Affix Patient Label here
Patient:_____
Date of Service:_____
DOB:_____
M.R.#:_____
MD:_____

Wisconsin Health Fund
6200 W Bluemound Rd.
Milwaukee, WI 53213
414-771-5600

INITIAL PAIN MANAGEMENT QUESTIONNAIRE

Referred by: _____ **Primary Doctor:** _____

Pain History: _____ **Date of Onset**: _____

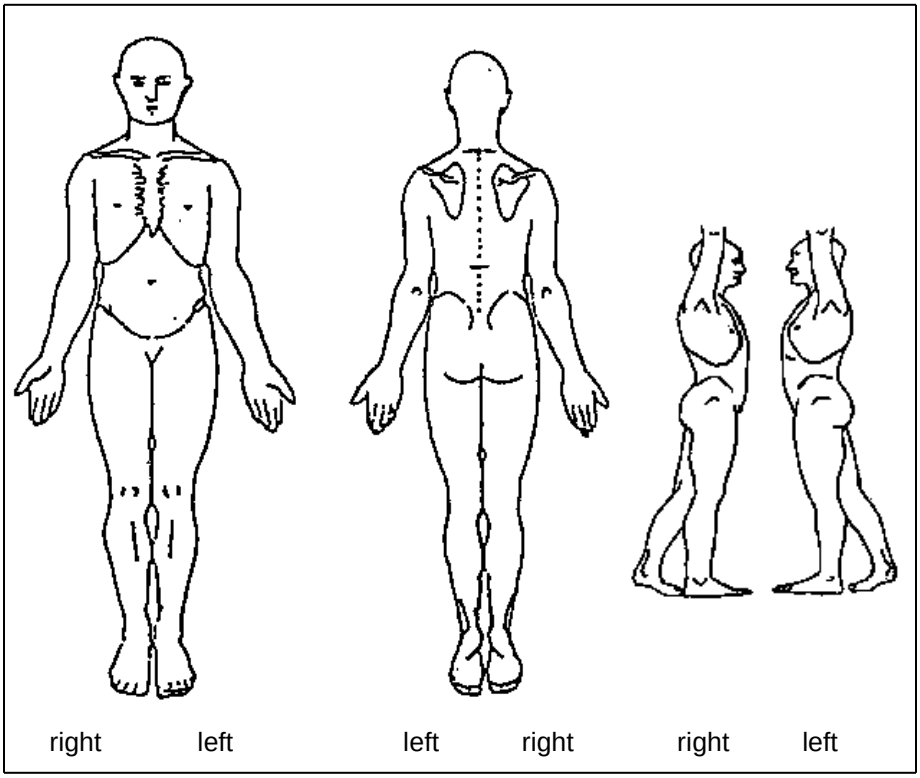
Circumstances of Pain Onset: (check which one applies)

- ☐ Accident at work
- ☐ Accident at home
- ☐ At work, not an accident
- ☐ Pain just began, no apparent reason
- ☐ Motor vehicle accident
- ☐ Following surgery
- ☐ Following illness
- ☐ Other, details _____

Current Pain:
Indicate which of the following still apply:

- ☐ Throbbing
- ☐ Stabbing
- ☐ Cramping
- ☐ Hot/Burning
- ☐ Heavy
- ☐ Splitting
- ☐ Sickening
- ☐ Punishing/Cruel
- ☐ Shooting
- ☐ Sharp
- ☐ Gnawing/Nagging
- ☐ Aching
- ☐ Tender
- ☐ Fearful
- ☐ Tiring/Exhausting
- ☐ Numbness/Tingling

Show places where you hurt, have pain or have discomfort.
Rate the areas for your usual pain (0=no pain, 10=worst pain)



Pain Assessment:
What has made your pain worse?_____

_____

What has made your pain better?_____

_____

Does your pain last as long as it used to?

_____

Present Intensity of Pain:
(Rate the following, 0 = no pain, 10 = worst pain)
Pain level right now _____
Pain level at its worst _____
Pain level at its least severe _____
Acceptable pain level _____

Presence of Pain: (Check which one of the following is true for you at his time)

- ☐ Always present, always the same intensity
- ☐ Always present, intensity varies
- ☐ Usually present, but have short periods without pain
- ☐ Often present, but have pain free periods one to several hours
- ☐ Often present, but pain free for most of the day
- ☐ Occasionally present, have pain once to several times per day, lasting few minutes to an hour
- ☐ Occasionally present for brief periods, a few lasting for seconds to a few minutes
- ☐ Rarely present, have pain every few days or weeks

Sleep / Rest:
How many hours do you sleep per night? _____ Do you have problems sleeping because of pain? ☐ Yes ☐ No
Do you wake up at night because of pain? ☐ Yes ☐ No (If yes, how often? _____)
How would you describe your mood? _____

Medication History:
List any present pain medications/dosages and how often you take them.
(indicate changes from your last visit with a *)

_____ _____
_____ _____
_____ _____

Have you taken medication in the past for your pain that were not effective? ☐ Yes ☐ No
If yes, what medication and when did you take them? _____
_____

