Advanced Pain Treatment Center
INNOVATIVE HELP FOR MANAGING YOUR PAIN

BACKGROUND QUESTIONNAIRE

Name _____ Date:_____ DOB: _____ Sex : ☐ M ☐ F
Last First MI

Primary Care Physician:_____ Telephone #_____

Address of PCP: _____ REFERRED BY ☐ PCP OR ☐ _____

Please answer all questions very carefully and as completely as possible, as it would allow me to understand your problem and help me formulate a good treatment plan for you. Your response will be considered strictly confidential as per HIPPA laws. Please clearly circle or put check marks where indicated. Please fill out all pages (1 – 8). Thank you for your cooperation. For any additional information, please use *additional section* in page 8.

PRAGYA B. GUPTA, M.D., F.R.C.S., D.A.B.P.M.

ARE YOU ALLERGIC TO ANY MEDICATION ☐ YES OR ☐ NO, IF YES PLEASE PROVIDE THE NAMES BELOW.

MEDICATION / ALLERGEN	REACTION	MEDICATION /ALLERGEN	REACTION
1		3	
2		4	

PAIN DIAGRAM:

1. Please shade in the location of your pain and put an X on the area that hurts the most and also for abnormal sensation mark as directed in the diagram below.

For Pins and needle mark XXXXX For aching and cramping \\\\\\ For stabbing ZZZZZ
For Numbness mark ++++++ For Burning mark BBBBBBB Other OOOOO

% OF NECK PAIN;

% OF ARM PAIN:

R L

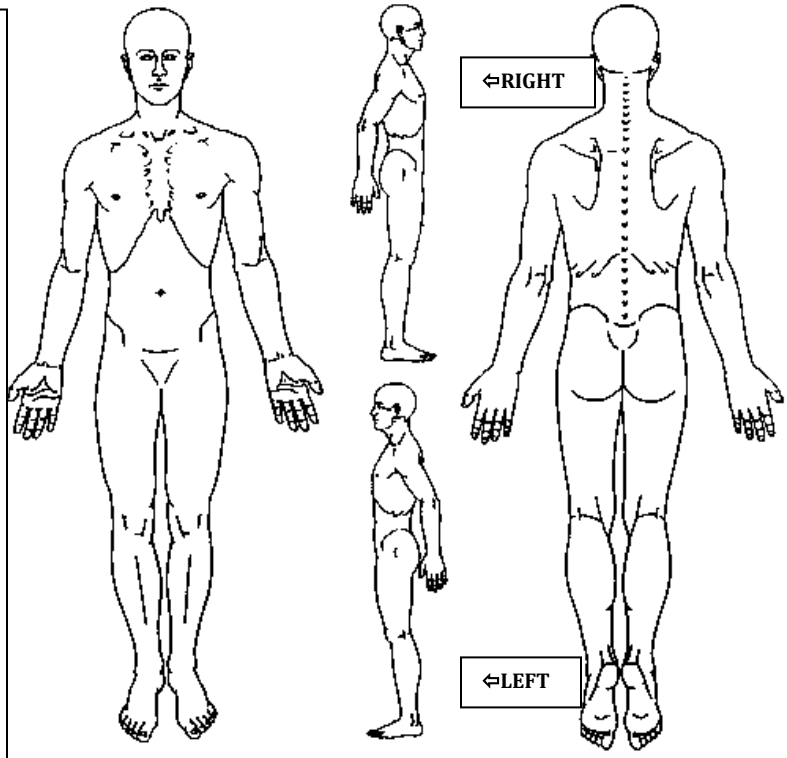
% Of THORACIC PAIN

_____

% of BACK PAIN:

% of LEG PAIN:
R L

% ABDOMEN/ PELVIC/GROIN AND OTHER PAIN:



