



Pain Care
 6420 Clayton Road
 St. Louis, MO 63117
 Phone 314-768-8491

Through our exceptional
 health care services,
 we reveal the healing
 presence of God.

SSM Health Pain Care New Patient Questionnaire

***Please bring current list of your medications to your scheduled visit.**

Name: _____ **DOB:** _____

Referring Physician: _____ **Primary Care:** _____

Chief complaint / Location of pain: _____

How long have you had this pain? # of years _____ # of Months _____ # of days _____

What do you rate your pain today? 1 2 3 4 5 6 7 8 9 10 (Out of 10)

What was your worst pain in the last 30 days? 1 2 3 4 5 6 7 8 9 10 (Out of 10)

What caused you pain? (Circle all that apply)

Work injury Motor Vehicle Accident Pedestrian Accident Fall Lifting Heavy Object Twisting Bending Nothing
 No Trauma/Injury Gradual Worsening

Other, please explain: _____

How do you describe your pain? (Circle all that apply)

Shooting Dull Sharp Burning Throbbing Aching Electric Shock Stabbing Other: _____

Do you have any other symptoms associated with this pain? (Circle all that apply)

Numbness Weakness Tingling Headache Bowel/bladder issues Nausea/Vomiting NONE

What makes the pain worse? (Circle all that apply)

Coughing Sitting Physical Activity Exercise Walking Standing Lying Down Weather Changes Bright Lights Nois
 Cold Driving/Riding in Car Touch Rolling in Bed Moving from Sit to Stand Taking Stairs Stress/Fatigue Sexual
 Activity Menstrual Cycle

Which factors relieve the pain? (Circle all that apply)

Sitting Standing Lying Down Stretching Heat Ice Walking Activity Modification Medicine Massage
 Relaxation Nothing

The quality of pain is: (Circle all that apply)

Mild Moderate Severe Intermittent Constant

My pain is worse in the: (Circle all that apply)

Morning Midday Evening Night Same all the time

What conservative treatments have you tried in the past? (Circle all that apply)

Physical Therapy Aqua Therapy Chiropractic Therapy Acupuncture Occupational Therapy Acupuncture Heat Ice Bed Rest Exercise Surgery TENS Unit Nerve Blocks Nerve Ablation Steroid Injection Epidural Injection Trigger Point Injection Traction Psychotherapy Hypnosis Biofeedback NONE

Have you had physical therapy for *this* issue? YES NO

When was your last session (Month and Year) _____ Where? _____

How many weeks did you attend? _____ Did it? Help the pain Make it worse No change

If you have previously had injections for this pain:

Name of the Office/Doctor: _____ Most Recent Visit: _____

Type of Treatment/Injection: Nerve Block Ablation Cortisone/Steroid Epidural Trigger Point

Did it: Help the pain Make it worse No Change

What medications have you taken/are you taking for pain? (Circle all that apply)

Muscle Relaxers: Flexeril Robaxin/Methocarbamol Soma Tizanidine Baclofen Other: _____

NSAIDs: Aspirin Aleve/Naproxen Diclofenac/Voltaren Ibuprofen Meloxicam/Mobic Toradol
Celebrex Piroxicam Ketoprofen

Other Medications: Gabapentin Lyrica Oral Steroids Tramadol Oxycodone Hydrocodone Morphine
Methadone Dilaudid Cymbalta Lidocaine Patch Other: _____

Are you currently taking a blood thinner? YES NO

If yes, circle all that apply: Aspirin Coumadin Plavix Eliquis Xarelto Pradaxa Lovenox Heparin Effient
Ticlid Aggrenox Pletal Brillanta Other: _____

Who is the prescribing physician for your blood thinner? _____

Have you had any imaging related to this pain? Yes No

If yes, what kind? MRI CT Scan Xray Ultrasound EMG/Nerve Conduction Study Other: _____

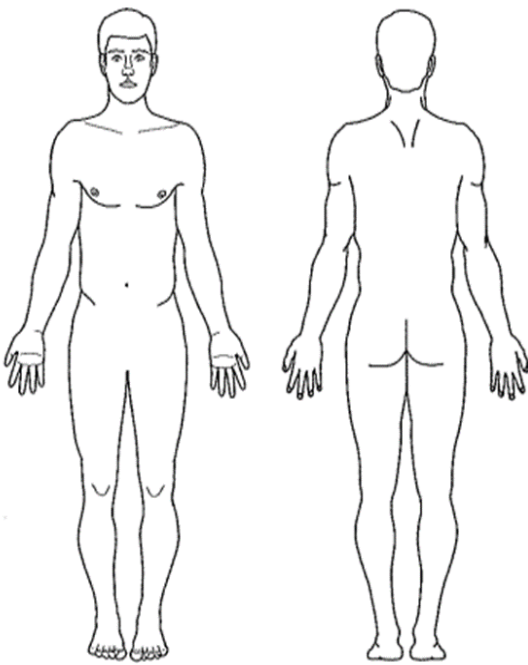
When and where was it performed: _____

If it was outside of SSM, did you bring a copy of the image disc and report with you? Yes No

Surgical History – Please include any spine or joint procedures.

Date	Procedure	Surgeon	Location

Circle your area of pain:



FUNCTIONAL RATING INDEX SCORE TOOL

Pain Intensity

0 – No Pain 1 – Mild Pain 2 – Moderate Pain 3 – Severe Pain 4 – Worst Possible Pain

Sleeping

0 – Perfect Sleep 1 - Mildly disturbed 2 - Moderately disturbed 3 - Greatly disturbed
4 – Totally disturbed

Personal Care (Washing, dressing, etc)

0 – No pain/restrictions 1 – Mild pain/no restrictions 2 – Moderate pain/need to go slowly 3 – Moderate pain/need some assistance 4 – Severe pain/need 100% assistance

Travel (driving, etc)

0 – No pain on long trips 1 – Mild pain on long trips 2 – Moderate pain on long trips
3 – Moderate pain on short trips 4 – Severe pain on short trips

Work

0 – Can do usual work plus unlimited extra work 1 – Can do usual work/no extra work
2 – Can do 50% of usual work 3 – Can do 25% of usual work 4 – Cannot work

Recreation

0 – Can do all activities 1 – Can do most activities 2 – Can do some activities
3 – Can do a few activities 4 – Can't do any activities

Frequency of Pain

0 – No pain 1 – Occasional pain/25% of day 2 – Intermittent pain/50% of day
3 – Frequent pain/75% of day 4 – Constant pain/100% of day

Lifting

0 – No pain with heavy weight 1 – Increased pain with heavy weight 2 – Increased pain with moderated weight 3 – Increased pain with light weight 4 – Increased pan with any weight

Walking

0 – No pain/any distance 1 – Increased pain after 1 mile 2 – Increased pain after ½ mile
3 – Increased pain after ¼ mile 4 – Increased pain with all walking

Standing

0 – No pain after several hours 1 – Increased pain after several hours
2 – Increased pain after 1 hour 3 – Increased pain after ½ hour
4 – Increased pain with any standing

Total Score