Name: _____ DOB: _____

History of Present Illness

History of Present Illness-Chief Complaint

What is bothering you today?

_____

_____

_____

_____

_____

Are there any symptoms associated with your pain (check all that apply)?

☐ Numbness	☐ Tenderness of affected area	☐ Redness
☐ Weakness	☐ Pain with only a light touch	☐ Tingling
☐ Urinary Incontinence	☐ Cool, pale skin	☐ Sleeplessness
☐ Incontinence of bowel	☐ Swelling	☐ Constipation

Other (describe): _____

_____

_____

_____

History of Present Illness-Location(s) of Your Pain

Describe the location(s) of your pain: _____

_____

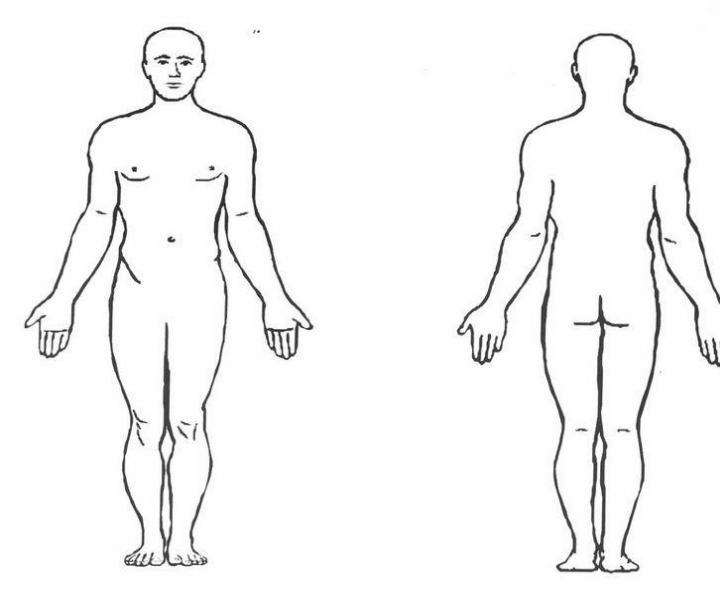
_____

_____

_____

_____

On the diagram, SHADE in the areas where you feel pain.



Please list areas in order of greatest to least pain.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

History of Present Illness-Quality of Pain

Describe the characteristics of your pain (check the box in each column that best describes your average pain in the past month).

Intensity

- ☐ Excruciating
- ☐ Intolerable
- ☐ Very intense
- ☐ Extremely strong
- ☐ Severe
- ☐ Very strong
- ☐ Intense
- ☐ Strong
- ☐ Uncomfortable
- ☐ Moderate
- ☐ Mild
- ☐ Weak
- ☐ Very weak
- ☐ Just noticeable
- ☐ Extremely weak
- ☐ None

Reaction

- ☐ Agonizing
- ☐ Intolerable
- ☐ Unbearable
- ☐ Awful
- ☐ Miserable
- ☐ Distressing
- ☐ Unpleasant
- ☐ Uncomfortable
- ☐ Tolerable
- ☐ Bearable
- ☐ None

Sensation

- ☐ Piercing
- ☐ Stabbing
- ☐ Shooting
- ☐ Burning
- ☐ Grinding
- ☐ Throbbing
- ☐ Cramping
- ☐ Aching
- ☐ Stinging
- ☐ Squeezing
- ☐ Numbing
- ☐ Itching
- ☐ Tingling
- ☐ None

History of Present Illness-Severity of Pain

1. Rate your pain by circling the number to best describe your pain at its WORST in the past month.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be

2. Rate your pain by circling the number to best describe your pain at its LEAST in the past month.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be

3. Rate your pain by circling the number to best describe your pain on AVERAGE.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be

4. Rate your pain by circling the number to best describe your pain RIGHT NOW.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be

History of Present Illness-Duration of Pain

How long have you had the pain problem you are currently experiencing?