MMPQ questionnaire: FOR THEMOST SIGNIFICANT SYMPTOM ONLY				
Quality of pain	None	Mild	Moderate	Severe
Throbbing	0	1	2	3
Shooting	0	1	2	3
Stabbing	0	1	2	3
Sharp	0	1	2	3
Cramping	0	1	2	3
Gnawing	0	1	2	3
Hot – Burning	0	1	2	3
Heavy	0	1	2	3
Tender	0	1	2	3
Splitting	0	1	2	3
Tiring/Exhausting	0	1	2	3
Sickening	0	1	2	3
Fearful	0	1	2	3
Punishing / Cruel	0	1	2	3
SCORE:				

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2. What is the problem that you would like us to help you with (chief complain)?

_____

_____

_____

3. If you have more than one problem, please indicate first the most severe one followed by less severe ones :

_____

_____

_____

4. PAIN ASSESSMENTS (PEG):

I. **What number best describes your pain on average in the past week :**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere --mild----------I I----------moderate--------I I----severe------- pain as bad as you can imagine)

II. **What number best describes how, during the past week, pain has interfered with your enjoyment of life?**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere mild----------I I----------moderate--------I i--------severe------- completely interferes

III. What number best describes how, during the past week, pain has interfered with your general activity (such as ability to do your household work, activities of daily living, e.g., taking care of yourself etc.)?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere mild----------I I----------moderate--------I I-------severe------- completely interferes

PEG **AVERAGE SCORE:**

5. **PHQ – 2**

Over the past two weeks, how often have you been bothered by any of the following problems?	**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**

Score: _____ If the score is > 3 then have the patient fill out **PHQ – 9.**

6. HOW LONG HAVE YOU HAD THIS PAIN FOR (DURATION): _____

7. ONSET OF PROBLEM: ☐ SUDDEN ☐ INSIDIOUS OR GRADUAL

8. FREQUENCY OF PAIN: ☐ CONSTANT ☐ INTERMITTENT

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9. DIURNAL VARIATION: WHEN IS THE PAIN WORSE?

☐ MORNING ☐ NOON ☐ EVENING ☐ ALL DAY

10. DOES THE PAIN WAKE YOU UP FROM SLEEP? ☐ YES ☐ NO

11. CONTEXT:

DATE OF ONSET OF PAIN IF KNOWN: _____

What triggered or started pain? _____

If it is work related injury, please give date of injury: _____

If it is from MVA or AUTO accident: Date of Injury _____

12. Which of the following factors RELIEVE S or WORSEN your pain?

ONLY FOR BACK PAIN	RELIEVING FACTOR	WORSENING FACTOR	NO EFFECT
SPONTANEOUSLY			
STANDING			
SITTING			
WALKING			
LEANING OVER			
LEANING BACKWARD			
LYING			
RESTING			
RISING FROM CHAIR			
HEAT			
COLD			
ANXIETY			
MASSAGE			
PHYSICAL ACTIVITY			
ALCOHOLIC BEVERAGES			
COUGHING			

ONLY FOR NECK PAIN	RELIEVING FACTOR	WORSENING FACTOR	NO EFFECT
SPONTANEOUSLY			
ROTATION OF NECK TO LEFT			
ROTATION OF NECK TO RIGHT			
BENDING OF NECK TO RIGHT			
BENDING OF NECK TO LEFT			
BENDING OF NECK FORWARD			
BENDING OF NECK BACKWARD			
RAISING ARM OVER HEAD			
RESTING OR LYING ON LEFT SIDE			
RESTING OR LYING ON RIGHT SIDE			

13. ACTIVITIES LIMITED BY YOUR PAIN (PLEASE ☑ APPROPRIATE RESPONSE):

	SIGNIFICANT	MODERATE	MINIMAL	NO EFFECT
WALKING				
SITTING				
STANDING				
BENDING				
TWISTING				
LYING				

14. WALKING ABILITIES:

How many blocks can you walk?	More than 3 blocks	Up to 3 blocks	Less than 1
Does the pain subside after resting completely?	No	Yes	
Is the pain worse while going upstairs?	Yes	No	
I s the pain worse while going down stairs?	Yes	No	
Does Leaning over reduces pain?	Yes	No	

