Iron County Hospital
301 North Highway 21 ● P.O. Box 548 ● Pilot Knob, MO. 63663

PAIN MANAGEMENT
PATIENT HEALTH QUESTIONNAIRE

Please check the appropriate box and fill in the blanks(s) as needed.

Date: _____

Patient Name: _____ Date of Birth: _____

Please complete the questionnaire as fully as possible to assist us with your evaluation and treatment. **Please return to our office before your appointment.** Please reach each question carefully and answer to the best of your ability. This information is part of your medical recorded, and will not be released without your permission.

Referring Provider: _____ Phone Number: _____

Primary Provider: _____ Phone Number:_____

Briefly describe your pain that you were referred here for:

_____

_____

_____

When did your pain first begin? (date): _____

Under what circumstances did the pain begin:

☐	Accident at work	☐	At work, but not an accident
☐	Accident at home	☐	Auto accident
☐	Following surgery	☐	Following an illness
☐	Pain just began	☐	Other reason: _____

Briefly describe the circumstance(s) you checked:

_____

_____

Are you receiving compensation or disability payments now? ☐ Yes ☐ No

Are you involved in a lawsuit because of you pain or injury? ☐ Yes ☐ No

Have you contacted a lawyer because of you pain or injury? ☐ Yes ☐ No

What are your expectations from the Pain Center?

_____

_____

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How does your pain affect your activities of daily living?

- ☐ Does not inerfere
- ☐ Mildly interferes
- ☐ Somewhat interferes
- ☐ Greatly interferes
- ☐ Completely interferes

Do you use one of the following?

- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Brace

Please answer the following questions regarding your pain. These questions are based on the pain scale with 0 having no pain and 10 the worst pain possible.

What is your pain level at the present time? _____

What is your pain level at its worst? _____

What is your pain level at its least? _____

What is your average pain level? _____

Which word (or words) best describes the patterns of your pain?

- ☐ Comes and goes
- ☐ Always present

Is your pain usually **WORSE** during a certain time of day? ☐ Yes ☐ No

If yes, when? _____

Is your pain ususally **BETTER** during a certain time of day?

If yes, when? _____

Please describe your pain. Check all that apply.

- ☐ Throbbing
- ☐ Stabbing
- ☐ Gnawing
- ☐ Aching
- ☐ Tender
- ☐ Tingling
- ☐ Dull
- ☐ Catching
- ☐ Shooting
- ☐ Cramping
- ☐ Hot-Burning
- ☐ Piercing
- ☐ Numbness
- ☐ Tiring-Exhausting
- ☐ Stiffness
- ☐ Other: _____

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Please Check how your pan reacts to the following:

	Better	Worse	No Change
Straining at stool			
Twisting			
Change in position			
Walking			
Lifing			
Bending (back and forward)			
Lying flat			
Weather/Temperature Change			
Standing			
Sitting			
Stress/Worry			
Heat			
Ice			
Rest			
Medications			
Light touch			
Coughing			
Sneezing			
Straining			
Physicial Therapy			

Where is your pain?

Using the symbols listed below, mark on the drawings the areas where you feel pain. If you feel more than one sensation in the same area, mark over that area with additional symbols that apply. Show all affected areas.

Symbols:

___ = Numbness

000 = Pins and needles

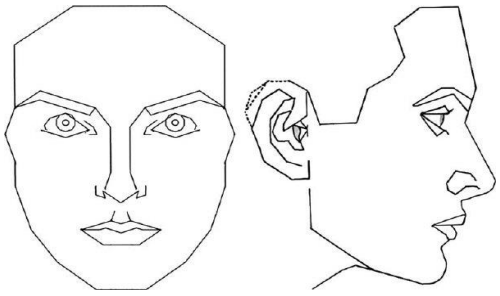
Xxx = Burning

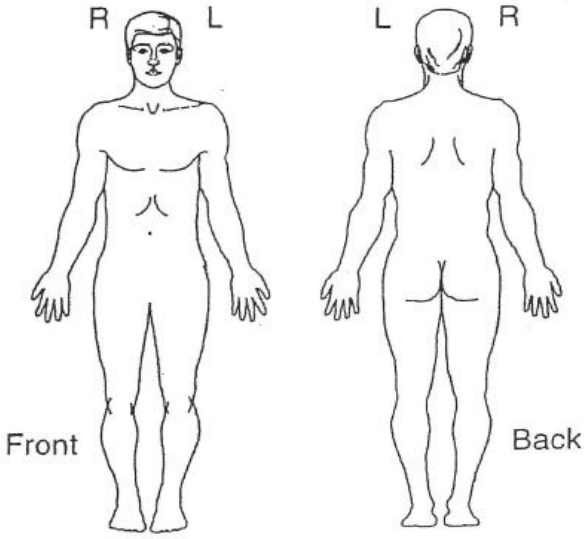
/// = Stabbing

+++ = Aching

E = External (on or outside of body)

I = Inside (inside of body





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During the past month, how much did pain interfere with the following activities? Check the box for each of the questions that best describes your situation.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Driving					
Performing household chores i.e. sweeping/vacuuming					
Yard work or shopping					
Socializing with friends					
Recreation and hobbies					
Having sexual relations					
Physical Exercise					
Sleep					
Appetite					
Bathing					
Cooking					
Childcare					
Work					

PRIOR TREATMENTS:

Prior Treatments for your pain, check all the boxes that apply:

	Helpful	Not Helpful
Surgery		
Epidural Steroid Injections/or other injections		
TENS UNIT/MENS		
Physical Therapy		
Occupational Therapy		
Biofeedback/Relaxation Therapy		
Acupuncture		
Chiropractor		
Other Pain Centers		
Professional Psycholgical Support		
Other: _____		

DIAGNOSTIC TESTS:

	Date	Facility
MRI		
CT Scan		
X-Ray		
EMG		
Nerve Conduction Study		

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Please check all conditions which you currently have:

General
- ☐ Fever
- ☐ Fatigue
- ☐ Obesity
- ☐ History of falls
- ☐ Hisotry of MRSA
- ☐ Weight loss/gain
- ☐ Poor appetite
- ☐ Increased sleep
- ☐ Decreased sleep

Eyes/Ears/Nose/Mouth/Throat
- ☐ Eye pain
- ☐ Glaucoma
- ☐ Glasses or contacts
- ☐ Blurred vision
- ☐ Double vision
- ☐ Color blindness
- ☐ Vision loss
- ☐ Ear discharge
- ☐ Hearing difficulty or aid
- ☐ Face pain
- ☐ Nose congestion
- ☐ Nose bleeds
- ☐ Dentures
- ☐ Oral ulcers
- ☐ Hoarseness
- ☐ Ringing or pain
- ☐ Nose drainage
- ☐ Chronic Sinusitis
- ☐ TMJ
- ☐ Sore throat

Neck
- Neck pain
- Neck stiffness
- Swollen glands

Cardiovascular
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Heart stent
- ☐ Pacemaker
- ☐ PVD
- ☐ Swelling of ankles
- ☐ CHF
- ☐ Irregular heart beats
- ☐ Murmur
- ☐ Leg cramps
- ☐ Shortness of breath on exertion
- ☐ Cold upper extremities
- ☐ Cold lower extremities

Respiratory
- ☐ Painful breathing
- ☐ Productive cough
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Asthma
- ☐ COPD

Breast
- ☐ Breast pain
- ☐ Breast swelling
- ☐ Breast mass

Gastronintestinal
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Nausea and vomiting
- ☐ Constipation
- ☐ Ulcers
- ☐ Balck bloody stools
- ☐ Pain with bowel movement
- ☐ Incontinence of stool
- ☐ Hiatal hernia
- ☐ Diarrhea

Genitourinary
- ☐ Painful urination
- ☐ Urinary incontinence
- ☐ Frequency
- ☐ Hesitancy
- ☐ Blood in urine
- ☐ Sexually transmitted disease
- ☐ Excessive menstrual bleeding
- ☐ Painful intercourse

Musculoskeletal
- ☐ Arthritis
- ☐ Muscle pain
- ☐ Swollen joints
- ☐ Fibromyalgia
- ☐ Back pain
- ☐ Low back pain
- ☐ Osteoarthritis
- ☐ Pain in feet
- ☐ Rheumatoid arthritis
- ☐ Gout

