

**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.*

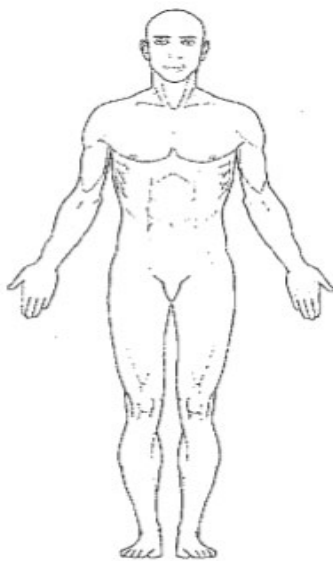
Age: \_\_\_\_\_ Marital Status: (single) (married) Number of Children: \_\_\_\_\_

Currently Working: (circle one) Yes / No

What kind of work do you do? \_\_\_\_\_

Are you right or left handed? \_\_\_\_\_

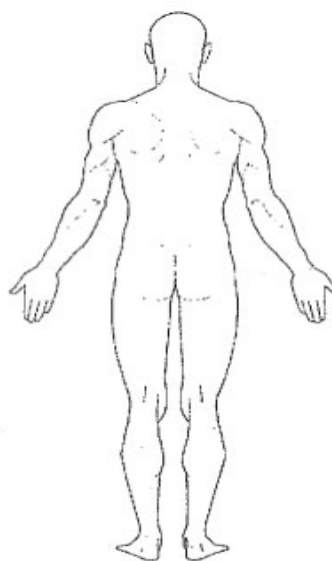
**1. Pain Drawing:** *Mark the areas on your body where you feel your typical pain. Please include all affected areas. Use **XXX** to mark painful areas. Use **000** to mark areas of numbness or tingling.*



Front



Left side



Back



Right side

**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 INCREASE your pain:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**16. List specific activities or things you do to RELIEVE 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 \_\_\_\_\_