EPiC
Excel Pain Consultants

Patient Initial Questionnaire

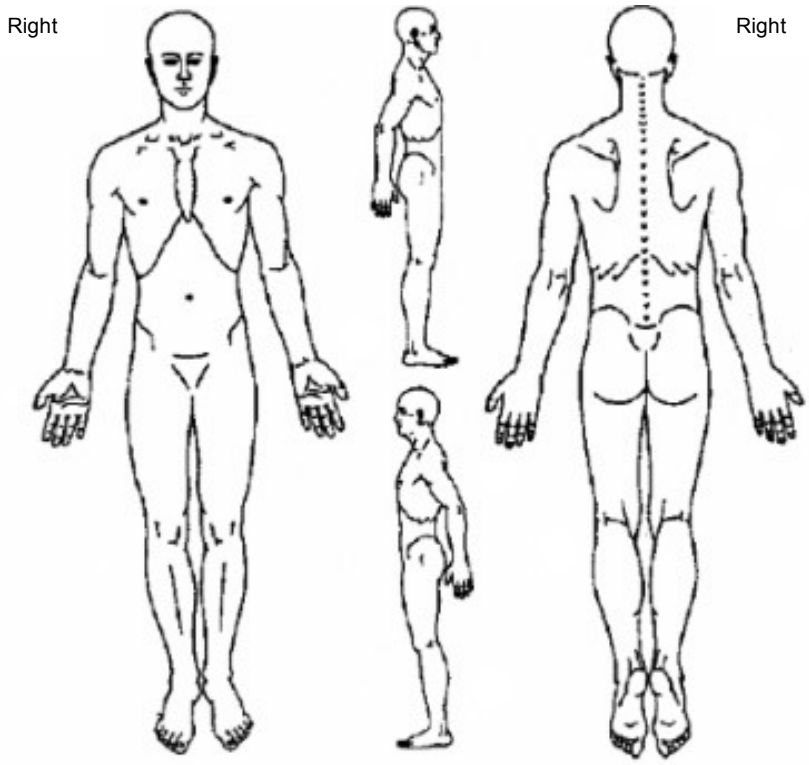
Name: _____ Age: _____ Date of Birth: _____

Referring Physician _____ Primary Care Physician _____

How did your pain originally begin? (Check one)

□ *Accident At Work*	*Date: ____ / ____ / ____*	□ *Auto Accident*	*Date:*
□ *Following Surgery*	*Date: / / ____*	□ *Following An Illness*	*Date:*
□ *Pain Just Began*	*Date: ____ / ____ / ____*		
□ *Other*			*Date:*

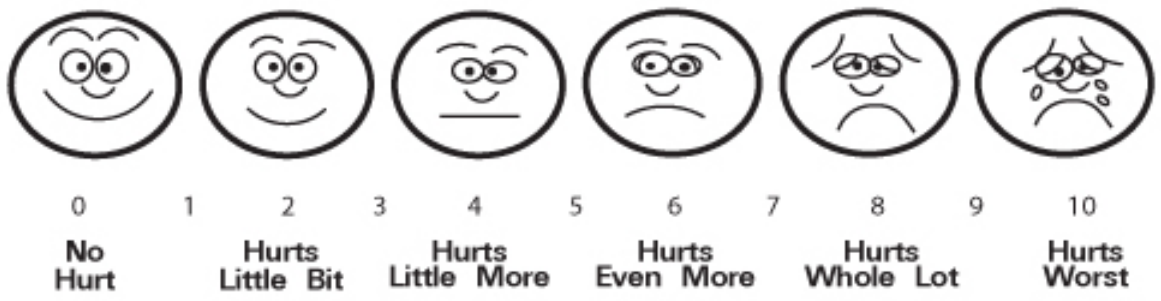
□ ***Below, please shade in the area where you have pain, put an "X" over the area that hurts the most.***



How you describe your pain?

☐Sharp	☐Shooting	☐Stabbing	☐Throbbing	☐Cramping	☐Stinging	☐Squeezing
☐Hot	☐Burning	☐Piercing	☐Tingling	☐Tender	☐Aching	☐Splitting
☐Cold	☐Dull	☐Numb	☐Gnawing	☐Other_____		

Rate your pain by placing an 'X' on the line to describe your AVERAGE pain the past month:



How often do you have your pain?
☐Constant ☐Most of the time ☐Occasionally ☐Rarely

In general, when is your pain worse?
☐No Specific Time ☐Morning ☐Afternoon ☐Evening ☐Bedtime