15. Do you have the following associated symptoms?

Weakness	Arms/ hands	Legs/ feet	none
Numbness (loss of feeling)	Arms/ hands	Legs/feet	none
Tingling (falling asleep)	Arms/ hands	Legs/ feet	None

16. Bladder control (urine) (please check the appropriate box)
☐No Problem ☐Can't empty bladder ☐Loss of Urine (accidents)

17. Bowel Control; Please check the appropriate box.
☐ No Problem ☐Constipation ☐Loss of control (accidents).

18. What treatment have you had for the current problem? Circle appropriate answer and give the date of last treatment.

Physical therapy ☐Yes / ☐No **Helped / Did not help / Worsened pain, Date:** _____
Chiropractic treatment ☐Yes/ ☐No **Helped/ Did not help / Worsened pain: Date:** _____
Nerve block / Epidural ☐Yes/ ☐No **Helped/ Did not help / Worsened pain, Date:** _____
Psychological Consultation and treatment; Yes/ No. If yes please give details including the name of the treating Psychologist or Psychiatrist _____

19. What diagnostic procedures have you had so far?
1. _____ None
2. X- rays: ☐Yes/ ☐No If yes which body part and date?_____
3. MRI Scan ☐ Yes/ ☐No, If yes which body part and date?_____
4. CT Scan ☐Yes/☐ No, If yes which body part and date?_____
5. Myelogram: ☐Yes/ ☐No. If yes which body part and date?_____
6. Discogram: ☐Yes/ ☐No: Neck/ upper back/ lower back and date?_____
7. EMG and NCS; ☐Yes / ☐No If yes ? date and where was it done?_____
8. Bone Scan: ☐Yes/ ☐No Date? _____
9. DEXA Scan: ☐Yes/ ☐No Date of your last scan_____

20. Have you had SURGERY ON YOUR SPINE OR BACK? If yes please give details.

WHAT SURGERY	DATE	SURGEON/ HOSPITAL/ CITY	Did it help?
			Yes/ No
			Yes/ No
			Yes/ no
			Yes/ No

21. List any surgery OTHER THAN SPINE SURGERY:

WHAT SURGERY	DATE	SURGEON/ HOSPITAL/ CITY	Did it help?
			Yes/ No
			Yes/ No
			Yes/ No
			Yes/ No
			Yes/ No

22. List of all Medication that you are taking including pain medication, over the counter medication and herbals.

Medication	Reason taken	How often	Prescriber's name
Pain medication used in past:			

23. PAST Medical History:

If none please check this box ☐

Circle all conditions below that you currently have or had previously.

Heart: High Blood Pressure, Heart Attack, Abnormal Heart Rhythm (pace maker), Congestive Heart Failure, Myocarditis, Pericarditis, Heart valve disease (aortic/ mitral), Cardiac Effusion etc. ____

Lungs: Chronic Bronchitis, Acute Bronchitis (recent date _____), Emphysema, Pleural Effusion, Bronchial asthma, Sarcoidosis, Fungal lung infection, Tuberculosis, Bronchiectesis, COPD, etc_____

Gastro intestinal: Peptic ulcer disease, GERD (Hiatus hernia), Duodenal Ulcer, Irritable Bowel Syndrome, Crohn's Disease, Ulcerative colitis, GI bleeding, GI perforation, Gall bladder stone, Liver failure, Acute Pancreatitis, Chronic Pancreatitis, etc_____

Endocrine system: Diabetes (Insulin dependent/ Non Insulin dependent), Hypo Thyroid, Hyper Thyroid, Hypo Adrenalism, Hyper adrenalism, Growth hormone problems, etc _____

Kidney and Genitourinary System: Kidney stone, Kidney failure, Kidney infection (pyelonephritis), Nephropathy, etc
Skin, & Breast:: Dermatomyositis, Allergic skin diseases, dermatitis, Breast tumor (cancer/ benign).

