at home and at work. Relieving your pain means that you can continue to do the day-to-day things that are important to you.

Most Pain Can Be Helped

Your doctor will work with you to find the treatment that may be best for your pain.
The key to effective pain control is to have the RIGHT AMOUNT, of the RIGHT TREATMENT, at the RIGHT TIME. You should have your pain treatment on a regular schedule, as your doctor, nurse, or

pharmacist tells you. Try not to wait until the pain becomes severe. Pain is easier managed before it has reached full force.

If your pain treatment wears off too soon, is not relieving the pain, or causes problems with side effects, you should call your doctor because you may need to have your treatment plan changed.

<u>Comments:</u> Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.

_____

_____

_____

_____

_____

_____

_____

_____

_____

<u>Patient Medical Questionnaire:</u>

Please answer each question carefully and return the completed sheet to the receptionist. This is not a substitute for a history and examination by your attending doctors.

Please mark the appropriate box with an "**X**" to answer each question

17. Do you have private health insurance or extended benefits?

    Yes No Don't Know

18. Do you take medication for the treatment of:

a. Heart Disease (ex. Angina or Heart Failure)

    Yes No Don't Know

b. Lung Disease (ex. Bronchitis or Asthma)

    Yes No Don't Know

c. High Blood Pressure

    Yes No Don't Know

d. Depression or Psychiatric Disorders

    Yes No Don't Know

19. Do you suffer from:

a. Chest Pain

    Yes No Don't Know

b. Shortness of Breath

    Yes No Don't Know

c. Any recent illness

    Yes No Don't Know

d. A tendency to, or excessive bleeding (ex. Easy Bruising or Nosebleeds)

    Yes No Don't Know

e. Heartburn, Regurgitation or Esophagitis

    Yes No Don't Know

20. Have you ever received a steroid medication in the last year? (ex. Prednisone, Cortisone, ACTH) (<u>oral or injections</u>)

    Yes No Don't Know

21. Have you ever had a reaction or complication to a local anesthetic ("freezing" medication)?

    Yes No Don't Know

22. Do you have loose or false teeth?

    Yes No Don't Know

23. Are you allergic to any medications? If so, list:

_____

_____

_____

_____

24. Please list any medication you are taking, or include a list on a separate page:

_____

_____

_____

_____

_____

25. Please list any blood thinner medication you are taking:

ASA (Aspirin) Warfarin (Coumadin)

Apixaban (Eliquis) Rivaroxaban (Xarelto)

Dabigatran (Pradaxa) Plavix,

Edoxaban (Savaysa) Enoxaparin / Heparin,

Other:_____ None (I am not taking any)

26. Please list any major operations and medical conditions:

    _____
    _____
    _____
    _____
    _____
    _____

27. Do you currently, or have you ever regularly smoked (cigarettes / cannabis)?

    Yes No

    if yes, indicate if you currently smoke:

    Yes or Quit

    *how long ago, and how many years did you smoke for:*_____

28. Do you currently, or have you ever regularly (daily or almost daily) consumed alcohol?

    Yes No

    if yes, indicate if you currently consume alcohol:

    Yes or quit

    *If yes, please estimate how many alcohol drinks do you currently consume per week:*_____

29. What is your weight? _____

30. What is your height? _____

31. Emergency contact name and phone number:

    _____

Psychology Intake Form

Name: _____
Date of Birth:_____

Many people experience emotional difficulties as a result of their chronic pain. Please indicate which of the following common occurrences you experience.

YES NO

- disturbing nightmares
- frequent sadness or crying
- sleeping difficulties, including trouble falling asleep or staying asleep
- increased fear while being in or around cars
- changes in appetite
- increased stress in your relationships with others
- feeling tense, worried or nervous
- difficulties with concentration and getting things done
- low energy, including less interest in previously enjoyed activities
- memory problems
- irritability, frustration or outbursts of anger
- difficulty coping with the pain
- efforts to avoid situations that are associated with ……
- flashbacks or intrusive thoughts of ……..

Date: _____

Signature of Patient, Parent or Guardian: _____

Your Gender: Male Female

Do you have a family history (e.g. parents, siblings, children etc.) of substance abuse involving any of the following?

- Alcohol Yes No
- Prescription drugs Yes No
- Drugs (e.g. cocaine, ecstasy, marijuana etc.) Yes No

Do you have any history yourself of substance abuse, or have you been diagnosed with a substance abuse disorder involving any of the following?

- Alcohol Yes No
- Prescription drugs Yes No
- Drugs (e.g. cocaine, ecstasy, marijuana etc.) Yes No

Your age: 16-45 over 45

Do you have, or have you ever been diagnosed with any of the following:

- attention-deficit/hyperactivity disorder
- obsessive compulsive disorder
- bipolar disorder
- schizophrenia

Yes No

Do you have, or have you ever been diagnosed with depression?

Yes No

We understand that this may be a sensitive matter, and your answer will be treated in the strictest confidence within your family circle of care, however it is important in your assessment. Do you have a history of preadolescent abuse?

None Physical Emotional Sexual