Integrated Sleep & Wellness

Chronic Pain Questionnaire

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Today's Date_____ **Patient's Name** _____ **Date of Birth**_____

Educational and Work History *Please check all that apply*

Years of education: _____	**I am working** ☐ **Full-time** ☐ **Part-time.**	☐ **Not Employed**

What kind of work do you do, or have you usually done?

Last Employer: **Last Date Worked:**

	Yes	No		Yes	No
Receiving Disability			Workman's Compensatio		
Filing for Disability			Workplace Conflict		

Family Information

☐Married ☐Living with Significant Other ☐Divorced or Separated ☐Never Married ☐Widowed

Number of Previous Marriages_____ Number of Children___ Ages_____

Who lives in your household now?

Name	Relationship	Age	Name	Relationship	Age
1.			**5.**		
2.			**6.**		
3.			**7.**		

History of Pain Problem

1. When did your pain start?
2. Where is the pain?
3. What caused your pain?
4. How many ***Emergency Room*** **(ER)** visits in the past 12 months ***for pain***? _____
5. What has been the most effective ***medical*** treatment so far?
6. Is spirituality helpful in dealing with your pain? ☐Yes ☐No

How does your pain make you feel? ·Useless · Overwhelmed · Broken · Anxious Angry ·Terrified · Depressed · Suicidal ·Tormented ·Punished *Other*:_____

Please describe your pain: Numb Cramping Crushing Hot Stabbing Tender Stinging Sharp Burning Throbbing Cold Shooting Electrical ***Other***:_____

Please rate your pain experience.

Pain Level	**Mild ►**			**Irritating ►**		**Miserable ►**			**Excruciating ►**		
Lowest	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Highest	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Average	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Please rate procedures that you have had for your pain.	**Good**	**Fair**	**Poor**
Spine Surgery			
Injections _			
Facet Neurotomy			
Spinal Cord Stimulator			
Implanted Medication Pump			

Physical Therapy			
***Other Procedures*?**			

What medical procedures are *you* doing now to reduce the pain?

Are you currently involved in legal and/or worker's compensation claim? Please explain?

Negative Life Events History	**Yes**	**Age**	**No**
Motor Vehicle Accident			
Active Military Combat or Military Injury			
Domestic or spouse abuse			
Sexual, Emotional or Physical *before age 18*			
Upsetting Sexual Experience *before age 18* you couldn't tell to adults			
Sexual Assault *after age 18*			
You had to take care of yourself before you were old enough			

Other frightening or life-threatening events (e.g., flood, tornado, being the victim of crime, deaths)?

Psychological and Mental Health History

	Yes	**No**	**When**
Depression			
Suicidal Thoughts			
Attempted Suicide			
Anger			
Paranoid thinking			
Mania/Bipolar Disorder			
PTSD/Post traumatic stress disorder			
Other Problem:			

Any *outpatient* treatment with a psychologist, psychiatrist, or counselor? ☐ **Yes** ☐ **No**
When? _____

Currently, are you seeing a psychologist, psychiatrist, or counselor? ☐ **Yes** ☐ **No**
Who?_____

Any *inpatient* mental health or substance abuse

Tobacco, Alcohol, and Other Drug use

	Age Started	***Most* ever used *in one day*?**	**How much per day now?**	**Date last used**	**Any Problems?**	
					Yes	**No**
Caffeine						
Tobacco						
Alcohol						
Marijuana						
Meth or						
Other Drug						

Has anyone ever told you that you have a drug or alcohol problem? ☐ **No** ☐ **Yes** **Who?**_____

Please explain any current and/or past mental health treatments you have been involved in. This includes any psychiatric hospitalizations.

_____

_____

_____

Please explain in your own words how pain impacts you emotionally (i.e., angry, sad, etc.) and what do you do to manage these symptoms?

_____

_____

Medical History

Surgery	Surgeries: YES	NO	When?
Tonsillectomy	☐	☐	_____
Hernia	☐	☐	_____
Cardiac Bypass	☐	☐	_____
Hysterectomy	☐	☐	_____
Appendectomy	☐	☐	_____
Nasal Surgery	☐	☐	_____

Other:_____

_____

_____

_____

_____

Condition	YES	NO	When Diagnosed?
Allergies/Asthma	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Cardiovascular Disease	☐	☐	_____
Diabetes	☐	☐	_____
Digestive Problems	☐	☐	_____
Hypertension	☐	☐	_____
Kidney Problems	☐	☐	_____
Liver Problems	☐	☐	_____
Respiratory Problems	☐	☐	_____
Thyroid Disorder	☐	☐	_____
Seizure Disorder	☐	☐	_____

Have you ever experienced a head injury?

☐ Yes ☐ No

If yes, when?_____

_____

_____

Other:_____

_____

_____

Prescription Medications	**Dosage**	**Taken For**	**How Long?**
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
17)			
18)			

19) _____ _____ _____ _____
20) _____ _____ _____ _____

Over the counter medications _____
_____
_____
_____

Are you currently using opiates and/or pain medications as part of treatment? YES ☐ NO ☐
If **YES**, do you ever increase the dosage/frequency of these medications If so, how much?_____
_____
_____
_____
_____

Do you use your pain medications for mental health reasons (i.e., depression, anxiety)? YES ☐ NO ☐
If **YES**, please describe _____
_____
_____

Have you ever had a problem with your pain medications? YES ☐ NO ☐
If **YES**, please explain?_____
_____
_____
_____

Do you think you currently have a problem with your medication? YES ☐ NO ☐
If **YES**, please explain?_____
_____
_____
_____

I would like to get a sense of how pain impacts your daily life. Can you describe a typical day? What time do you get up and how do you spend your time? _____
_____
_____
_____
_____

Has pain impacted daily functioning? (Check all that apply and provide description)?

√	Activity	Description
	Sleep	
	Energy/Activity Level	
	Sex life/intimacy	
	Appetite	
	Memory	
	Relationships	
	Other	

Do you require assistance with any of your daily activities (Check all that apply and provide description)?

√	Activity	Description
	Personal Grooming	
	Cooking	
	Cleaning	
	Taking medications	
	Driving	
	Shopping	
	Finances	

Expectations/Beliefs:

What are your expectations for the treatment of your pain in general? _____

_____

_____

_____

_____

What is your pain goal (what would be tolerable level from 0 to 10)? _____

_____

_____

_____

_____