Patient Name:

DOB:

MR #:

UW Health
(University of Wisconsin Hospitals and Clinics Authority)
CONFIDENTIAL PAIN CLINIC QUESTIONNAIRE

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Date: _____

Referred by: _____ Primary Care Provider: _____

Describe brief history of the pain problem you were sent here for: _____

_____

_____

How long has pain been present? _____ Work-related? ☐ Yes ☐ No Legal case? ☐ Yes ☐ No

Describe the pain (burning, sharp, etc.): _____

What makes the pain worse? _____

What makes the pain better? _____

How do you spend your day? _____

You use a: ☐ Cane ☐ Crutches ☐ Walker ☐ Scooter ☐ Wheelchair

Handedness: ☐ Left ☐ Right

TREATMENT: If you have tried any of these treatments, right ↑ if helpful, ↓ if made worse, **-** if no difference.

	Current	Past		Current	Past		Current	Past
Physical Therapy (PT)			Heat			Trigger point injection		
Occupational Therapy (OT)			Cold			Spinal injection		
Exercises			Traction			Implanted pump		
Water exercise/aerobics			Acupuncture			Implanted stimulator		
Splints or braces			Chiropractic			Nerve blocks		
Psychological care for pain			Meditation/relaxation			Nerve ablation/burning		
Pain management classes			Massage			TENS unit		

SLEEP: Please check all that apply to you:

☐ Trouble falling asleep ☐ Snore ☐ Restless legs ☐ Fatigued much of the time
☐ Nap during the day ☐ Sleep apnea ☐ Use CPAP ☐ Wake in the middle of the night

EXERCISE: What you do for exercise: _____ How often? _____ For how long each time? _____

MOOD: Describe your *current* emotional state (check all that apply):

☐ Happy ☐ Optimistic ☐ Well-adjusted ☐ Angry ☐ Hopeless
☐ Depressed ☐ Suicidal ☐ Anxious ☐ Confused ☐ Indifferent

Please indicate if you have a history of (check all that apply):

☐ Depression ☐ Anxiety ☐ Attention deficit ☐ Bipolar disorder
☐ Suicide attempt(s) ☐ Abuse experiences ☐ Other problems: _____

Are you currently seeing a psychiatrist? ☐ Yes ☐ No If yes, name: _____

Are you currently seeing a counselor and/or psychologist? ☐ Yes ☐ No If yes, name(s): _____

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HOME / SCHOOL: Who lives with you? _____

Marital Status: ☐ Married ☐ Single ☐ Engaged ☐ Divorced ☐ Separated ☐ Widowed

If you have children, how many and ages: _____

Highest grade reached in school: _____ Have you spent time in the military? ☐ Yes ☐ No

WORK: Do you work outside the home?

☐ Yes. If yes, occupation: _____ ☐ Full-time ☐ Part-time ☐ Light/limited duty

Do/did you miss work due to pain? ☐ Yes ☐ No

☐ No. If no, when did you last work? _____ Why did you stop working? _____

If no, source of income: _____ Do you intend to return to work? ☐ Yes ☐ No

MEDICATIONS: ***Please bring a complete list of your current medications to your clinic appointment. Bring current pill bottles (with pills) if possible.***

What medications have you tried to treat your pain condition? (Please check all that apply)

☐ Vitamins ☐ Herbals ☐ Glucosamine ☐ Other supplements: _____	☐ Helpful ☐ Not helpful
Over-the-counter Pain Relievers: ☐ Tylenol ☐ Generic acetaminophen ☐ Aleve ☐ Naproxen ☐ Generic ibuprofen ☐ Celebrex ☐ Others: _____	☐ Helpful ☐ Not helpful
Opioids/narcotics: ☐ Oxycodone ☐ Hydrocodone ☐ Percocet ☐ Vicodin ☐ Morphine ☐ Dilaudid ☐ Fentanyl ☐ Butrans ☐ Methadone ☐ Suboxone ☐ Kadian ☐ Tramadol ☐ Nucynta ☐ Other(s): _____	☐ Helpful ☐ Not helpful
Muscle Relaxants: ☐ Carisoprodol ☐ Cyclobenzaprine ☐ Skelaxin ☐ Baclofen ☐ Tizanidine ☐ Other(s): _____	☐ Helpful ☐ Not helpful
Anti-seizure Medications: ☐ Gabapentin ☐ Lyrica ☐ Pregabalin ☐ Topamax ☐ Topiramate ☐ Other(s): _____	☐ Helpful ☐ Not helpful
Antidepressants: ☐ Amitriptyline ☐ Nortriptyline ☐ Cymbalta ☐ Duloxetine ☐ Sertraline ☐ Escitalopram ☐ Paroxetine ☐ Fluoxetine ☐ Savella ☐ Milnacipran ☐ Other(s): _____	☐ Helpful ☐ Not helpful
Sedatives/Anti-anxiety Medications: ☐ Diazepam ☐ Lorazepam ☐ Clonazepam ☐ Other(s): _____	☐ Helpful ☐ Not helpful
Sleeping Aids: ☐ Benadryl ☐ Diphenhydramine ☐ Ambien ☐ Zolpidem ☐ Sonata ☐ Other(s): _____	☐ Helpful ☐ Not helpful
Topicals: ☐ Lidoderm patch ☐ Lidocaine cream ☐ Ben-Gay ☐ Capsaicin ☐ Qutenza ☐ Tiger Balm ☐ Voltaren gel ☐ Other(s): _____	☐ Helpful ☐ Not helpful

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HABITS: ☐ I have never smoked ☐ I currently smoke ☐ I have quit smoking ☐ I chew tobacco or inhale snuff

Average number of caffeinated beverages per day: _____

I have about _____ alcoholic drinks per ☐ day ☐ week ☐ month (check appropriate time period).

