Official Use Only

Patient Name: _____

MRN/FIN: _____

PATIENT DATABASE & PAIN INVENTORY (STD)

Who is your family doctor? _____

Work status

☐ Employed ☐ Stay-at-home ☐ Disability ☐ Student
☐ Retired ☐ Unemployed ☐ WorkSafe (WCB) ☐ Other

Who is/was your employer? _____

What type of work do/did you do? _____

My current symptoms are as a result of a: ☐ Work Place Injury Injury Date: _____
☐ Motor Vehicle Collision ☐ Other: _____

Please list all of your current or past health problems including any operations and injuries you have had

_____
_____
_____
_____

Current Medications (Please include all medications/supplements you currently take even those not taken for pain)

_____
_____
_____
_____

Allergies / Sensitivities: _____

_____
_____

	I currently use	I have used	The last time I used was (if applicable)	Average use / week (if applicable)
Smoking / Tobacco	☐ Yes ☐ No	☐ Yes ☐ No		
Alcohol	☐ Yes ☐ No	☐ Yes ☐ No		
Marijuana	☐ Yes ☐ No	☐ Yes ☐ No		
Other illicit substances	☐ Yes ☐ No	☐ Yes ☐ No		

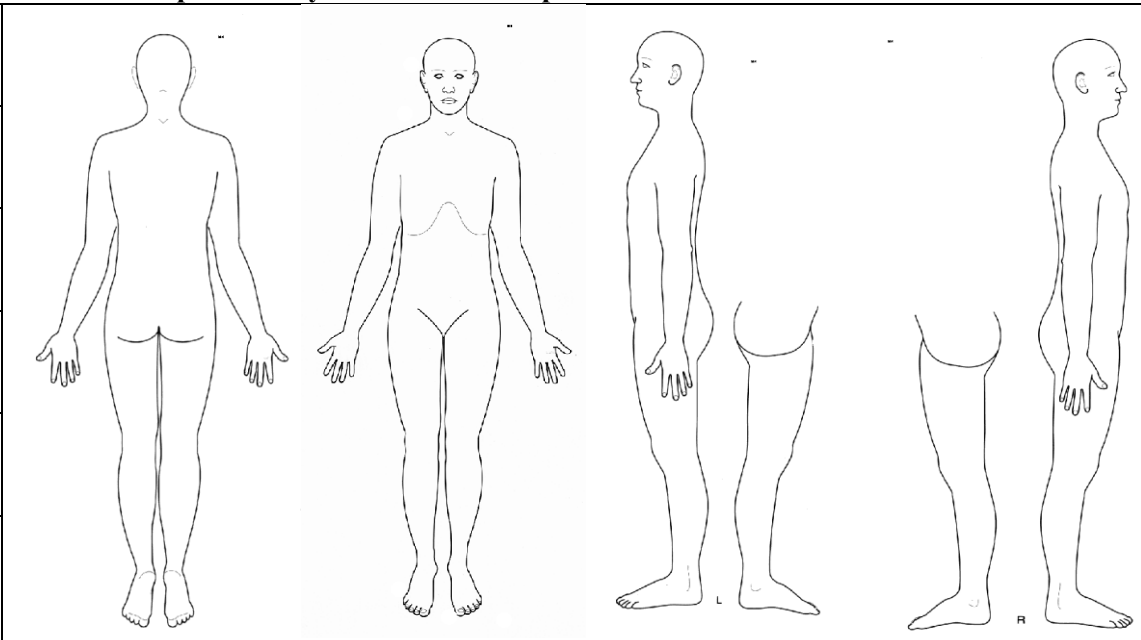
Have you had pain during the last week (besides everyday pain such as minor headaches, sprains, & toothaches)?

☐ Yes ☐ No

On the diagrams, please shade the area(s) where you feel pain (use different colors if desired).

