SWEDISH

SWEDISH PAIN AND HEADACHE CENTER INITIAL QUESTIONNAIRE

Name _____ **Today's Date** _____ **Date of Birth** _____

Please list your main areas of pain, how long you have had pain in each area and how severe the pain is on average (EX: low back pain, since 2000, moderately painful).

Body area	**Date started**	**Pain on average (mild, moderate, severe)**
EX: low back, left leg	August 2000	Moderate
1.		
2.		
3.		
4.		

Briefly describe how each of the pain problems you listed above started

Area1 _____

_____

Area 2 _____

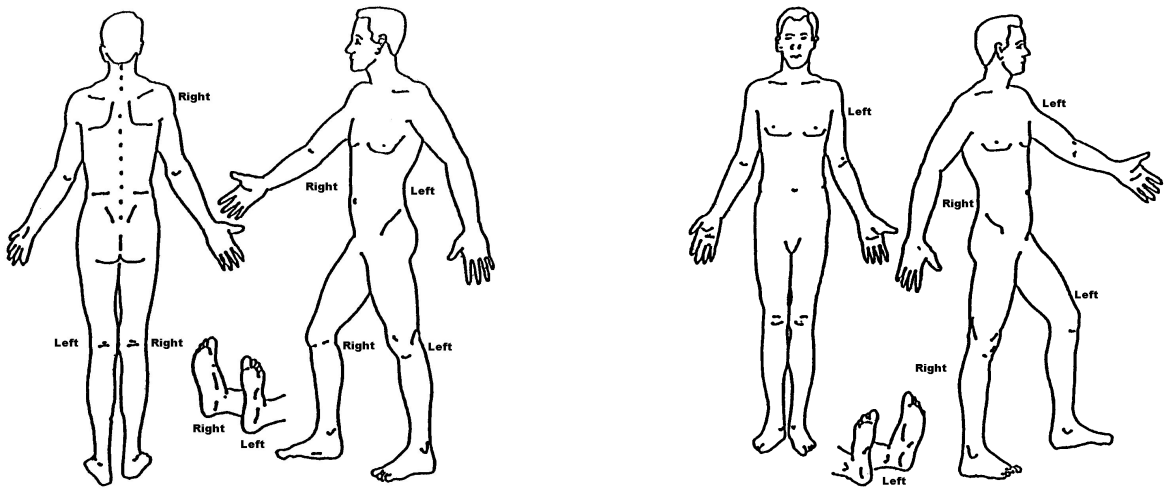
_____

Area 3 _____

_____

Please indicate where your present pain is:

/// Stabbing **XXX** Burning **====** Numbness **000** Pins and Needles



Pain Score

How would you best describe your pain? (Please check all that apply)

☐ Dull, throbbing, aching ☐ Shock-like, numb, or tingling ☐ Burning ☐ Other

Please rate your pain by circling the one number that best describes your pain on the average over the past few days. (While taking your pain medication)

1 2 3 4 5 6 7 8 9 10

What makes your pain worse?

☐ Standing ☐ Walking ☐ Sitting ☐ Bending or twisting ☐ Ice ☐ Heat

What makes your pain better?

☐ Standing ☐ Walking ☐ Sitting ☐ Bending or twisting ☐ Ice ☐ Heat

To what degree has pain interfered with the following activities? (1 = no interference, 10 = maximum interference)

Your sleep	1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 10
General activity	1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 10
Mood	1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 10
Walking ability	1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 10
Normal work (at home and outside)	1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 10
Relations with others	1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 10
Enjoyment of life	1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 10