_____ Days _____ Weeks _____ Months _____ Years

What caused your current pain to start? _____

_____

_____

How often do you have pain? (circle one)

a. Constantly (80-100% of time)
b. Nearly Constant (50-80% of time)
c. Intermittently (25-50% of time)
d. Occasionally (less than 25% of time)

History of Present Illness-Timing of Pain/Alleviating and Aggravating Factors

What kinds of things make your pain feel better? _____

_____

_____

_____

What kinds of things make your pain feel worse? _____

_____

_____

History of Present Illness-Previous Adjuvant Therapy

For each treatment listed below that you have tried, choose ONE number indicating the result:

1. No relief or pain worsened
2. Some relief-temporary
3. Some relief-permanent
4. Complete relief-temporary

☐ Acupuncture
☐ Biofeedback
☐ Chiropractor
☐ Epidural Steroid Injection
☐ Exercise
☐ Brace
☐ Heat ☐ Cold Treatment
☐ Hospital Bed Rest
☐ Hypnosis
☐ Nerve Block
☐ Physical Therapy
☐ Collars
☐ Psychotherapy
☐ Surgery
☐ TENS (Elec Stim)
☐ Traction
☐ Ultrasound
☐ Corset
☐ Other (specify): _____

History of Present Illness-Previous Medications

Check all of the medication(s) you have tried for your current pain problem. Using the scale below, indicate the amount of relief obtained.

1. No relief or pain worsened
2. Some relief-temporary
3. Some relief-permanent
4. Complete relief-temporary

_____ Acetaminophen

☐ Acetaminophen

_____ NSAIDs

☐ Aleve ☐ Anaprox ☐ Aspirin ☐ Cataflam ☐ Celebrex
☐ Clinoril ☐ Daypro ☐ Dolobid ☐ Feldene ☐ Ibuprofen
☐ Indocin ☐ Lodine ☐ Mobic ☐ Motrin ☐ Naprosyn
☐ Nuprin ☐ Relafen ☐ Tolectin ☐ Voltaren
☐ Other: _____

_____ Oral Narcotics

☐ Codeine ☐ Dilaudid ☐ Kadian ☐ Lorcet ☐ Lortab

☐ Methadone ☐ Morphine ☐ MS Contin ☐ Norco ☐ Opana

☐ Oxycodone ☐ OxyContin ☐ Percocet ☐ Percodan ☐ Talacen

☐ Talwin ☐ Tylenol #3 ☐ Tylox ☐ Vicodin

☐ Other: _____

_____ Narcotic Patches

☐ Duragesic/Fentanyl

_____ Antidepressants

☐ Celexa ☐ Cymbalta ☐ Desyrel ☐ Effexor ☐ Elavil

☐ Fetzima ☐ Lexapro ☐ Luvox ☐ Nardil ☐ Paxil

☐ Pristiq ☐ Prozac ☐ Savella ☐ Serzone ☐ Tofranil

☐ Trazodone ☐ Viibryd ☐ Wellbutrin ☐ Zoloft

☐ Other: _____

_____ Barbiturates

☐ Fioricet/Fiorinal ☐ Nembutal ☐ Seconal

_____ Sleeping Medications (including some benzodiazepines)

☐ Ambien ☐ Chloral Hydrate ☐ Dalmane ☐ Halcion ☐ Lunesta

☐ Restoril ☐ Rozerem ☐ Sonata

☐ Other: _____

_____ Injectable Narcotics

☐ Demerol ☐ Morphine

_____ Benzodiazepines (anxiety)

☐ Ativan ☐ Klonopin ☐ Librium ☐ Serax ☐ Xanax

☐ Valium ☐ Other: _____

_____ Antipsychotics

☐ Haldol ☐ Risperdal ☐ Thorazine ☐ Seroquel

☐ Other: _____

_____ Muscle Relaxants

☐ Baclofen ☐ Flexeril ☐ Norflex ☐ Parafon Forte ☐ Robaxin

☐ Skelaxin ☐ Soma ☐ Zanaflex

☐ Other: _____

_____ Seizure medications for Neuropathic Pain

☐ Depakote ☐ Lyrica ☐ Neurontin ☐ Tegretol ☐ Topamax

☐ Other: _____

_____ Steroids

☐ Celestone ☐ Decadron ☐ Depo-Medrol ☐ Kenalog ☐ Prednisone

☐ Solu-Medrol

☐ Other: _____

History of Present Illness-Interventional Therapies

☐ Pumps ☐ Stimulators ☐ Steroid Injections ☐ Intramuscular/Spine

☐ Rhizotomy ☐ Spine Surgery ☐ Spinal Facet Blocks

Who and where performed: _____

History of Present Illness-Affect

Would you say that your pain has affected your mood? ☐ Yes ☐ No

Have you ever had any thoughts of wanting to die? ☐ Yes ☐ No

Do you feel tense or worry all the time?	☐ Yes	☐ No
Have you had any panic attacks?	☐ Yes	☐ No
Do you ever feel irritable or angry due to your pain?	☐ Yes	☐ No
Do you ever act in angry or aggressive ways?	☐ Yes	☐ No
Do you presently have any thoughts of harming or hurting anyone?	☐ Yes	☐ No
Do you have any history of mental health treatment?	☐ Yes	☐ No
Have you ever been hospitalized for psychiatric reasons?	☐ Yes	☐ No
Do you feel rested during the day?	☐ Yes	☐ No
Have there been changes in your sleeping pattern during the past two weeks?	☐ Yes	☐ No