Which of the following makes your pain worse? (Check all that apply)
☐Sitting ☐Standing ☐Walking ☐Bending/Twisting ☐Lifting ☐Lying ☐Exercise
☐Heat ☐Stress ☐Cold ☐Bright Lights ☐Inactivity ☐Menstruation
☐Meals ☐Poor Sleep ☐Alcohol ☐Weather Changes ☐Loud Noise
☐Medication: _____ ☐Others_____

Which of the following makes your pain better? (Check all that apply)
☐Cold ☐Exercise ☐Activity ☐Warm Shower ☐Relaxation ☐Prayer ☐Heat
☐Distraction ☐Medication: _____ ☐Other: _____

Are there any other symptoms associated with your pain?
☐Numbness ☐Weakness ☐Tenderness ☐Vomiting
☐Redness ☐Bowel Incontinence ☐Urinary Incontinence ☐Fatigue
☐Swelling ☐Blurred Vision ☐Night time movements ☐Anger
☐Sleep Apnea ☐Sexual Dysfunction ☐Other:

Have your pain affected your mood? ☐No ☐Yes

SLEEP
Has the pain affected your sleep? ☐Never ☐Rarely ☐Occasionally
How many hours do you sleep nightly? _____
Does your pain awaken you during the night? ☐Never ☐Rarely ☐Occasionally

Place an "X" on the line to describe how pain has interfered with your:

Normal Daily Activity

Does NOT interfere_____Completely Interferes

Normal Work (inside and outside of home):

Does NOT interfere_____Completely Interferes

TREATMENTS:

Please check any of the following treatments that you have tried to treat your pain: □ NONE

□ Acupuncture □ Chiropractor □ Physical Therapy □ Hypnosis
□ Biofeedback □ Traction □ TENS □ Psychotherapy
□ Bed Rest □ Exercise □ Injection Therapy
□ Other: _____

Have you been seen in a pain clinic in the past ☐*No* ☐*Yes* *if yes, please list*

_____

_____

Please write ALL current and past medications that you have taken for your current pain condition.

_____

_____

CURRENT MEDICAL HISTORY:

Do you have any of the following? (Please check all that apply) ☐**No Problems**

☐High Blood Pressure	☐Heart Attack	☐Stomach Ulcer	☐Asthma
☐Kidney Disease	☐GERD	☐Depression	☐Arthritis
☐Diabetes	☐Stroke	☐Hepatitis	☐Cancer
☐Thyroid Disease	☐Liver Disease	☐Lung Disease	☐ HIV
☐Fibromyalgia	☐Peripheral Neuropathy	☐Seizure	☐Migraines
☐Low Blood Pressure	☐Bowel Disease		

Others: _____

_____

SURGICAL HISTORY:

Have you ever had any type of surgery? ☐*No* ☐*Yes* *If yes, please list*

Procedure	*Date*	*Surgeon*

PAST MENTAL HEALTH HISTORY:

Have you ever had mental health treatment? ☐No ☐Yes (approximate date)_____

Are you in current mental health treatment? ☐No ☐Yes (Name of Provider)_____

Have you even been hospitalized for psychiatric reasons? ☐No ☐Yes (approximate Date)_____

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Who lives in your household? _____

EDUCATION:

Highest Education / Vocational level: _____

ALLERGIES: ☐ *No Known Drug Allergies*

Name	**Type of Reaction**	**Name**	**Type of Reaction**
☐*Penicillin*	_____	☐*Sulfa*	_____
☐*Latex*	_____	☐*IV Dye*	_____
☐*Shellfish*	_____	☐*Others:*	_____

PHARMACY INFORMATION:

Name of Pharmacy: _____

Pharmacy Address: _____

Please list ALL medications that you are CURRENTLY taking. (Include meds for pain, heart, diabetes, blood pressure, blood thinners, as well as over the counter medications and herbal products, etc)

Date Started	*Medication*	*Dosage*	*Frequency*	*Ordering Physician*

EMPLOYMENT:

Current Occupation: _____ N/A

Present Employment Status: ☐Full Time ☐Part time ☐Student ☐Home Maker

☐Retired ☐Workers Compensation ☐Unemployed ☐Leave of absence ☐Disability

If not working, when was your last day of work? _____ Date you returned to work after injury: _____

Would you return to work if you had less pain? ☐Yes ☐No ☐N/A

Have you tried to return to work? ☐Yes ☐No ☐N/A

Do you have an application pending for compensation or disability? ☐Yes ☐No ☐N/A

Do you have a pending lawsuit because of your pain or injury? ☐Yes ☐No ☐N/A

LIFESTYLE HABITS:

How much Caffeine (coffee, tea, pop/soda) do you consume in a day? _____ cups

Do you smoke? ☐Never ☐Yes: Number of packs per day: _____ ☐Quit: When? _____

Do you drink alcohol? (wine, beer, liquor) ☐Never ☐Quit: When?_____

☐None ☐Rarely (1 per month) ☐Occasionally (less than 1 per week)

☐Daily ☐Regularly (2-3 per week) ☐Yearly

Have you ever participated in a drug or alcohol rehab program?

