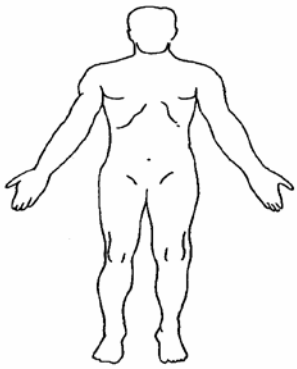
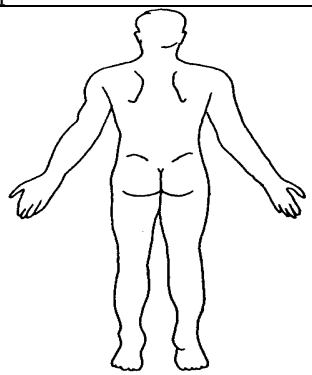
ADVANCE PAIN MANAGEMENT INSTITUTE
apmi
www.paininstitute.org

Date: ____/_____/_____

PROCEDURE QUESTIONNAIRE

Name (last) _____ (first) _____ DOB _____ Age _____ Sex: Male Female

CURRENT SYMPTOMS Please mark the location(s) of your pain with an "X" and show where it goes with an arrow.
If whole areas are painful, shade in the painful area. Circle the words which best describe you pain.

sharp throbbing cutting dull, aching pressure muscle pain cramping	 *Front* right left	shooting electric-like pins and needles weakness numbness	 *Back* left right	burning skin sensitivity to light touch, cold abnormal swelling, hair/nail growth abnormal sweating abnormal skin color changes abnormal skin temperature limited movement

Do you have this pain: ☐ constantly (90-100% of the time), ☐ frequently (75%), ☐ intermittently (50%), ☐ occasionally (25%)

Pain Intensity: Circle your pain intensity with "0" representing no pain and "10" the most severe pain imaginable	Current	None 0 1 2 3 4 5 6 7 8 9 10	Severe
	Least pain score the last 7 days	None 0 1 2 3 4 5 6 7 8 9 10	Severe
	Worst pain score the last 7 days	None 0 1 2 3 4 5 6 7 8 9 10	Severe
	With medications	None 0 1 2 3 4 5 6 7 8 9 10	Severe
	Without medications	None 0 1 2 3 4 5 6 7 8 9 10	Severe

Please list ALL medications from all providers and mark refills you'll need before your next visit

Medication	Dose	How many at a time	How many times a day	Benefits/ side effects	Last intake?	Refill needed?

Prior injections or procedures

DATE	NAME OF PROCEDURE	HOW MUCH PAIN RELIEF?	FOR HOW LONG?	SIDE EFFECTS
1.		%		
2.		%		

Comments/Goals for this appointment: _____

Have there been any significant changes in your health or pain control since your last visit? ☐ No ☐ Yes, if **yes** explain: _____

_____

Were you able to increase your activities? ☐ Yes ☐ No Were you able to decrease your intake of pain medication? ☐ Yes ☐ No

Activity Scale (Circle) Work full time/ Work part time/ Able to leave home without help/ Require help to leave home/ House confined

I sleep in _____hour increments, for a total of_____ hours in a 24 hour period. Do you feel rested? ☐ Yes ☐ No

What makes your pain worse? _____

What makes your pain better? _____

Daily activities: _____

Weekly activities: _____

What do you do to improve your pain control? _____

What are your goals with treatment? _____ Are we helping you meet your goals? ☐ Yes ☐ No

Is constipation a problem? ☐ Yes ☐ No Do you feel depressed? ☐ Yes ☐ No

Do you use alcohol? ☐ No ☐ Yes If yes, list frequency/ amount: _____

Do you use marijuana or any other recreational drugs? ☐ No ☐ Yes _____

Have you taken Aspirin, Plavix or Coumain within last 7 days? ☐ No ☐ Yes _____

Have you taken Ibuprofen or Naprosyn within last 3 days? ☐ No ☐ Yes _____

Are you pregnant? ☐ No ☐ N/A ☐ Not sure ☐ Yes _____

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THE OSWESTRY DISABILITY INDEX

Date: ___/_____/_____

This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life activities. We realize that you may consider more than one statement in a section applicable to you but please mark the one box that most closely describes your present day situation.