History of Present Illness-Activity

Circle the number that best describes how pain has interfered with your:

a. Normal daily activities

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

b. Mood

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

c. Walking ability

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

d. Normal work (includes both work outside the home and housework)

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

e. Sleep

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

f. Family relationships

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

g. Relationship with your spouse/partner

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

h. Social activities with other people

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

i. Enjoyment of life

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

Review of Systems

Check all that apply:

Constitutional:

☐ Fatigue ☐ Weight loss/gain ☐ Night sweats ☐ Fevers

ENT:

☐ Hearing ☐ Smelling ☐ Swallowing ☐ Hoarseness

Cardiovascular:

☐ Chest pain ☐ Wheezing ☐ Skipped beats ☐ Swelling

Respiratory:

☐ Wheezing ☐ Coughing ☐ Sputum

GI:

☐ Belly pain ☐ Constipation ☐ Reflux/burning ☐ Blood in stool ☐ Vomiting

☐ Nausea ☐ Grey or black stools ☐ Yellow jaundice

Renal:

☐ Burning urination ☐ Blood in urine ☐ Foul odor of urine ☐ Frequent Urination

Musculoskeletal:

☐ Pain in joints ☐ Cool hands and/or feet ☐ Swollen or red joints

☐ Cracking or popping of joints

Neurologic:

☐ Headache ☐ Facial pain ☐ Vision loss ☐ Tingling ☐ Numbness

Hematology/Oncology:

☐ Easy Bleeding ☐ Bruising ☐ Feel or look pale ☐ Lumps/bumps that are new

☐ Sore that will not heal

Endocrine:

☐ Hair/Skin changes ☐ Excessive thirst ☐ Frequent urination ☐ Cold or heat intolerance

Psychiatric:

☐ Depression ☐ Anxiety ☐ Insomnia ☐ Nervousness

OB/GYN:

☐ Pregnant ☐ Breast Feeding

Intervention-related questions:

☐ Metal in your body or pacemaker ☐ Coumadin or other blood thinners you forgot to mention

Screening Tools

CAGE Questionnaire

Mark each box that applies

(Yes = 1/No = 0)

1) Have you ever felt you should **C**ut down on your drinking? ☐ Yes ☐ No

2) Have people **A**nnoyed you by criticizing your drinking? ☐ Yes ☐ No

3) Have you ever felt bad or **G**uilty about your drinking? ☐ Yes ☐ No

4) Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)? ☐ Yes ☐ No

Total Score (count "Yes" boxes checked) _____

PEG (**P**ain, **E**njoyment, **G**eneral activity) scale (0-10)

1. What number best describes your **Pain** on average <u>in the past week</u>?

   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, <u>during the past week</u>, pain has interfered with your **Enjoyment** of life?

   0 1 2 3 4 5 6 7 8 9 10

   _____

   (Does not interfere) (Completely interferes)

3. What number best describes how, <u>during the past week</u>, pain has interfered with your **General activity**?

   0 1 2 3 4 5 6 7 8 9 10

   _____

   (Does not interfere) (Completely interferes)

General Anxiety Disorder 7-item (GAD-7) Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column				
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

Opioid Risk Tool

Mark each box that applies:

1) Family History of Substance Abuse:	Alcohol	☐ Yes	☐ No
	Illegal Drugs	☐ Yes	☐ No
	Prescription Drugs	☐ Yes	☐ No
2) Personal History of Substance Abuse:	Alcohol	☐ Yes	☐ No
	Illegal Drugs	☐ Yes	☐ No
	Prescription Drugs	☐ Yes	☐ No
3) Age: Are you between the ages 16 – 45		☐ Yes	☐ No
4) History of Preadolescent Sexual Abuse:		☐ Yes	☐ No
5) Psychological Disease:	Attention Deficit Disorder	☐ Yes	☐ No
	Obsessive Compulsive	☐ Yes	☐ No
	Bipolar	☐ Yes	☐ No
	Schizophrenia	☐ Yes	☐ No
	Depression	☐ Yes	☐ No