Over the last two weeks or more have you noticed the following:	**Not at all**	**Rarely**	**Sometimes**	**Often**	**Most of the time**
1. I feel sad, down in the dumps, or unhappy.					
2. I can't concentrate or focus.					
3. Nothing seems to give me much pleasure.					
4. I feel tired I have no energy.					
5. I have had thoughts of suicide.					
6. Changes in sleeping patterns					
a. I have difficulty sleeping.					
b. I have been sleeping too much.					
7. Changes in appetite					
a. I have lost some appetite.					
b. I have been eating more.					
8. I feel tense, anxious; I can't sit still.					
9. I feel worried or fearful.					
10. I have attacks of anxiety or panic.					
11. I worry about dying or losing control.					
12. I am nervous or shaky in social situations.					
13. I have nightmares or flashbacks.					
14. I am jumpy or feel startled easily.					
15. I avoid places that strongly remind me of a bad experience.					
16. I feel dull, numb or detached.					
17. I can't get certain thoughts out of my mind.					
18. I feel I must repeat certain acts or rituals.					
19. I feel the need to check and recheck things.					
20. Had more energy energy than usual.					
21. Felt unusually irritable or angry.					
22. Felt unusually excited, revved up or high.					
23. Need less sleep than usual.					
Indicate whether any of the above symptoms					
24. Interferes with work or school.					
25. Affects my relationships with friends or family.					
26. Has led to me using alcohol to get by.					
27. Has led to me using drugs.					

Sleep History: Mark the ones that best describe your sleep.

☐ Have you ever had a sleep study?	☐ Yes	☐ No
☐ Do you have a prescibed sleeping device? (ex: CPAP, BIPAP)	☐ Yes	☐ No
☐ Have you been told you snore a lot?	☐ Yes	☐ No
☐ Have you been told you often gasp stop breathing during sleep?	☐ Yes	☐ No
☐ Do you often have problems with restlessness (creeping, crawling, or other uncomfortable feelings) in the legs keeping you awake so you have to get up and walk around?	☐ Yes	☐ No
☐ Does your bed partner report that your legs jerk during sleep	☐ Yes	☐ No
☐ Do you usually awaken in the morning feeling refreshed	☐ Yes	☐ No

Goals for treatment

Please put down four things in your life which you can't do or have difficulty doing because of your pain, and which you would most DEARLY like to do if the treatments decrease your pain by 50%.
These four things can't be vague or general such as "to be free of pain" or "to be whole again". They have to be activities that you do and which someone else could see you doing.

1. _____

2. _____

3. _____

4. _____

Past medications tried for pain (medications you are no longer taking):

Name of drug	Strength	Number per day	Reason for stopping (ex: side effects, ineffective, other)

Did the pain medicine cause a problem?

	No	Mild	Moderate	Severe
Nausea				
Constipation				
Drowsiness				
Confusion				
Dry mouth				
Headache				
Weight gain				
Sexual problems				

Have you ever had the following types of treament for your present pain problem and what was the result?

Type of treatment:	No	Improved	No change	Worse
Occupational Therapy				
Physical therapy				
Passive (Heat, ultrasound, gentle massage)				
Mobilizations				
Exercise				
Pool exercises				
Biofeedback				
Home TENS machine				
Chiropractic manipulations				
Deep tissue massage				
Psychological counseling for pain				
Trigger point injections				
Epidural steroid injections				

(Continued) Have you ever had the following types of treatment for your present pain problem and what was the result?

Type of treatment:	No	Improved	No change	Worse
Psychological counseling for pain				
Trigger point injections				
Epidural steroid injections				
Facet (spine joint) injections				
Nerve blocks				
Other				

Do you use any of these substances regularly in the four hours before going to bed?
☐ Alcohol ☐ Caffeine (coffee, tea, sodas) ☐ Tobacco ☐ Decongestants
☐ Beta blockers (for blood pressure or heart problems e.g. atenolol, propanolol)

Habits
Do you smoke? ☐ Yes ☐ No
If Yes,
☐ Half to one pack a day
☐ One or more packs a day
☐ Is the early morning cigarette the most pleasurable of the day? ☐ Yes ☐ No

If you are a former smoker, when did you stop? _____

Do you have any history of addiction or substance abuse? ☐ Yes ☐ No
- If Yes, was it an addiction to: ☐ Alcohol ☐ Other drugs

Have you ever used the following substances?