Put an "X" on the spot where you have the most pain

S Sharp / Stabbing
B Burning
N Numbness
P Pins & Needles
A Aching
Shooting Pain



Select the word(s) that best describe(s) your pain

☐ Tingling	☐ Numb	☐ Cramping	☐ Lancinating	☐ Gnawing
☐ Radiating	☐ Tearing	☐ Deep	☐ Excruciating	☐ Other (List):
☐ Shooting	☐ Throbbing	☐ Aching	☐ Exhausting	_____
☐ Tender	☐ Stabbing	☐ Cutting	☐ Unbearable	_____
☐ Sharp	☐ Penetrating	☐ Piercing	☐ Burning	_____
☐ Splitting	☐ Boring	☐ Continuous	☐ Heavy	_____

Using a scale of 0-10 (where 0 = no interference and 10 = completely unable to function), please rate your pain:

At its worst in the past week _____ On Average _____

At its least in the past week _____ Right now _____

What pain medication(s) have you taken in the past (for this pain)?

☐ Ibuprofen (Advil)	☐ Topiramate	☐ Meloxicam	☐ Morphine ☐ Tylenol
☐ Naproxen (Aleve)	☐ Tylenol #3	☐ Methadone	☐ Tramadol ☐ Flexadril
☐ Diclofenac (Voltaren)	☐ Amitriptyline	☐ Nortriptyline	☐ Arthrotec ☐ Capsaicin
☐ Fentanyl patch	☐ Gabapentin	☐ Cymbalta	☐ Dilaudid ☐ Lyrica
☐ Butrans patch	☐ Hydrocodone	☐ Oxycodone	☐ Capsaicin ☐ Celebrex

☐ Other (List) _____

Within a 24 hour period, I take my pain medications(s):

☐ I don't take medications ☐ 1-2 times a day ☐ 5-6 times a day ☐ Other: _____
☐ Not every day ☐ 3-4 times a day ☐ More than 6 times a day

Other forms of treatment I have tried include:

☐ Physiotherapy ☐ Acupuncture ☐ Massage ☐ IMS ☐ Heat
☐ Chiropractic ☐ Pain Education Class ☐ Stretching ☐ TENS ☐ Cold
☐ Other (List) _____

Have you been to a pain clinic in the past?

☐ Yes ☐ No If yes, what type(s)? _____

Have you had spinal, epidural, facet or other injections for pain control?

☐ Yes ☐ No If yes, what type(s)? _____

How often do you perform these non-work related exercise activities?

	Daily	4-5/wk	2-3/wk	When I Can	Duration or distance
Stretching	☐	☐	☐	☐	_____
Exercise (gym, yoga, etc.)	☐	☐	☐	☐	_____
Aerobic exercise (walking, cycling, etc.)	☐	☐	☐	☐	_____

What physical activities/chores do you do on an average day? _____

Using the same 1-10 scale, how much during the past week, has pain interfered with your:

Sleep _____ Normal Work _____ General activity _____
Mood _____ Walking ability _____ Relations w/ other people _____

Sleep patterns		**Reasons:**
I have trouble falling asleep	☐ Yes ☐ No	_____
I wake up during the night	☐ Yes ☐ No	_____
I have trouble falling back asleep if I wake	☐ Yes ☐ No	_____
How many nights/wk is your sleep affected? _____		

What activities does your pain prevent you from doing? _____

Do any of the following make your pain:

	Better	Worse	Does not affect my pain
Sitting	☐	☐	☐
Lying down	☐	☐	☐
Walking	☐	☐	☐
Standing	☐	☐	☐
Resting	☐	☐	☐
Stretching	☐	☐	☐
Medications	☐	☐	☐
Nothing at all	☐	☐	☐
Other (List):_____	☐	☐	☐

What are your goals for attending the Bitterroot Physician's Clinic? If your goals include reduced pain, how much of a reduction would you be happy with? _____

What questions would you like answered during your consultation? _____

Are there specific topics or treatments that you would like to discuss during your appointment? _____

Please attach any additional information that you think is important for us to know ahead of time.