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ALLEVIO
PAIN MANAGEMENT

you can save this form and email it to:
info @ allevioclinic . com

To help us better understand your current situation, please complete the following questionnaire as fully as possible. Please mail, fax or drop off as soon as you are finished to get an appointment. Fax (647) 427-4100.

TODAY'S DATE: _____ NAME: _____
Year/Month/Day First Middle Last

HEALTH CARD #: _____ WSIB #: _____

Is your pain related to an accident? ◯ Yes ◯ No If yes, is your insurance claim still open? ◯ Yes ◯ No

If yes, please fill in the insurance information form and return with this questionnaire.

DATE OF BIRTH: _____ Age: _____ SEX: ◯ Male ◯ Female HEIGHT: _____ WEIGHT: _____
Year/Month/Day In years

ADDRESS: _____
_____ _____
City Province Postal Code

TELEPHONE: _____ _____ _____
Home Work Cellular

FAMILY DR: Dr. _____ Phone: _____ Fax: _____

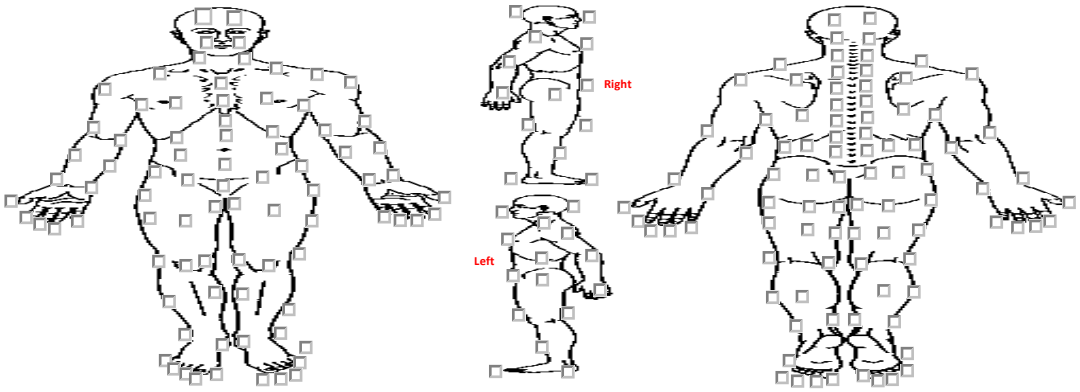
REFERRING Dr. Dr. _____ Phone: _____ Fax: _____

1. a) When and how did you current pain problem start? _____

b) When the pain first started, how did it start? ◯ Gradually ◯ Suddenly

c) Has your pain changed since it began? ◯ No change ◯ Decreased ◯ Increased

2. Location of pain: Please mark an "X" on the drawings where you feel pain.



3. Please circle a number to indicate how much of the time you were in pain during the past 2 weeks:

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯

Not at all All of the time

ALLEVIO
PAIN MANAGEMENT

4. On the following pain scales, 0 means no pain and 10 means the most excruciating pain possible.

a) Out of 10, how bad was your **worst pain** over the past **two weeks**:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain imaginable

b) Out of 10, how bad was your **lowest/least pain** over the past **two weeks**:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain imaginable

5. Place an X beside the words that describe your pain. **Only** fill the columns that are relevant to your pain.

	Back pain	Neck pain	Headache	Shoulder pain	Other:
Sharp	☐	☐	☐	☐	☐
Shooting	☐	☐	☐	☐	☐
Stabbing	☐	☐	☐	☐	☐
Throbbing	☐	☐	☐	☐	☐
Aching	☐	☐	☐	☐	☐
Heavy/tight	☐	☐	☐	☐	☐
Hot, burning	☐	☐	☐	☐	☐
Cramping	☐	☐	☐	☐	☐

6. Describe everything that aggravates your pain: ☐ lifting ☐ bending ☐ walking ☐ standing ☐ sitting ☐ coughing ☐ looking up ☐ looking down ☐ turning the head ☐ thinking ☐ reading ☐ stress ☐ sleep ☐ other: _____

7. Describe everything that relieves your pain, even mildly or temporarily: ☐ medication ☐ rest ☐ sleep ☐ exercise ☐ bending ☐ stretching ☐ physical therapy ☐ relaxation ☐ injections ☐ Other: _____

8. Which of the following symptoms do you experience? (Check only the ones that apply)

☐ Numbness, where? _____

☐ Pins and needles, where? _____

☐ Shooting pain down the arm(s), which one? ○ right ○ left

☐ Shooting pain down the leg(s), which one? ○ right ○ left

☐ Bowel incontinence (Bowel incontinence is the loss of bowel control, leading to an involuntary passage of stool.)

☐ Urinary incontinence (Urinary incontinence (UI), involuntary urination, is any involuntary leakage of urine.)

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MEDICAL INFORMATION/SOCIAL & WORK HISTORY:

9. Please list any major illnesses or hospitalizations you have had. Include smoking, depression, anxiety, problems with blood pressure, heart, lungs, kidneys, brain and bone: _____
_____

10. a) List ALL medications you are currently taking:

Name	Dose	# per day	Name	Dose	# per day	Name	Dose	# per day

b) List all medications you have taken and discontinued in the past for your pain problem, as well as the reason for stopping:

c) List medical allergies:

11. Do you smoke cigarettes, cigars or a pipe? Yes No How many per day?

Since your pain began, has your weight changed? Increased Decreased No change

13. Does your pain affect your sleep? Yes No Sometimes

14. Do you drink alcohol to control your pain? Yes No

Have you been treated for a drug or alcohol problem? Yes No

How many alcoholic drinks do you drink in a typical week? _____ drinks _____ oz

15. a) Does your pain affect your mood? Yes No

b) Check any terms that apply to your mood: Sad/depressed Fatigued Irritable
Angry/frustrated Unable to cope Poor memory Unable to concentrate Want to be alone

c) Are you currently in treatment for anxiety or depression? Yes No With whom?

16. Do you exercise regularly? Yes No Describe:

17. Marital status: # Children:

18. To what extent does the pain interfere with your relationship with your family life?

No Interference 1 2 3 4 5 6 7 8 9 Extensive interference

19. OCCUPATION: Describe your current work status:

20. Overall, to what extent do you feel the pain has interfered with your life?

Not at all 1 2 3 4 5 6 7 8 9 Extreme interference

_____

THANK YOU