Integumentary (skin)
- ☐ Rash
- ☐ Bruise
- ☐ Skin change in color
- ☐ Itching
- ☐ Shingles

Neurological
- ☐ Headache
- ☐ Seizures
- ☐ Stroke
- ☐ Weakness/numbness/tingling
- ☐ Dizziness
- ☐ Confusion
- ☐ Multiple sclerosis
- ☐ Trouble walking
- ☐ Tremors
- ☐ Neuropathy
- ☐ Weakness in extremities

Psychiatric
- ☐ Memory loss
- ☐ Depression
- ☐ Irritability
- ☐ Alzheimer's
- ☐ Anxiety/panic attacks
- ☐ Thoughts of suicide
- ☐ BI-Polar
- ☐ Inability to concentrate

Endocrine
- ☐ Sweats
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Libido change

Hemotolgic/Lymphatic/Immunological
- ☐ Leukemia
- ☐ Bleeding disorder
- ☐ Hepatitis
- ☐ Easy bruising
- ☐ AIDS/HIV
- ☐ Cancer:_____
- ☐ Use of blood thinners
- ☐ Blood clot
- ☐ Anemia

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Family Medical History

Has anyone in your family ever had any of the following conditions? Please check all that apply.

	Father	Mother	Brother	Sister	Grandparent
Anxiety					
Cancer					
Chronic pain					
Depression/Mental illness					
Diabetes					
Disability					
Drug Addition/Abuse					
Heart Disease					
High Blood Pressure					
Physical/Verbal Abuse					
Stroke					
Suicide					
Thryoid disease					
Cause of Death					

Other Medical History/Past Surgeries

Other Medical Conditions Now or Past	Surgeries	Date

Do you have any medical devices implanted in your body? ☐ Yes ☐ No

(i.e. pacemaker, port-a-cath, pump, rods, prosthesis, stimulator, etc.) _____

Allergies

Allergies/Sensitivities	Reaction	Allergies/Sensitivities	Reaction

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Current Pain Medications			
Date Started	Medication	Dose/How Often do you take medication?	Benefit

Are you afraid of becoming addicted to your medicaitons? ☐ Yes ☐ No

Are you on any blood thinners? ☐ Yes ☐ No

Other Current Medications:

Date Started	Medication	Dose/How Often do you take medication?

Previous Pain Medications:		
Previous medicaiton taken for pain **(Important please contact your physician or pharmacy for list)**		

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Psychosocial

Significant other: _____

Relationship: _____

Do you take care of other family members? ____ Yes ____ No

(i.e. parents, children, etc.) _____

Do you live alone? ____ Yes ____ No

Education level: _____

Are you currently working? ____ Yes ____ No If no, why? _____

Previous/Current Occupation: _____

Do you smoke? ____ Never ____ Previously, but quit on: _____

Number of years smoking? ____ Number of packs per day? ____

Have you ever used recreational drugs? ____ Yes ____ No

If yes, please indicate what drugs: _____

Do you drink alcohol? ____ Yes ____ No If yes, how often? ____ Never ____ Currently ____ Daily ____ Rarely

How much per week? _____ Previously, but quit on: _____

Have you ever been in a 12 step recovery program? ____ Yes ____ No

Psychosocial

Please check which describes how you have been feeling:

During the pas month have you been tense or anxious?

____ Never ____ Seldom ____ Sometimes ____ Frequently ____ Always

During the past month have you been depressed or discouraged?

____ Never ____ Seldom ____ Sometimes ____ Frequently ____ Always

Hospital Admission for Mental Illness? ____ Yes ____ No

During the past month have you been irritable or upset?

____ Never ____ Seldom ____ Sometimes ____ Frequently ____ Always

When you are in pain, how often is your husband/wife/other family supportive and encouraging?

____ Never ____ Seldom ____ Sometimes ____ Frequently ____ Always

When you are in pain, how often does your husband/wife/other family ignore you or become angry?

____ Never ____ Seldom ____ Sometimes ____ Frequently ____ Always

Form completed by (Patient/Other): _____ _____

Signature Relationship

Date/Time: _____

PLEASE BRING THE COMPLETED QUESTIONNAIRE WITH YOU TO YOUR NEXT APPOINTMENT.