ATARAXIA
PAIN MANAGEMENT CLINIC

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Ataraxia Pain Management Clinic – Patient Pre-Consult Questionnaire

Please complete this form and fax it to 416-221-0585 and we will contact you as soon as possible to schedule an appointment.

Client First Name: _____ Claim #: _____

Client Last Name: _____

DOB (YYYY/MM/DD): _____

MRN: _____ Date of Service: _____

Referring Doctor: _____ **Doctor's Tel:** _____

Doctor's Address: _____

Clinician/MD Name: *(Print)* Clinician/MD Signature:

_____ _____

***INSTRUCTIONS**: This questionnaire will help us better understand your pain problem. Please read and answer each question as carefully and completely as possible. Please feel free to provide additional information that will help us better understand your needs.*

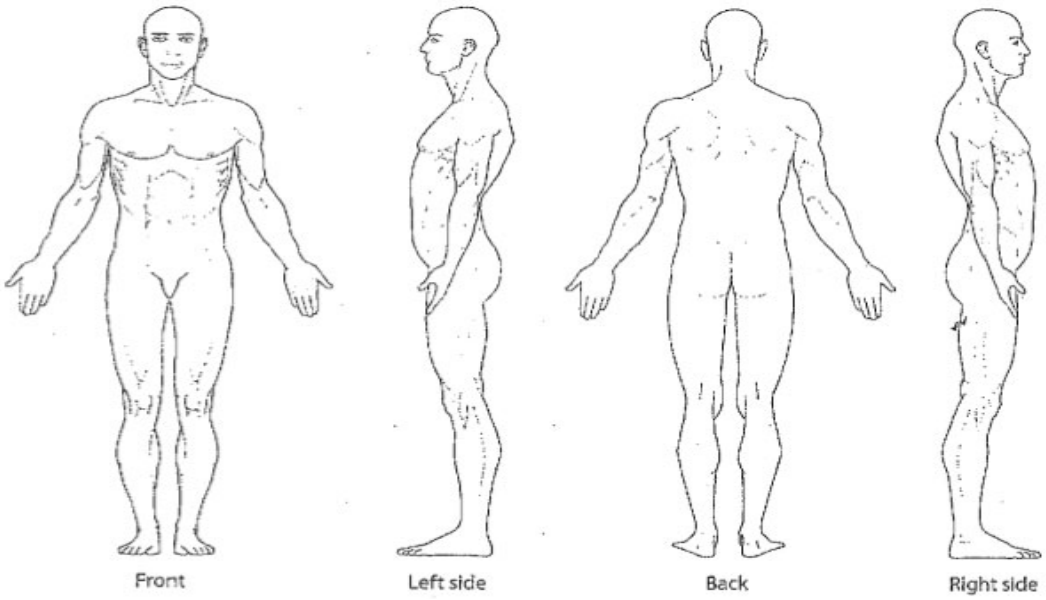
Age: _____ **Marital Status:** (single) (married) **Number of Children:** _____

Currently Working: (circle one) **Yes** / **No**

What kind of work do you do? _____

Are you right or left handed? _____

1. **Pain Drawing:** *Mark the areas on your body where you feel your typical pain. Please include all affected areas. Use* **XXX** *to mark painful areas. Use* **000** *to mark areas of numbness or tingling.*



2. When and how did your pain begin? _____

3. Describe your pain problems: _____

4. Why do you think you have pain? What do you think is wrong?

_____

_____

5. Do you think that your pain problem is due to something more serious than, or different from what the doctors have told you? (circle one) **Yes / No**

6. Why were you referred to this clinic?

_____

7. Which of the following best describes the circumstances related to the onset of your problems? (check one)

[ ] Accident at work. [ ]Accident someplace other than work (ex: home, auto).

[ ]Pain "just began", no obvious reason. [ ]Following an illness. [ ]Following surgery.

