EAST WEST PAIN INSTITUTE, PLLC

425 N Park Blvd, Suite # 201
Lake Orion, MI 46362
Tel: 248-929-8165, Fax: 248-929-8930

NEW PAIN CLINIC PATIENT QUESTIONNAIRE

PLEASE FILL IN BOTH SIDES

Patient's Name: ___________________________________ Date of Birth: _________________ Age: ___

Family Physician: _____________________________ Referring Physician: __________________________

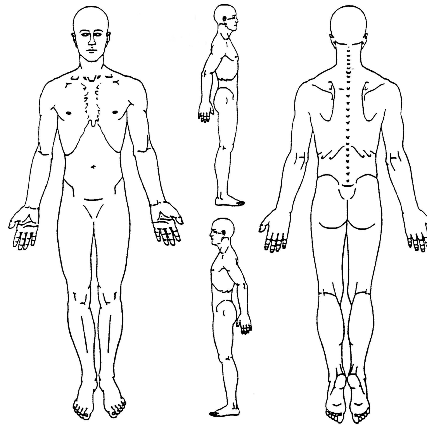
How did your pain problem start:

Any accidents, fall or Injury before pain problems:

How long have you had this pain: _______ Days _______ Weeks _______ Months ________ Years

PAIN LOCATION: **Please mark the painful areas in the diagram**

- ❑ Neck
- ❑ Arms
- ❑ Lower back
- ❑ Legs
- ❑ Upper back
- ❑ Mid back
- ❑ Whole body
- ❑ Wrist
- ❑ Hands



- ❑ Head
- ❑ Shoulder
- ❑ Abdomen
- ❑ Pelvis
- ❑ Hip
- ❑ Knee
- ❑ Ankle
- ❑ Foot
- ❑ Tail bone

PAIN SEVERITY: In a scale of 0 to 10 (0 is no pain and 10 is maximum pain, one can imagine): At present (0-10 pain scale): ______, Pain usually at (0-10 pain scale): _______ Pain Range (lowest to highest):__

TYPE OF PAIN: How do you describe it:

- ❑ Sharp
- ❑ Dull
- ❑ Achy
- ❑ Throbbing
- ❑ Pressing
- ❑ Burning
- ❑ Hot
- ❑ Spasm
- ❑ Cramping
- ❑ Cold
- ❑ Squeezing
- ❑ Lacerating
- ❑ Electric
- ❑ Pinching
- ❑ Tingling
- ❑ Penetrating
- ❑ Pressure
- ❑ Other:

PAIN IS INCREASED BY:

- ❑ Activity
- ❑ Standing
- ❑ Walking
- ❑ Sitting
- ❑ Bending Forward
- ❑ Bending Backward
- ❑ Driving
- ❑ Turning
- ❑ Lifting
- ❑ Reaching
- ❑ Stress
- ❑ Sneezing
- ❑ Coughing

PAIN IS DECREASED BY:

- ❑ Never
- ❑ Resting
- ❑ Lying down
- ❑ Relaxing
- ❑ Sitting
- ❑ Sleep
- ❑ Medication
- ❑ PT
- ❑ Manipulation
- ❑ Reclining
- ❑ Heating pad
- ❑ Others:

DOES THE PAIN MAKE YOU FEEL:

- ❑ Annoyed
- ❑ Miserable
- ❑ Dreadful
- ❑ Unbearable
- ❑ Intense
- ❑ Insecure
- ❑ Troublesome
- ❑ Afraid
- ❑ Terrified
- ❑ Frightened

DO YOU HAVE OR FEEL:

- ❑ No appetite
- ❑ Loss of sleep
- ❑ Loss of energy
- ❑ Lack of interest
- ❑ Feeling of hopelessness

ANY SENSORY LOSS (Any Tingling & or Numbness, any heat or cold sensation problems):
❑No ❑Yes. If yes, where: ____

ANY ARM OR LEG WEAKNESS: ❑No ❑Yes. If yes, where ______________________________

ANY BLADDER OR BOWEL CONTROL PROBLEMS: ❑No ❑Yes. If yes, explain:_______________

ARE YOU USING ANY:

- ❑ None
- ❑ Cane
- ❑ Walker
- ❑ Wheelchair
- ❑ Brace
- ❑ Collar

Type of Brace:

ALLERGY:

CURRENT MEDICATION FOR PAIN CONTROL:

NAME OF MEDICINE with dose	FREQUENCY: How often you take	TOTAL PILLS PER DAY	HOW MUCH PAIN RELIEF			
			No help	Some	Good	Very good

MEDICATIONS USED IN THE PAST (For Pain Control):

- ❑ Tylenol
- ❑ Motrin
- ❑ Naprosyn
- ❑ Aleve
- ❑ Mobic
- ❑ Oral Steroids
- ❑ Darvocet
- ❑ Vicodin
- ❑ Norco
- ❑ Percocet
- ❑ Oxycodone
- ❑ Roxycodone
- ❑ Morphine
- ❑ Dilaudid
- ❑ Methadone
- ❑ Opana
- ❑ Oxycontin
- ❑ MS Contin
- ❑ Fentanyl patch
- ❑ Neurontin
- ❑ Lyrica
- ❑ Cymbalta
- ❑ Topamax
- ❑ Butrans
- ❑ Capsaicin
- ❑ Lidocaine
- ❑ Suboxone

LIST ALL OTHER MEDICATIONS (except pain medications):

Medication with dose	How often you take	Medication with dose	How often you take
1.		2.	
3.		4.	
5.		6.	

Medication with dose	How often you take	Medication with dose	How often you take
7.		8.	
9.		10.	
11.		12.	