☐Never ☐Yes (Indicate when)_____

Have you ever used recreational (street) drugs? ☐Never ☐Yes: List Below

NAME OF STREET DRUG	Current User		Quit
Cocaine	☐*Yes*	☐*No*	☐
Heroin	☐*Yes*	☐*No*	☐
Marijuana	☐*Yes*	☐*No*	☐
Others	☐*Yes*	☐*No*	☐

FAMILY HISTORY:
Does your immediate family (parents, brother/sister etc) have a history of? Please mention the relation as well

Back Disorder	☐No ☐Yes _____		Diabetes	☐No ☐Yes _____	
Thyroid Disease	☐No ☐Yes _____		Stroke	☐No ☐Yes _____	
High Blood Pressure	☐No ☐Yes _____		Heart Disease	☐No ☐Yes _____	
Heart attack under age 50	☐No ☐Yes _____		Migraines	☐No ☐Yes _____	
Cancer:	☐No ☐Yes: (type) _____				
Pain Problem	☐No ☐Yes: (type) _____				
☐Others: _____					
☐Adopted	☐Unknown				

REVIEW OF SYSTEMS:

Please check all CURRENT symptoms:

CONSTITUTIONAL	☐**No Problem**	
☐Lack of energy	☐Weight Loss:	☐Trouble Sleeping
☐Weight Gain:	☐Poor Appetite	☐Fevers
☐Chills	☐Night Sweats	
EAR, NOSE, THROAT:	☐**No Problem**	
☐Hearing Loss ☐Left ☐Right	☐Dizziness	☐Ringing In Ears
☐Frequent Sore Throat	☐Hoarseness	☐Discharge From Nose
☐Snoring	☐Other:	
VISION:	☐**No Problem**	
☐Vision Loss In One Eye	☐Double Vision	☐Blurred Vision
☐Vision Loss In Both Eyes	☐Glasses/Contacts	☐Other
RESPIRATORY:	☐**No Problem**	
☐Shortness Of Breath	☐Chronic Cough	☐Wheezing
☐Oxygen: @_____ L/min (Circle) Day, Night or Continuous		☐Other:
CARDIOVASCULAR:	☐**No Problem**	
☐Chest Pain	☐Leg Pain/ Poor Circulation	☐Swelling In Legs & Feet
☐Palpitations	☐Irregular Heart Beats	☐Cold Hands & Feet
☐Color Changes in Hand & Feet	☐Narrowing Of Arteries Of Neck	☐Other:
GASTROINTESTINAL:	☐**No Problem**	
☐Difficulty In Chew or Swallow	☐Poor Appetite	☐Diarrhea
☐Constipation	☐Blood In Stool	☐Nausea/ Vomiting
☐Abdominal Pain	☐Abdominal Cramps	☐Yellow Skin
☐Weight Loss	☐Stool Incontinence	☐Other:
HEMATOLOGICAL:	☐**No Problem**	
☐Easy Bruising	☐Trouble with Blood Clotting	☐Other:
ENDOCRINE:	☐**No Problem**	
☐Weight Gain	☐Always Cold	☐Always Hot
☐Other:		
MUSCULOSKELETAL:	☐**No Problem**	
☐Muscle Pain	☐Joint Pain	☐Muscle Loss
☐Weakness	☐Stiffness	☐Cramps
☐Bone Pain	☐Other:	
NEUROLOGICAL	☐**No Problem**	
☐Headache	☐Fainting	☐Difficulty Finding Words
☐Difficulty Walking	☐Poor Memory	☐Falls

☐Numbness or Tingling Where:		☐Other:
PSYCHIATRIC:	☐**No Problem**	
☐Frequent Sadness/ Unhappy	☐Panic	☐Excessive Worry
☐Unusual High Energy	☐Suicidal Thoughts	☐Anger
GENITURINARY:	☐**No Problem**	
☐Urinary Frequency	☐Urinary Incontinence	☐Pain When Urinating
☐Pain During Sex	☐Blood In Urine	☐Other:
GYNAECOLOGICAL	☐**N/A**	☐**No Problem**
☐Period Irregularity	☐Hot Flashes	☐Heavy Periods
☐Painful Periods	☐Other	

THANK YOU FOR COMPLETING THIS FORM

_____

Signature of Patient/Guardian or Patient Representative

Office Use Only

PHYSICAL EXAMINATION:

Temp: Blood Pressure: Pulse: RR: Ht: Wt:

Pertinent Positive Finding:

Plan:

_____

Physician's/ Examiner's Signature