[ ]Other: _____

14. Please indicate if any of the following are currently involved in your pain problem? (check one)

[ ]Worker's Safety Insurance Board (Formerly WCB) [ ]Disability Insurance

Other Litigation: _____

Other Insurance: _____

15. List specific activities that <u>INCREASE</u> your pain:

_____

_____

_____

16. List specific activities or things you do to <u>RELIEVE</u> your pain:

_____

_____

_____

17. What are some of your usual recreational activities that you can no longer do because of your pain?

_____

_____

18. Please indicate on the scale below how intense your pain has been during the past TWO weeks:
(circle your answer on the scale)

A. How intense has your pain been AT ITS MOST?
No Pain— 0 1 2 3 4 5 6 7 8 9 10 —Most Pain Imaginable

B. How intense has your pain been AT ITS LEAST?
No Pain— 0 1 2 3 4 5 6 7 8 9 10 —Most Pain Imaginable

C. How intense has your pain been ON THE AVERAGE?
No Pain— 0 1 2 3 4 5 6 7 8 9 10 —Most Pain Imaginable

D. How intense is your pain been RIGHT NOW?
No Pain— 0 1 2 3 4 5 6 7 8 9 10 —Most Pain Imaginable

19. Indicate all of the words below that best describe your primary pain: (circle)
Throbbing Constant Shooting Stabbing Pins/Needles Sharp Dull Cramping Aching
Hot/Burning Cold Tender Sickening Fearful Punishing/Cruel Gnawing
Tiring/Exhausting Other (explain): _____

20. Indicate any or all of the following if they are associated with your pain problem: (circle)
Weakness Muscle Spasms Swelling Sweaty Skin Colour Change
Skin painful to touch Other: _____

21. Please list all the medications you are CURRENTLY taking:

	Name	Dosage	How often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

22. Please list all the medications you have tried for pain control and the reason you STOPPED taking it:

Medication Name: _____Reason for STOPPING: _____

_____ _____

_____ _____

_____ _____

23. Please list your MEDICATION ALLERGIES:

_____

_____

_____

24. What MEDICAL PROBLEMS do you have besides pain?

_____

_____

_____

25. Have you already had surgery for you pain problem? (circle) **Yes / No**

If so, please list all your surgeries below:

_____

26. Please indicate which of the following treatments you have tried for your pain: (circle)

Hot Packs Homeopathic Medicine Traction Cold Packs Aerobics Counseling,
Ultrasound Biofeedback E.R. Visit(s) Strength Exercises Relaxation Physiotherapy,
Chiropractor Specialist Referral(s) Body Mechanics Family Doctor Herbal Medicine
Bed Rest Visits TENS Unit Injections Hospitalization(s)
Other: _____

27. Do you smoke? Yes / No If yes, how much? _____

28. Do you drink alcohol? Yes / No If yes, how much? _____

29. Please indicate on the scale below how much of a problem you are having with each of the following: (circle your answer on the scale)

Anxiety or Nervousness

None— 0 1 2 3 4 5 6 7 8 9 10 —Severe

Depression

None— 0 1 2 3 4 5 6 7 8 9 10 —Severe

Irritability

None— 0 1 2 3 4 5 6 7 8 9 10 —Severe

30. Have you ever experienced any emotional/verbal/physical abuse? (circle) **Yes / No**

31. During the past year, please CHECK MARK if you have had:

SYMPTOM:	BRIEF EXPLANATIONS & OTHER COMMENTS:
[ ] Unexplained Fever	_____
[ ] Night Sweats	_____
[ ] Weight Loss of 10lb. or more	_____
[ ] Weight Gain of 20lb. or more	_____
[ ] Difficulty Sleeping	_____
[ ] Snoring	_____
[ ] Easy Bruising or Bleeding	_____
[ ] Any Lumps in Neck, Armpits or Groin	_____
[ ] Chest Pain or Tightness	_____
[ ] Trouble Breathing with Exercise	_____
[ ] Trouble Breathing Lying Flat	_____
[ ] Coughing Up Blood	_____
[ ] Swollen Ankles	_____
[ ] Stomach Pain	_____
[ ] Change in Bowel Habits	_____
[ ] Persistent Diarrhea	_____
[ ] Excessive Constipation	_____
[ ] Dark Black Stools	_____
[ ] Pain or Burning When Urinating	_____
[ ] Difficulty Urinating	_____
[ ] Blood in Urine	_____
[ ] Need to Urinate More at Night	_____
[ ] Generalized Morning Stiffness	_____
[ ] Persistent Eye Redness	_____
[ ] Muscle Tenderness	_____
[ ] Joint Pain or Tenderness	_____
[ ] Skin Rashes	_____