Golden Triangle Interventional Pain Associates

Date: _____ Name:_____ DOB:_____

REVIEW OF SYSTEMS: Please check all symptoms you have experienced in the last **MONTH**.

Constitutional/General
- o Fever
- o Chills
- o Heavy sweating/Night sweats
- o Loss of Appetite
- o Sleep Disturbances
- o Unexplained Weight Loss/Gain
- o Other_____

Eyes
- o Blurry Vision
- o Double Vision
- o Wear glasses
- o Other_____

Ear/Nose/Throat
- o Sore Throat
- o Mouth Sores
- o Nasal Congestion/Sinus issues
- o Hearing Loss
- o Other_____

Respiratory
- o Excessive Thirst or Fluid Intake
- o Temperature Intolerance
- o Feeling Tired
- o Hot Flashes
- o Other_____

Endocrine
- o Excessive Thirst or Fluid Intake
- o Temperature Intolerance
- o Feeling Tired (Fatigue)
- o Hot Flashes
- o Other_____

Cardiovascular
- o Chest pain or discomfort
- o Swelling of Feet, Ankles, Legs
- o Irregular Heartbeat
- o Heart Attack
- o Heart Failure
- o Palpitations
- o Varicose veins
- o Other_____

Gastrointestional
- o Abdominal pain
- o Nausea/Vomiting
- o Indigestion/Heartburn
- o Blood in stool
- o Change in bowel habits
- o Rectal bleeding
- o Diarrhea
- o Constipation
- o Swallowing Difficulties
- o Other_____

Psychological
- o Depression
- o Anxiety
- o Other_____

Hematological/Lymphatic
- o Swollen Glands
- o Bloot Clotting Problem
- o Easy Brusing
- o Bleeding Tendencies
- o Other_____

Genitourinary
- o Painful Urination
- o Urinary Frequency
- o Loss of Urinary Control
- o Enlarged Prostate
- o Difficulty Urinating
- o Other_____

Skin
- o Skin Rash
- o Itching
- o Discoloration of skin
- o Lumps or masses
- o Other_____

Musculoskeletal
- o Joint Pain
- o Joint Swelling
- o Limitation of motion
- o Back Pain
- o Neck Pain
- o Pain with walking
- o Other_____

Neurological
- o Tremors
- o Dizzy Spells
- o Numbness and Tingling
- o Headache
- o Unsteady Gait
- o Feeling Weak
- o Convulsions/Seizures
- o Other_____

Patient Signature:_____

PATIENT PAIN QUESTIONAIRE

Name:_____ Date_____

1. How long have you had chronic pain?_____ days, weeks, months or years

Where is it located? Back, Neck, Legs, Arms, Shoulders, Buttocks, Knees, Hips, Other_____

2. How would you rate your ability to perform your daily activities?

Excellent Good Fair Poor

3. Has your pain changed since your last visit? Better About the same Worse

4. Is the amount of pain relief you receive from your pain treatment enough to do the things you want to do?

Yes No

5. In the past week, how much relief have pain treatments or medications provided? Please circle the percentage that most shows how much relief you have experienced.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No relief Complete relief

6. What activities are limited or different due to your pain?

7. Circle the one number that describes how, during the past week, pain has interfered with:

(Rate on the 10 point scale 1=none; 10=maximum interference)

	No interference									Maximum interference
Sleep:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
General Activity:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Mood:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Walking Ability:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Relations with others:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Enjoyment of life:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

8. What **drug side effects** or **symptoms** are you having? Circle the number that best describes your experience during the past week.

Constipation: Barely noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medication

Tired/Fatigue: Barely noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medication

Difficulty thinking: Barely noticeable 0 1 2 3 4 5 6 7 8 9 10 Severe enough to stop medication

9. Have you noticed a problem with pain flares? Yes No

When is it occurring? Morning, Night, With activity, At the end of medication dose
Other_____

10. What is your current pain level today?_____

Pain meds taken with date and time of last dose:

1._____

2._____

3._____

Are you taking any Benodiazepines? Xanex/alprazolam, Valium/diazepam, Paxipam/halazepam, Ativan/lorazepam, Klonopin/clonazepam, Restoril/temazepam, Other:_____

Last dose:_____

11. Are you using any other therapies now to help with your function?

___counseling, support groups ___stretching, massage, yoga ___exercise, aquarobics, water walking
___biofeedback, relaxation, distraction ___physical therapy ___other (specify)_____
___none

12. Setting goals to improve your pain and quality of life are important. They should be realistic and measurable. Please check off or write in your own goal that you would like to commit to working towards for the next month.

___Walk 20 min daily ___10 min of stretching daily ___use a step counter to track increased movement

___lose 3 pounds ___cook 1 full meal per week ____make a weekly chore chart to complete

___complete yardwork ___park farther away from store entrance ___attend social events

___take up an active hobby ___water walking/aerobics ___reading at bedtime ___better sleep routine

Other:_____

13. Did you make progress toward your goals since last visit?

___No, didn't try ___Almost achieved ___Achieved ___Achieved and more

___I do not have treatment goals