1: Pain Intensity
☐0. My pain is mild to moderate. I do not need painkillers.
☐1. The pain is bad but I manage without taking painkillers.
☐2. Painkillers give complete relief from pain.
☐3. Painkillers give moderate relief from pain.
☐4. Painkillers give very little relief from pain.
☐5. Painkillers have no effect on the pain.

2 Personal Care
☐0. I can look after myself normally without causing pain.
☐1. I can look after myself normally but it causes extra pain.
☐2. It is painful to look after myself and I am slow and careful.
☐3. I need some help but manage most of my personal care.
☐4. I need help every day in most aspects of self-care.
☐5. I do not get dressed; I wash with difficulty and stay in bed.

3 Lifting
☐0. I can lift heavy weights without causing extra pain.
☐1. I can lift heavy weights but it causes extra pain.
☐2. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (i.e. on a table)
☐3. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
☐4. I can lift very light weights.
☐5. I cannot lift or carry anything at all.

4 Walking
☐0. I can walk as far as I wish.
☐1. Pain prevents me from walking more than 1 mile.
☐2. Pain prevents me from walking more than ½ mile.
☐3. Pain prevents me from walking more than ¼ mile.
☐4. I can walk only if I use a cane or crutches.
☐5. I am in bed or in a chair for most of every day.

5. Sitting
☐0. I can sit in any chair for as long as I like.
☐1. I can sit in my favorite chair only, but for as long as I like.
☐2. Pain prevents me from sitting for more than 1 hour.
☐3. Pain prevents me from sitting for more than ½ hour.
☐4. Pain prevents me from sitting for more than 10 minutes.
☐5. Pain prevents me from sitting at all.

6. Standing
☐0. I can stand as long as I want without extra pain.
☐1. I can stand as long as I want but it gives me extra pain.
☐2. Pain prevents me from standing for more than 1 hour.
☐3. Pain prevents me from standing for more than ½ hour.
☐4. Pain prevents me from standing for more than 10 min.
☐5. Pain prevents me from standing at all.

7. Sleeping
☐0. Pain does not prevent me from sleeping well.
☐1. I sleep well but only when taking medicine.
☐2. Even when I take medication, I sleep less than 6 hours.
☐3. Even when I take medication, I sleep less than 4 hours.
☐4. Even when I take medication, I sleep less than 2 hours.
☐5. Pain prevents me from sleeping at all.

8. Social Life
☐0. My social life is normal and causes me no extra pain.
☐1. My social life is normal but increase the degree of pain.
☐2. Pain affects my social life by limiting only my more energetic interests such as dancing, sports, etc.
☐3. Pain has restricted my social life and I do not go out as often.
☐4. Pain has restricted my social life to my home.
☐5. I have no social life because of pain.

9. Sexual Activity
☐0. My sexual activity is normal and causes no extra pain.
☐1. My sexual activity is normal but causes some extra pain.
☐2. My sexual activity is nearly normal but is very painful.
☐3. My sexual activity is severely restricted by pain.
☐4. My sexual activity is nearly absent because of pain.
☐5. Pain prevents any sexual activity at all.

10. Traveling
☐0. I can travel anywhere without extra pain.
☐1. I can travel anywhere but it gives me extra pain.
☐2. Pain is bad but I manage journeys over 2 hours.
☐3. Pain restricts me to journeys of less than 1 hour.
☐4. Pain restricts me to necessary journeys under ½ hour.
☐5. Pain prevents traveling except to the doctor/hospital

Patient Signature: _____ Date: _____ / ____ /_____

Name: _____ Score: _____ / _____