Infectious disease: HIV / AIDS, Hepatitis A/ B/ C, or any other recent infection such as Upper respiratory tract infection, Urinary tract infection, Skin infection etc _____

Musculoskeletal: Osteo arthritis, Systemic Lupus Erythematosus (Lupus), Rheumatoid arthritis, Sclerosis, Polymyositis, Giant cell arteritis.

Nervous system (including neuromuscular) : Neuropathy, Stroke, Multiple Sclerosis, Porphyria, Bells palsy, Myasthenia gravis, Myotonia, Parkinson's disease, Migraine etc.

Hematology and Oncology: Anemia, Leukemia, Lymphoma, Cancer of (Breast, Spine, Liver, Pancreas, Bone etc).
Any history of abnormal bleeding disorder? Yes/ No If yes please give details _____

Psychiatry: Depression, Anxiety, Schizophrenia, Family history of Suicide : Yes / No.

24. Social History:

Marital Status (circle one answer)

☐ Single ☐ Married ☐divorced ☐ Widowed ☐ Lives with spouse/ friend
Perception of marriage: ☐Excellent ☐ Good ☐Average ☐ poor ☐ Intolerable
Sexual Activities: (please circle one): ☐Capable, ☐ Increased discomfort, ☐Incapable, ☐Previously capable,☐ Do not practice.
Family Support: Do you have a supportive family ☐Yes ☐ No

Drug abuse:

Recreational drug abuse: ☐Yes / No ☐ If yes what drug have you abused _____
Alcohol: Do you drink alcoholic beverages: Yes/ No.
Frequency of Drinking: ☐Never ☐Rarely ☐Socially ☐Daily.
Cigarettes smoking: ☐Yes, ☐No. If YES then how many packets per day _____, and for ___yrs.
Ex-smoker: Yes/ No, if yes then ____ packets per day for _____ yrs., not smoking since: _____.
Family history of drug abuse: ☐Yes ☐Relationship: _____ ☐ what drug/s? _____

Education: Please check the highest level of education:

- ☐ Grammar school ☐High School ☐ GED ☐ College ☐Post – Graduate ☐ Vocational
-

Employment Status: Employed ☐FT or ☐PT Current Occupation: _____

- Do you enjoy your work: ☐Yes or ☐No
- Does your symptom interfere with your work? ☐Yes or ☐No
- Is the work setting is supportive of your condition? ☐Yes or☐ No
- Unemployed: ☐Laid off, ☐Student, ☐Homemaker, ☐ Retired ☐ Disabled (☐Permanent ☐Temporary), if disabled, date made Disable: _____. Cause of Disability: _____
- What TYPE of disability? : ☐Short term disability; ☐ Long term disability; ☐ Social Security
  Before having pain, did you normally work (circle answer): ☐Yes or ☐No
- Past Occupation: _____
- Are you involved in litigation? ☐Yes / ☐No. If yes, is it ☐pending or☐ settled?
- Type of litigation: ☐ Workers Compensation, ☐Motor Vehicle ☐Social Security.
- Is there any possibility of retraining in case of inability to perform present job? ☐ Yes or ☐No,
- Do you foresee going back to work? ☐YES ☐NO

25. FAMILY HISTORY:

- ☐ I do not know the medical history of my biologic parents.
- Mother: age ___. Healthy; ☐ Yes ☐No. If no, list the medical condition (major)_____
- If deceased cause of death _____
- Father: age ___. Healthy; ☐Yes ☐No. If no, list the medical condition (major)_____
- If deceased cause of death _____
- **Please check the condition that is present in your family (please circle one):**
- Osteo-arthritis, Rheumatoid Arthritis, Cancer, Chronic back problems, Chronic fatigue syndrome, history of back surgery, Diabetes, Fibromyalgia, Lupus, Multiple sclerosis, Muscle pain, Osteoporosis, Major, Depression, and Neuropathy . Any other history of chronic painful condition in your family? _____