	Never	Once or Twice	Monthly	Weekly	Daily	Last Used
Cannabis (Marijuana, pot, grass, etc.						
Alcoholic beverages (Beer, wine, hard liquor, etc.)						
Cocaine (coke						
Methamphetamine (speed, crystal, etc.)						
Prescription stimulants (Ritalin, Dexedrine, Adderall, diet pills)						
Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)						
Street opioids (heroin, opium, etc.)						

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.
Have you ever felt you ought to cut down on your drug or alcohol use? ☐ Yes ☐ No
Have people annoyed you by criticizing your alcohol or drug use? ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?

ER visits
In the past year have you been treated in the Emergency Room for your pain problem? ☐ Yes ☐ No
If Yes, how many times? ☐ 1 ☐ 2-5 ☐ 6-10

Do you suffer from headaches? ☐ Yes ☐ No
If Yes,
In the past two weeks, did you suffer from headaches? (Choose one answer)
☐ I had no headache at all.
☐ I had mild headaches which came infrequently.
☐ I had moderate headaches which came infrequently.
☐ I had moderate headaches which came frequently.
☐ I had severe headaches which came frequently.
☐ I had headaches almost all the time.

Type of headaches (Mark the ones that best describe your main headaches)

Do the headaches last 4 to 72 hours?	☐ Yes	☐ No
Are your headaches one sided?	☐ Yes	☐ No
Do the headaches affect both sides?	☐ Yes	☐ No
Are the headaches pulsating in nature?	☐ Yes	☐ No
Are the headaches pressing or tightening or non pulsating	☐ Yes	☐ No
Are they worsened by or do you to avoid physical activity?	☐ Yes	☐ No
Are they moderate to severe in intensity?	☐ Yes	☐ No
Do they cause you to feel sick or to vomit?	☐ Yes	☐ No
Does bright light or any noise make the headache worse?	☐ Yes	☐ No

Do you suffer from abdominal pain? ☐ Yes ☐ No

If Yes**,**

For at least three months (which do not need to be together) in the last year, have you had abdominal pain which is:

☐ Relieved by having a bowel action?		
☐ Associated with a change in the frequency of stool?	☐ Yes	☐ No
☐ Associated with hard lumpy or loose watery stools?	☐ Yes	☐ No
☐ Associated with the passage of mucus?	☐ Yes	☐ No
☐ Associated with the feeling of being bloated?	☐ Yes	☐ No

Do you suffer from pelvic or bladder pain? ☐ Yes ☐ No

If Yes,

☐ Does your urine burn you when you go to the toilet?	☐ Yes	☐ No
☐ Do you ever see blood in your urine?	☐ Yes	☐ No

How many times do you go to the bathroom during the day?

☐ 3 -6 ☐ 7-10 ☐ 11-14 ☐ 15-19 ☐ 20+

How many times do you go to the bathroom at night?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Do you still have urgency after you go to the bathroom?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

If you have urgency, is it usually: ☐ Mild ☐ Moderate ☐ Severe

Family History

Did you have any immediate family members suffering from:

Diabetes	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Severe Arthritis	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
The same types of pain you suffer from	☐ Yes	☐ No

Social History

Did you have a happy childhood?	☐ Yes	☐ No
Have you ever been sexually and or physically abused?	☐ Yes	☐ No
Do you currently feel threatened in your environment?	☐ Yes	☐ No
Have you ever seriously considered or attempted suicide?	☐ Yes	☐ No
Do you have a suicide plan at the moment?	☐ Yes	☐ No

Are you: ☐ Married, ☐ Divorced, ☐ Widowed, ☐ Single, ☐ Living with someone?