Total Score (count “Yes” boxes checked): _____

Pain Disability Index

Pain disability index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst. For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. **A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.**

Family/Home responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Recreation: This category includes hobbies, sports, and other similar leisure-time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Social Activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Self-Care: This category includes activities that involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Life-Support Activity: This category refers to basic life-supporting behaviors such as eating, sleeping and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Personal Health Questionnaire Depression Scale PHQ-9

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (circle one number on each line)

How often during the past 2 weeks were you bothered by:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Add the score for each column				
Total Score (add your column scores) =				

Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R)

The following questions are given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

		Never	Seldom	Sometimes	Often	Very Often
1.	How often do you have mood swings?	0	1	2	3	4
2.	How often have you felt a need for higher doses of medication to treat your pain?	0	1	2	3	4
3.	How often have you felt impatient with your doctors?	0	1	2	3	4
4.	How often have you felt that things are just too overwhelming that you can't handle them?	0	1	2	3	4
5.	How often is there tension in the home?	0	1	2	3	4
6.	How often have you counted pain pills to see how many are remaining?	0	1	2	3	4
7.	How often have you been concerned that people will judge you for taking pain medication?	0	1	2	3	4
8.	How often do you feel bored?	0	1	2	3	4
9.	How often have you taken more pain medication than you were supposed to?	0	1	2	3	4
10.	How often have you worried about being left alone?	0	1	2	3	4
11.	How often have you felt a craving for medication?	0	1	2	3	4
12.	How often have others expressed concern over your use of medication?	0	1	2	3	4
13.	How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
14.	How often have others told you that you had a bad temper?	0	1	2	3	4
15.	How often have you felt consumed by the need to get pain medication?	0	1	2	3	4
16.	How often have you run out of pain medication early?	0	1	2	3	4
17.	How often have others kept you from getting what you deserve?	0	1	2	3	4
18.	How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4
19.	How often have you attended an AA or NA meeting?	0	1	2	3	4
20.	How often have you been in an argument that was so out of control that someone got hurt?	0	1	2	3	4
21.	How often have you been sexually abused?	0	1	2	3	4
22.	How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
23.	How often have you had to borrow pain medications from your family or friends?	0	1	2	3	4
24.	How often have you been treated for an alcohol or drug problem?	0	1	2	3	4

Universal Precaution Compliance Assessment

1. Do you have any prior pending charges and/or convictions?	☐ Yes	☐ No
2. Ever attempted suicide?	☐ Yes	☐ No
3. Suicidal or planning suicide?	☐ Yes	☐ No
4. Any thoughts of suicide in the past or present?	☐ Yes	☐ No
5. Ever made plans for suicide?	☐ Yes	☐ No
6. Ever overdosed?	☐ Yes	☐ No
7. Ever addicted?	☐ Yes	☐ No
8. Drug treatment, rehab, or detox?	☐ Yes	☐ No
9. Drug conviction, indictment, or investigation?	☐ Yes	☐ No
10. Ever bought, sold, or abused drugs?	☐ Yes	☐ No
11. Any recreational drug use?	☐ Yes	☐ No
12. Ever felt you should cut down substance abuse?	☐ Yes	☐ No
13. Ever felt annoyed by others' criticism of your substance use?	☐ Yes	☐ No
14. Ever felt guilty about your substance use?	☐ Yes	☐ No
15. Ever had a morning eye opener to start your day?	☐ Yes	☐ No
16. Have you ever sued or planning to sue any healthcare provider?	☐ Yes	☐ No
17. Have you ever received medications over the internet?	☐ Yes	☐ No
18. Have you ever abused any illegal substances?	☐ Yes	☐ No
19. Have you ever abused any legal substances?	☐ Yes	☐ No
20. Have you ever been diagnosed with schizophrenia, psychosis, hallucinations, major depression, bipolar, antisocial or borderline personality disorder, hepatitis C, AIDS, or liver disease?	☐ Yes	☐ No
21. Do you have or have you ever had any needle track marks on your skin?	☐ Yes	☐ No
22. Has anyone in your family or household had any type of substance abuse or drug problems?	☐ Yes	☐ No

Explain all yes answers:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Treatment Goals

Please select at least two goals from below:

☐ Decreased pain ☐ Improved function ☐ Ability to return to work ☐ Ability to return to school

☐ Complete Evaluation with Vocational Rehab ☐ Other: _____

What specific things do you hope to be able to do with this treatment that you can't do now? (please be specific)

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____