I have used non-prescribed drugs: ☐ Yes ☐ No If yes, check appropriate boxes:

☐ Marijuana	☐ Now ☐ In the past
☐ Cocaine	☐ Now ☐ In the past
☐ Heroin	☐ Now ☐ In the past
☐ Amphetamines	☐ Now ☐ In the past
☐ CBD	☐ Now ☐ In the past
☐ Fentanyl	☐ Now ☐ In the past
☐ Opioid Pills	☐ Now ☐ In the past
☐ Kratom	☐ Now ☐ In the past
☐ Other(s): _____	☐ Now ☐ In the past

ALCOHOL / DRUG ADDICTION (please select all that apply)**:**

☐ I have a history of alcohol and/or drug addiction. ☐ I have been treated for addiction.
☐ I am in treatment now. ☐ I need treatment

HEALTH HISTORY: Please check the items that apply to you. Provide details at right.

General:	☐ Fatigue	☐ Fevers/Chills	☐ Weight loss/gain	☐ Night sweats	☐ Hot flashes
Details or other problems:					
Head/Neck:	☐ Poor vision	☐ Poor hearing	☐TMJ	☐ Head/neck cancer	☐ Swollen glands/nodes
Details or other problems:					
Blood/Immune:	☐ Easy bruising/bleeding	☐ Anemia	☐ Lymphoma or leukemia	☐ Transfusions	☐ Transplant
Details or other problems:					
Bones/Joints:	☐ Broken bones	☐ Joint swelling	☐ Stiff joints	☐ Osteoarthritis	☐ Very flexible joints
	☐ Morning stiffness	☐ Lupus	☐ Rheumatoid		
Details or other problems:					
Skin:	☐ Rashes	☐ Sores/ulcers	☐ Scars	☐ Eczema	☐ Skin cancer
Details or other problems:					
Lungs/Chest:	☐ Shortness of breath	☐ Cough	☐ Asthma	☐ Emphysema/COPD	☐ Pneumonia
	☐ Lung cancer	☐ Lung surgery			
Details or other problems:					
Heart:	☐ Chest pain (from heart)/Angina	☐ High blood pressure	☐ Heart attack	☐ Low blood pressure	☐ Irregular heartbeat
	☐ Valvular disease	☐ Swollen legs/arms	☐ Aneurysm	☐ Cold hands/feet	
Details or other problems:					
Spine:	☐ Scoliosis	☐ Disc problems	☐ Fracture	☐ Neck injury	☐ Back injury
	☐ Spinal arthritis	☐ Spine surgery	☐ Spinal tumor		
Details or other problems:					
Endocrine:	☐ Diabetes	☐ Goiter	☐ Thyroid disease	☐ Low testosterone / estrogen	☐ Pancreatic disease
Details or other problems:					

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Genital / Urinary and Pelvic	☐ Kidney stones	☐ Kidney failure	☐ Kidney cancer	☐ Prostate problem	☐ Urinary infection
	☐ Problems controlling urine	☐ "Fallen bladder"	☐ Painful intercourse	☐ Erectile dysfunction	☐ Prostate/bladder cancer
	☐ Menstrual problems	☐ Pelvic pain	☐ Ovarian / uterine / cervical cancer		
Details or other problems:					
Abdomen/GI:	☐ Heartburn/GERD/Hiatal hernia	☐ Peptic ulcer	☐ Gallstones	☐ Hepatitis	☐ Diarrhea
	☐ Constipation	☐ Irritable bowel	☐ Ostomy	☐ Crohn's disease	☐ Ulcerative colitis
	☐ Cancer	☐ Gastric bypass	☐ Problems controlling bowels	☐ Blood in stool	☐ Liver disease
Details or other problems:					
Neuro-Muscular:	☐ Headache	☐ Vertigo (spinning)	☐ Lightheadedness	☐ Stroke	☐ Seizures/epilepsy
	☐ Tremor	☐ Falls	☐ Balance problems	☐ Weakness	☐ Muscle pain
	☐ Fibromyalgia	☐ CRPS/RSD	☐ Brain tumor	☐ Parkinson's	☐ Multiple sclerosis
	☐ Double vision	☐ Peripheral neuropathy	☐ Chronic fatigue	☐ Spinal cord injury	☐ Muscular dystrophy or myopathy
	☐ Head injury/concussion				
Details or other problems:					
Other:	☐ Now pregnant	☐ Now breastfeeding	☐ Planning pregnancy	☐ HIV infection	☐ Artificial joint or disc
	☐ Cancer	☐ Pacemaker, defibrillator, stent(s), artificial heart valve(s)			

OTHER MEDICAL HISTORY: _____

_____

SURGICAL HISTORY: _____

_____

FAMILY MEDICAL HISTORY:

FAMILY MEMBER	MEDICAL PROBLEM(S)	FAMILY MEMBER	MEDICAL PROBLEM(S)
Father		Child	
Mother		Child	
Sibling		Others	

Signature of Patient/Representative: _____ Date: _____ Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Other: _____

Reviewed by: _____ Date: _____ Time: _____