Do you have any children?	☐ Yes	☐ No

If yes, how old are they? _____

Work History

What is your occupation?_____

Are you:

- ☐ Employed full time
- ☐ Employed part time
- ☐ Unemployed because of pain
- ☐ Unemployed because of other reasons
- ☐ Retired because of pain
- ☐ Retired but not because of pain
- ☐ In school or retraining
- ☐ Homemaker

How satisfied are you with your curent job? ☐ Very satisfied ☐ Neutral ☐ Very dissatisfied

☐ Do you have problems getting along with your co-workers? ☐ Yes ☐ No

☐ Do you have an attorney working on your injury claim? ☐ Yes ☐ No

If you are not working at present

Do you think you will be able to return to the same sort of job that you were doing before your pain?

☐ Yes ☐ No ☐ Not applicable

Are you actively considering a change of employment or a retraining program? ☐ Yes ☐ No

Overall, on a scale of 0-10 how close are you to returning to work (10 means ready to work full time, 0 means you are not even close to work at any job)

0 1 2 3 4 5 6 7 8 9 10

How many hours did you work last week?_____ ☐ Not applicable

How many hours did you work the week before?_____ ☐ Not applicable

Spirituality

Chronic pain is often a frightening, anxious, and lonely time for many sufferers.

Have you ever met with a spiritual counselor? ☐ Yes ☐ No

Would you be interested in metting with the hospital chaplain that works with the Pain and Headache Center? ☐ Yes ☐ No

The chaplains work at Swedish and have completed comprehensive theological and hospital chaplaincy training. They never impose religious preferences or personal philosophies on patients or families.

Past Medical History

Check off if you have had any of these conditions either now or in the past:

Constitutional

- ☐ Have you had an unexplained weight loss of more than 10 pounds in the last 6 months?
- ☐ Have you had a fever over the last few days?

Cardiovascular:

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Angina
- ☐ A heart attack
- ☐ Congestive cardiac failure
- ☐ Cardiac surgery
- ☐ Irregular heart beat

Pulmonary:

- ☐ Bronchitis
- ☐ Shortness of breath easily
- ☐ Asthma

Liver/Genitourinary:

- ☐ Hepatitis
- ☐ Other liver problems
- ☐ Kidney problems
- ☐ Bladder problems

Endocrine

- ☐ Diabetes
- ☐ Thyroid disease

Gastrointestinal

- ☐ Acid reflux
- ☐ Stomach ulcer

Nervous system

- ☐ Seizures
- ☐ Stroke
- ☐ Paralysis
- ☐ Peripheral neuropathy

Musculoskeletal

- ☐ Neck/back problems
- ☐ Arthritis
- ☐ Artificial joints

Psychiatric

- ☐ Depression
- ☐ Bipolar
- ☐ Panic disorder
- ☐ Post traumatic stress disorder
- ☐ Other

Other

- ☐ Cancer ☐ HIV
- ☐ Addiction or substance abuse: ☐ Yes ☐ No
  IF YES was it addiction to: ☐ Alcohol ☐ Other drugs
- ☐ Exposure to toxins such as asbestos, dyes, printing, rubber, arsenic

Past Surgical History

☐ None

Surgery (name)

_____Year

Surgery (name)

_____Year

Surgery (name)

_____Year

Surgery (name)

_____Year

Surgery (name)

_____Year

Surgery (name)

_____Year

Surgery (name)

_____Year

Other surgeries

_____

Patient name sticker

See reverse

Medication allergies

Are you allergic to any medication? An allergy means a rash, swelling, difficulty in breathing. It does NOT mean causing a stomach upset or dizziness. ☐ Yes ☐ No

If yes please list them:

Present Medications

Medications NOT FOR PAIN Please list all medications you are taking and how many times a day which are NOT for pain (e.g. blood pressure, cholesterol, heart, blood thinners)

Name of drug	Strength	Number per day

Medications FOR PAIN

Name of drug	Strength	Number per day

Patient name sticker