ALLEVIO
PAIN MANAGEMENT

PATIENT PRE-CONSULTATION QUESTIONNAIRE

To help us better understand your current situation, please complete the following questionnaire and Brief Pain Inventory. Please return by fax, mail or drop off as soon as possible to get an appointment.

Fax: (647) 427-4100 or Mail: 101–240 Duncan Mill Road, Toronto, ON, M3B 3S6

Date: _____ Name: _____
(First / Middle / Last)

Health card #: _____ WSIB # (if active): _____

Date of birth: _____ Age: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____ lbs/kg (circle)
(Mo/Day/Yr)

Home address: _____

_____
(City / Province / Postal Code)

Telephone: _____
(Home / Work / Cellular)

Family Doctor: _____ Phone: _____ Fax: _____

Pharmacy: _____ Phone: _____ Fax: _____

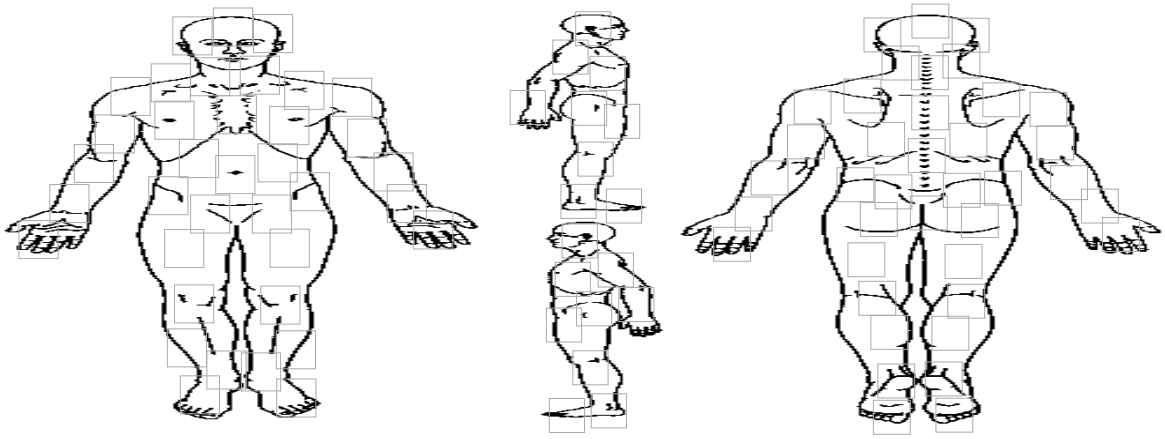
1. When and how did you current pain problem start? _____

   Has your pain changed since it began? ◯ No change ◯ More ◯ Less

2. Have you visited an emergency room for your pain in the past 12 months? ◯ Yes ◯ No

   If YES, how many times? _____; which hospital(s)? _____

3. How many times have you visited your family doctor in the past 3 months due to pain? _____
4. Location of pain: please mark an "X" on the drawings where you feel the WORST pain(s).



5. Rate your pain by circling the one number that best describes your pain:

0 = No Pain 10 = Bad as you can imagine

Worst in the last 24 hrs	0	1	2	3	4	5	6	7	8	9	10
Least in the last 24 hrs	0	1	2	3	4	5	6	7	8	9	10
Average	0	1	2	3	4	5	6	7	8	9	10
Right now	0	1	2	3	4	5	6	7	8	9	10

6. Check off everything that describes the way your most severe pain feels:

◯ shooting ◯ sharp ◯ stabbing ◯ throbbing ◯ aching ◯ heavy ◯ tight ◯ burning

◯ cramping ◯ numbness, where? _____ ◯ pins/needles ◯ tingling

◯ shooting pain down the ◯ right ◯ left ◯ arm ◯ leg

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

◯ Bowel incontinence (soiling yourself) ◯ Urinary incontinence (wetting yourself)

◯ Night sweats ◯ Unintended weight loss ◯ Weakness resulting in falls or dropping things

8. Check off everything that aggravates your pain:

◯ bending ◯ lifting ◯ walking ◯ standing ◯ sitting ◯ coughing ◯ turning the head

◯ reading ◯ thinking ◯ stress ◯ sleep ◯ looking up or ◯ down ◯ other:_____

9. Check off everything that relieves your pain, even mildly or temporarily:

◯ medication ◯ rest ◯ swimming ◯ exercise ◯ bending ◯ stretching

◯ relaxation ◯ injections ◯ sleep ◯ physical therapy ◯ other:_____

10. Circle the number that best describes how, during the past 24 hours, pain has interfered with your:

0 = Does not interfere 10 = Completely interferes

General Activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Walking ability	0	1	2	3	4	5	6	7	8	9	10
Normal work	0	1	2	3	4	5	6	7	8	9	10
Relations with other s	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of life	0	1	2	3	4	5	6	7	8	9	10

11. Please check off and specify any major illnesses or surgeries you have had:

◯ history of cancer in past 5 years? If yes, what type of cancer? _____

◯ smoking? ◯ cigarettes ◯ marijuana ◯ alcohol? ____ ounces per week of _____

◯ depression ◯ anxiety ◯ addiction, to what? _____

◯ heart attack/CHF ◯ heart surgery ◯ hypertension ◯ pacemaker or ICD

◯ sleep apnea ◯ kidney failure ◯ cirrhosis ◯ Hepatitis B or C ◯ HIV

◯ blood disorder (specify) _____ ◯ epilepsy/seizures ◯ neuropathy ◯ COPD

◯ rheumatoid arthritis ◯ joint replacement: _____

◯ spinal surgery: _____

◯ other: _____

12. Allergies: _____

13. List ALL medications you are currently taking (may attach list):

NOTE: Are you taking any strong blood thinners, such as Plavix, Ticlid, Pradaxa, Coumadin/Warfarin or Xarelto/Rivaroxaban? ◯ Yes (Please specify in table below) ◯ No

Name	Dose TAKEN	Times taken per day	For what condition?

14. List 3 functional goals that you wish to be able to do if your pain better controlled. For example, return to work, increase walking/activity level, play with children/grandchildren, use less medication, etc.

a. _____

b. _____

c. _____

INSURANCE INFORMATION

Your name: _____ Your birthday: _____
First Middle Last Month/Day/Year

1. Medication and Health Insurance (Extended Health):

   Company: _____ Policy #: _____

   Is Botox (DIN 01981501) covered? ◯ Yes ◯ No

   Check to see if the following Allied Health services are covered:

   a. Chiropractic ◯ Yes ◯ No
   b. Osteopathy (certified, with PhD) ◯ Yes ◯ No
   c. Kinesiology ◯ Yes ◯ No
   d. Massage Therapy ◯ Yes ◯ No
   e. Physiotherapy ◯ Yes ◯ No
   f. Social Work ◯ Yes ◯ No
   g. Psychology ◯ Yes ◯ No

2. Accident Insurance (if claim is still open):

   Date of accident: _____

   Company: _____

   Policy #: _____ Claim #: _____

   Agent's name: _____ Phone: _____ Fax: _____

3. If you were in an accident, did you have a chronic pain condition or mood disorder, such as depression or anxiety, prior to the accident?

   _____

   _____

   a. For how long have you had pain? _____

   b. Has your pain been continuous since the accident? ◯ Yes ◯ No

4. If you have a lawyer assisting you with your claim:

   Lawyer's name: _____ Firm:_____

   Phone: _____ Fax: _____