ANY BLOOD THINNERS USE: ❑ No ❑ Yes

- ❑ Aspirin **81 or 325**
- ❑ Plavix
- ❑ Coumadin
- ❑ Eliquis
- ❑ Xarelto
- ❑ Effient
- ❑ Brilinta
- ❑ Pradaxa
- ❑ Pletal
- ❑ Lovenox, Dose: Frequency:

Any Physical Therapy In The Past? ❑No ❑Yes. If yes, was it helpful: ❑No ❑Yes ______________________

TENS Unit Use: ❑No ❑Yes. If yes, was it helpful: ❑No ❑Yes ____

Have you been seen by any Neurologist, Neurosurgeon or Orthopedic surgeon? ❑No ❑Yes. If yes, please specify: ____

Have you been seen by any other pain physicians: ❑No ❑Yes. If yes, name and address: ______________

____

List pain procedures/shots in the past: ____

GENERAL HEALTH HISTORY: (CHECK ALL THAT APPLY)

- ❑ Coronary artery disease
- ❑ Heart Attack
- ❑ Irregular Heart Rate
- ❑ Hypertension
- ❑ High Cholesterol
- ❑ Angina
- ❑ Hypothyroid
- ❑ Obstructive sleep apnea (CPAP/ BiPAP use)
- ❑ Asthma
- ❑ COPD /Emphysema
- ❑ Diabetes: Insulin & or pills use
- ❑ Seizures
- ❑ Traumatic Brain Injury
- ❑ Migraines
- ❑ Stroke/TIA
- ❑ Kidney Stone
- ❑ Kidney problems
- ❑ Anemia
- ❑ Fibromyalgia
- ❑ Endometriosis
- ❑ Depression/ Bipolar
- ❑ Anxiety
- ❑ Jaundice
- ❑ Hepatitis A, B, C
- ❑ Cirrhosis
- ❑ Arthritis
- ❑ Peptic ulcer disease
- ❑ GERD/Acid reflex
- ❑
- ❑
- ❑

ANY SURGERY IN THE PAST: (CHECK ALL THAT APPLY)

- ❑ Lumbar spine surgery
- ❑ Cervical spine surgery
- ❑ Thoracic Spine surgery
- ❑ Hip: right left both
- ❑ Knee: right left both
- ❑ Foot: right left both
- ❑ Shoulder: right left both
- ❑ Hand: right left both
- ❑ Cardiac Stents
- ❑ Cardiac Bypass
- ❑ Thoracotomy
- ❑ Tonsillectomy
- ❑ Adenoidectomy
- ❑ Cataract
- ❑ Appendectomy
- ❑ Gall Bladder
- ❑ EGD
- ❑ Colonoscopy
- ❑ Bladder/cystoscopy
- ❑ Prostate
- ❑ C-Section
- ❑ Hysterectomy
- ❑ Tubal Ligation
- ❑ Breast Surgery
- ❑ Pacemaker
- ❑ Defibrillator/AICD
- ❑ Hernia repair: Rt or Lt groin/abdominal
- ❑

HISTORY OF TUMOR OR CANCER: ❑No ❑Yes. If yes, where:

____

Chemotherapy, Radiation, Surgery: if any: ____

Any metastasis/spreading: ❑No ❑Yes. If Yes, Where: ____________________________________

WORK HISTORY: Are you currently working: ❑No ❑Yes. If Yes, type of Job: ____________________

If not working, last time worked: ___________________________ Total no of years worked:______

Why did you leave:____

Highest level of Education:____

DOMESTIC SITUATION: With whom do you live? _____________ Children: ❑No ❑Yes. Ages: _____

Are there any substance abuse issues in your household? ❑No ❑Yes. If yes, expain?_______________

Are you able to take care of yourself? ❑No ❑Yes ____

Married: ❑No ❑Yes. Separated: ❑No ❑Yes. Divorced: ❑No ❑Yes._________________________

SUBSTANCE USES:

Tobacco: ❑No ❑Yes. Pack per day: ________. No of years smoking: _________________________

Quit: ❑No ❑Yes. When: ____

Alcohol: ❑No ❑Yes. How much:________________________ Quit: ❑No ❑Yes. When:__________

Marijuana:❑No ❑Yes. How frequently: __________________. No of years using: ________________

Quit: ❑No ❑Yes. When: ____

Are you **USING** any of the following: ❑Cocaine, ❑Heroin, ❑Amphetamines, ❑Barbiturates ❑_______

DID you USE any of the following: ❑Cocaine, ❑Heroin, ❑Amphetamines, ❑Barbiturates ❑_______

If quit, last time use:

FAMILY HISTORY:

CHECK ALL THAT APPLY:

- ❑ Edema
- ❑ Cyanosis
- ❑ Hiccup
- ❑ Shortness of Breath
- ❑ Nausea
- ❑ Vomiting
- ❑ Constipation
- ❑ Diarrhea
- ❑ Weight gain
- ❑ Weight loss
- ❑ Jaundice
- ❑ Confusion
- ❑ Headache
- ❑ Lack of sleep
- ❑ Depression
- ❑ Bleeding disorder
- ❑ Car Accident
- ❑ Suicidal idea
- ❑ Chest pain
- ❑ Angina
- ❑ Visual problems
- ❑ Urinary problems
- ❑ Dizziness
- ❑ Rashes
- ❑ Stomach Pain
- ❑ Seizures
- ❑ Anemia
- ❑ Chronic fatigue
- ❑ Sexual difficulty
- ❑ Swallowing difficulty
- ❑ Fracture: where:

____ ____________________

Signature of the patient/ Patient's representative/ Legal guardian Date and Time