Established Patient Health Information

Patient Name: _____ Age: _____ Date: _____

Today's pain level 0 = no pain, 10 = worst pain: **Please circle the correct number**

1 2 3 4 5 6 7 8 9 10

List the name and time you last took your pain medications? _____
List all other medications taken in the last 3 days: _____
_____

Are you being treated for breathing issues? Yes / No If yes, what is the name of your provider? _____
Is your breathing issue under good control? Yes / No What current treatments do you have for your breathing issues? _____

Please describe where your main chronic pain complaint is today? _____
_____

On a scale of 0 to 100% please rate your relief with current medications or treatment:
0 = no relief 100% = complete relief. **Please circle the correct rating:**

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

Do you have an implanted Intrathecal Pain Pump or a Spinal Cord Stimulator? Yes / No

Circle the words that best describe your pain:
constant intermittent daily weekly monthly sharp stabbing aching
burning shooting throbbing toothache radiating pins/needles tingling
Other: _____

What makes your pain worse: Please circle all that apply
walking sitting laying lifting bending stretching
Other: _____

Besides the medications and/or treatments prescribed what else helps you with your Pain?
heat ice stretching laying exercise resting sitting walking
Other: _____

Are you having any side effects from your current treatment? Yes / No
Are you having any problems with constipation? Yes / No When was your last bowel movement? _____
Are you currently pregnant? Yes / No

Are you currently or have you experienced any of these symptoms since your last visit?
Please circle all symptoms that apply.

Muscle ache/joint pain	Numbness, tingling, burning	Nausea, vomiting
Sleep Problems	Dizziness, light headedness	Weakness of body parts
Bruising, easy bleeding	Mouth sores, ulcer, dry mouth	Vision changes
Change in appetite	Sore throat, problem swallowing	Headache, sinus problems
Change in bowel or bladder	Hot flashes, flushing	Diarrhea constipation
Gait change (walk different)	Rash, itching, dry skin, hives	Trouble thinking/concentrating
Depression	Recent hospitalization	X-ray, CT, MRI, other tests
Sexual problems	Any recent traumas/falls	Shortness of Breath/Coughing

COMM

Patient Name: _____ Date: _____

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can. Pleas circle one from 0 - 4.

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very Often

1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems? 0 1 2 3 4

2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i,e., doing things that need to be done, such as going to class, work or appointments) 0 1 2 3 4

3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from Medications? (i.e., another doctor, the Emergency Room, friends, street sources) 0 1 2 3 4

4. In the past 30 days, how often have you taken your medications differently from how they are prescribed? 0 1 2 3 4

5. In the past 30 days, how often have you seriously thought about hurting yourself? 0 1 2 3 4

6 In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)? 0 1 2 3 4

7. In the past 30 days, how often have you been in an argument? 0 1 2 3 4

8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming etc.)? 0 1 2 3 4

9. In the past 30 days, how often have you needed to take pain medications belonging to someone else? 0 1 2 3 4

10. In the past 30 days, how often have you been worried about how you are handling your medications 0 1 2 3 4

11. In the past 30 days, how often have others been worried about how you are handling your medications 0 1 2 3 4

12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment? 0 1 2 3 4

13. In the past 30 days, how often have you gotten angry with people? 0 1 2 3 4

14. In the past 30 days, how often have you had to take more of your medications than prescribed? 0 1 2 3 4

15. In the past 30 days, how often have you borrowed pain medication from someone else? 0 1 2 3 4

16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep improve your mood, or relieve stress)? 0 1 2 3 4

17. In the past 30 days, how often have you had to visit the Emergency Room? 0 1 2 3 4

PATIENT HEALTH QUESTIONNAIRE - PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle a number.

0 = Not at all **1 = Several Days** **2 = More than half the days** **3 = Nearly Every Day**

1.	Little interest or pleasure in doing things	0 1 2 3
2.	Feeling down, depressed, or hopeless	0 1 2 3
3.	Trouble falling asleep, staying asleep, or sleeping too much	0 1 2 3
4.	Feeling tired or having little energy	0 1 2 3
5.	Poor appetite or overeating	0 1 2 3
6.	Feeling bad about yourself, or that you are a failure and have let you and your family down	0 1 2 3
7.	Trouble concentrating on things such as reading or watching television	0 1 2 3
8.	Moving or speaking slowly that other people could have noticed	0 1 2 3
9.	Being so fidgety or restless that you have been moving around a lot more than usual	0 1 2 3
10.	Thoughts that you would be better off dead or of hurting yourself in some way	0 1 2 3

If you answered 1 - 3 on any of the above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Please Check one

( ) Not difficult at all ( ) Somewhat difficult ( ) Very Difficult ( ) Extremely Difficult

Patient Name: _____

1. What number best describes how, during the past week, pain has interfered with your general activity? *

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

2. What number best describes your pain on average in the past week?*

0 1 2 3 4 5 6 7 8 9 10

No Pain Bad as could be

3. In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"?

0 1 2 3 4 5 6 7 8 9 10

No Pain Bad as could be

4. What number best describes how, during the past week, pain has interfered with your enjoyment of life?*

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

5. In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities."

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Unable to do activities

Below for office use only

PEG _____ AMP _____ Functionality_____

Patient Name _____ Date_____

With our limited time per patient appointments, we like to focus on a specific area of pain for today's visit. This is to ensure that all our patients have equal time with their medical provider. Please answer the two questions below. Thank you

Today's area of pain you would like to focus on **(Please be specific with only one area of pain)**

1._____

If time permits, what are other areas of pain **(One area of pain on each line)**

2._____

3. _____