26. . Do you have any criminal conviction/ Felony charges/ or DUI charges; ☐Yes ☐No

27. Review of System: (Very important) Do you have any of the following condition? Please circle yes or no for each item

General:

Recent weight loss of more than 10 pounds				Yes	No		
Recent weight gain of more than 10 pounds				Yes	No		
Fever	Yes	No					
Chills	Yes	No					
Night Sweats	Yes	No					
Seen primary care physician in last year			Yes	No			
HEENT:				Skin:			
Abnormal hearing	Yes	No		Open sore	Yes	No	
Hoarseness of voice	Yes	No		New Mole	Yes	No	
Abnormal smell	Yes	No		Poor Healing	Yes	No	
Double vision	Yes	No		Skin Infection	Yes	No	
Glaucoma	Yes	No					
Sinus infection	Yes	No		Bone/ Joints:			
Respiratory:				Shoulder pain	Yes	No	
Chronic cough	Yes	No		Wrist or hand pain:	Yes	No	
Asthma/ wheezing	Yes	No		Hip pain	Yes	No	
COPD/ Emphysema	Yes	No		Knee pain	Yes	No	
Pneumonia		Yes	No	Lupus	Yes	No	
Recent respiratory infection		Yes	No	Muscle weakness	Yes	No	
				Fibromyalgia	Yes	No	
				Dermatomyositis	Yes	No	

Cardiovascular:			Neurological:		
Chest Pain	Yes	No	Headache	Yes	No
Shortness of Breath	Yes	No	Tingling Numbness	Yes	No
High Blood Pressure	Yes	No	Burning Sensation	Yes	No
Heart Disease	Yes	No	Weakness	Yes	No
Swelling of ankle/leg	Yes	No	Tremors	Yes	No
Abnormal heart rhythm	Yes	No	Gait Disturbance	Yes	No
History of Heart Attack	Yes	No	Stroke	Yes	No
Blood clot in legs or lungs	Yes	No	Epilepsy/ Seizure	Yes	No
Varicose Veins	Yes	No	In-coordination	Yes	No
Endocrine:			Involuntary Movements	Yes	No
Excessive thirst	Yes	No	Dizziness	Yes	No
Heat or Cold Intolerance	Yes	No	Spasticity	Yes	No
Excessive Urination	Yes	No	**Gastrointestinal:**		
Thyroid Problem	Yes	No	GERD-Reflux	Yes	No
Diabetes	Yes	No	Heartburn	Yes	No
Osteoporosis	Yes	No	Abdominal Pain	Yes	No
Adrenal Gland problem	Yes	No	Nausea	Yes	No
Genitourinary:			Vomiting	Yes	No
Urinary Incontinence	Yes	No	Diarrhea	Yes	No
History of Jaundice	Yes	No	Liver problem	Yes	No
Pain with urination	Yes	No	**Mental Health:**		
Blood in urine	Yes	No	Depression	Yes	No
Kidney failure	Yes	No	Insomnia /Sleep disturbance	Yes	No
Recurrent Urinary Infection	Yes	No	Anxiety	Yes	No
Dyspareunia	Yes	No	Feeling of hopelessness	Yes	No
Hematological:			**Removal of Major Organ:**		
Bleeding disorders	Yes	No	History of removal of Spleen:	Yes	No
History of Lymph node swelling	Yes	No	History of removal of Kidney:	Yes	No
Anemia	Yes	No	**History of organ transplant:**	**Yes**	**No**
Easy Bruising	Yes	No	Which organ & and When?		
Are you taking blood thinner?	**Yes**	**No**			
History of Blood Transfusion?	Yes	No			

Additional Notes:

_____

_____

_____

_____

_____

THANK YOU