ALLEVIO
PAIN MANAGEMENT

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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.

Patient Information

Date: _____ Name: _____
Last name / First name / Middle name

Health Card #: _____ WSIB # (if active): _____ lbs/kg
(Circle)

Date of Birth: _____ ☐ Male ☐ Female Height: _____ Weight: _____
Month / Date / Year

Home Address: _____
Address / City / Province / Postal Code

Telephone #: _____
Home / Work / Cellular

Family Doctor: _____ Phone: _____ Fax: _____

Referring Physician: _____ Phone: _____ Fax: _____

Pharmacy: _____ Phone: _____ Fax: _____

Questionnaire

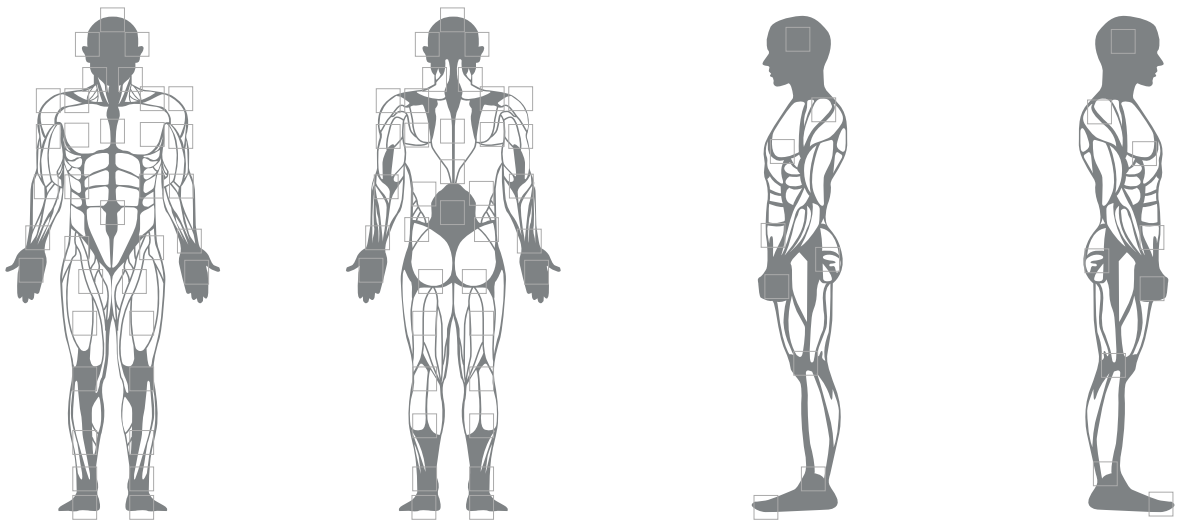
1.When and how did your current pain problem start? _____

- 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

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:

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

0 = No Pain **10 = Bad as you can imagine**

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:

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 others	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

0 = Does not interfere **10 = Completely interferes**

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 orXarelto/ Rivaroxaban?

☐ Yes ☐ 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 towork, increase walking/activity level, play with children/grandchildren, use less medication, etc.

a. _____

b. _____

c. _____

INSURANCE INFORMATION

Name: _____ Date of Birth: _____

Last name / First name / Middle name — Month / Date / 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 oranxiety, 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: _____