Have you had any diagnostic tests (such as MRI or X-Ray) in the past for this pain? ☐ Yes ☐ No
If yes, what? _____

Past Treatments:
Indicate which of the following treatments you have tried in the past and rate their effectiveness (0 = no relief, 10 = total relief)

☐ Chiropractic Therapy ____
☐ Heat Therapy ____
☐ Bed Rest ____
☐ Exercises ____
☐ Traction ____
☐ Acupuncture ____
☐ TENS ____
☐ Psychotherapy ____
☐ Hypnosis ____
☐ Biofeedback ____
☐ Epidural Injections ____
☐ Nerve Blocks ____
☐ Nerve Ablations/ Radiofrequency ____

Have you attended any other pain treatment centers? ☐ Yes ☐ No If yes, where?_____
Who was the physician who treated you? _____

Quality of Life: How would you rate your quality of life at this time? _____ (0 = worst quality, 10 = best quality)
How does your pain affect your activities of daily living (note decreased function, decreased quality of life). Please describe:
Accompanying symptoms: (e.g. nausea, dizziness, constipation) _____
Appetite: _____ Physical Activity: _____
Concentration: _____ Emotions: _____
Other Comments: _____

Vocational History:
Highest Level of Education Completed: _____ Are you currently employed? ☐ Yes ☐ No
Occupation/Job Title: _____ Last Date Worked (if app.) _____
Employer: _____ Job Satisfaction: Good Fair Poor
Is return to work possible? ☐ Yes ☐ No Explain: _____

Social History:
Marital Status: ☐ Never Married ☐ Married ☐ Divorced/Separated ☐ Widowed
Living Situation: ☐ Alone ☐ With Spouse/Significant Other ☐ With Spouse/Significant Other and children
☐ With other relatives ☐ With friend/roommate ☐ Other Explain _____

Who do you turn to for emotional support? _____ Rate your ability to cope with your pain _____
(0 = totally unable to cope, 10 = cope very well)
Any litigation due to your pain? ☐ Yes ☐ No If yes, describe _____
Are you receiving financial support related to your pain? ☐ Yes ☐ No
If yes, which? ☐ Workers Comp ☐ Private Insurance ☐ Social Security ☐ County Program ☐ Other _____

What is your plan/goal for your pain management? Pain Level = _____ Activity desired = _____
Quality of Life = _____ Function desired = _____

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Psychosocial History
Do you have a history of alcohol abuse? ☐ Yes ☐ No
Do you have family members with a history of alcohol abuse? ☐ Yes ☐ No
Do you have a history of drug abuse? ☐ Yes ☐ No
Do you have family members with a history of drug abuse? ☐ Yes ☐ No
Have you ever been treated for depression? ☐ Yes ☐ No
Have you ever been treated for emotional/behavioral disorders? ☐ Yes ☐ No
Do you have any history of suicide attempts? ☐ Yes ☐ No

Past Medical History
Please check all current or past medical issues:

Neurological
☐Stroke/TIA ☐Headache ☐Memory Loss ☐Seizures
☐Fainting ☐Sleep Apnea ☐Fibromyalgia

Cardiovascular
☐Heart Murmur ☐High Blood Pressure ☐Heart Failure ☐Heart Attack
☐Chest Pain ☐Blood Clots ☐Pacemaker ☐Arrhythmia
☐Aneurysm ☐Bleeding Disorder ☐High Cholesterol ☐Chest Pain

Respiratory
☐Asthma ☐Emphysema ☐Bronchitis/Pneumonia
☐Shortness of Breath ☐Cough ☐Wheezing ☐Oxygen Use

Gastrointestinal/Endocrine
☐Diarrhea ☐Nausea ☐Vomiting ☐Constipation
☐Heartburn ☐Ulcer ☐Anemia ☐Liver Disease
☐Diabetes ☐Thyroid Disease ☐Pancreatitis ☐Fecal Incontinence

Genitourinary
☐Painful urination ☐Blood in urine ☐Erectile Dysfunction ☐Urinary Incontinence
☐Kidney Disease ☐Bladder Disease ☐BPH ☐Prostate Cancer

Musculoskeletal
☐Muscle Disease ☐Bone Disease ☐Arthritis ☐Paralysis
☐Back Pain ☐Neck Pain ☐Joint Pain

Infectious Disease
☐Fever/Chills ☐Chickenpox/Shingles ☐Hepatitis ☐HIV or AIDS
☐TB ☐MRSA ☐Rheumatic Fever

Allergic/ENT
☐Environmental Allergies ☐Food Allergies ☐Dizziness
☐Ringing in the Ears ☐Vertigo ☐Nose Bleeds ☐Facial Pain
☐Nasal Congestion ☐Abnormal Vision ☐Dysphagia (Difficulty Swallowing)

Other
☐Cancer ☐Pregnancy ☐Unintentional Weight Loss or gain

Reviewed By: _____ Date: _____

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