SWEDISH
Extraordinary care. Extraordinary caring.℠

SWEDISH PAIN SERVICES:
Initial Visit Questionnaire

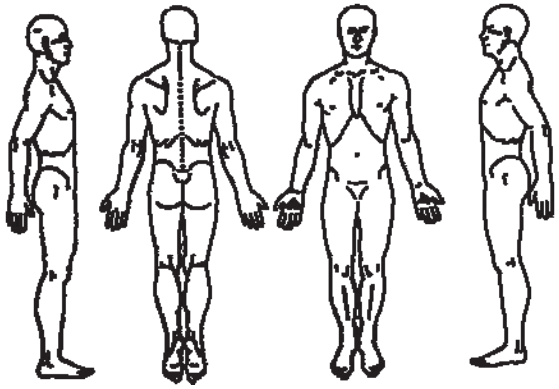
Name _____ Date of Birth _____ Today's Date _____

We realize that some of the questions might not address your exact situation but please answer them to your best ability.

Approximately how many years have you had your pain? _____Years

How many areas of your body are now affected by chronic pain? ☐ 1 ☐ 2-3 ☐ 3 or more

Please indicate where your present pain is:



What number best describes your pain ***on average in the last week***:

No pain — Pain as bad as you can imagine

0	1	2	3	4	5	6	7	8	9	10

Please check the box of the number that best describes how, ***during the last week***, pain has interfered with your:

No interference — Completely interferes

	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of life											
General Activity											

Activity difficulty: In order to monitor it during the course of your treatment, please list one important activity that is currently difficult for you to perform:

_____

How would you rate the difficulty you have performing this activity ***over past week***?

No difficulty — Extreme difficulty

0	1	2	3	4	5	6	7	8	9	10

Pain and everyday activities:

Please answer every section, and mark in each section the one box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but *please mark the box that most clearly describes your problem.*

Section 1- Pain intensity:

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment

Section 2 - Personal care (washing, dressing, etc.)

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

Section 3 - Lifting:

- ☐ I can lift heavy weights without causing extra pain
- ☐ I can lift heavy weights, but it causes me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned (eg. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking:

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can walk using a stick or crutches.
- ☐ I am in bed most of the time

Section 5 - Sitting:

- ☐ I can sit in any chair for as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 - Standing:

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 - Sleeping:

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain Because
- ☐ of my pain I have less than 6 hours sleep. Because
- ☐ of my pain I have less than 4 hours sleep. Because
- ☐ of my pain I have less than 2 hours sleep.. Pain
- ☐ prevents me from sleeping at all.

Section 8 - Sex life (if applicable):

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevent any sex life at all

Section 9- Social life:

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, sport
- ☐ Pain has restricted my social life, and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10 - Traveling:

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to necessary journeys under 30 minutes
- ☐ Pain prevents traveling except to receive treatment.

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious on edge	❑	❑	❑	❑
Not being able to control or stop worrying	❑	❑	❑	❑
Worrying too much about different things	❑	❑	❑	❑
Trouble relaxing	❑	❑	❑	❑
Being so restless that it's hard to sit still	❑	❑	❑	❑
Becoming easily annoyed or irritable	❑	❑	❑	❑
Feeling afraid as if something awful might happen	❑	❑	❑	❑

	Not at all	Several days	Over half the days	Nearly every day
Little interest or no pleasure in doing things	❑	❑	❑	❑
Feeling down, depressed, or hopeless	❑	❑	❑	❑
Trouble falling or staying asleep, or sleeping too much	❑	❑	❑	❑
Feeling tired or having little energy	❑	❑	❑	❑
Poor appetite or overeating	❑	❑	❑	❑
Feeling bad about yourself – or that you are a failure or you have let yourself or family down	❑	❑	❑	❑
Trouble concentrating on things, such as the newspaper or watching television	❑	❑	❑	❑
Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around more than usual	❑	❑	❑	❑
Thoughts that you would be better off dead or hurting yourself	❑	❑	❑	❑

In your life have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you:

	Yes	**No**
Have had nightmares about it or thought about it when you did not want to?		
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?		
Were constantly on guard, watchful, or easily startled?		
Felt numb or detached from others, activities, or your surroundings?		

With the ***last two weeks*** in mind, **if you have had back pain,** please answer the following questions:

	Disagree	**Agree**
My back pain has **spread down my leg(s)** at some time in the past 2 weeks		
I have had pain in the **shoulder or neck** at some time in the past 2 weeks		
I have only **walked short distances** because of my back pain		
In the past 2 weeks I have **dressed more slowly** than usual because of back pain		
It's really not safe for a person with a condition like mine to be physically active		
Worrying thoughts have been going through my mind a lot of the time		
I feel that **my back pain is terrible** and **it's never going to get any better**		
In general I have **not enjoyed** all the things I used to		

Overall how **bothersome** has your back pain been over the **last 2 weeks**

☐ **Not at all** ☐ **Slightly** ☐ **Moderately** ☐ **Very much** ☐ **Extremely**

Sleep	**Yes**	**No**
Has anyone observed you stop breathing during your sleep?		
Have you ever had sleep study?		
If yes, were you told you had sleep apnea?		
If yes, do you use a CPAP or other sleep device to help you sleep?		
Do you often have problems with restless legs (urge to move the legs, worse at rest, better with activity, worse at evening and night)?		
Do your legs frequently jerk during sleep?		

Fatigue/tiredness	**None**	**Mild**	**Severe**	**Very Severe**
How would you rate your fatigue ***on average***?				

Sleep Disturbance in the past seven days	**Very poor**	**Poor**	**Fair**	**Good**	**Very Good**
My sleep quality was					

In the past 7 days	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
My sleep was refreshing					
I had a problem with my sleep					
I had difficulty falling asleep					
My sleep was restless					
I tried hard to get to sleep					
I worried about not being able to sleep					
I was satisfied with my sleep					

		Yes	No
Family history of substance abuse	Alcohol		
	Illegal Drugs		
	Prescription drugs		
Personal history of substance abuse	Alcohol		
	Illegal Drugs		
	Prescription drugs		
Age between 16-45 years			
History of preadolescence sexual abuse			
Psychological disease	ADD Attention Deficit Disorder		
	Obsessive compulsive disorder		
	Bipolar disorder		
	Schizophrenia		
	Depression		

Family History	**Yes**	**No**	**Mother**	**Father**	**Fathers mother**	**Fathers father**	**Mothers mother**	**Mothers father**	**Other family member**
Family history of arthritis									
Family history of fibromyalgia									
Family history of migraines									
Family history of heart disease									
Family history of diabetes									

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

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

0	1	2	3	4	5	6	7	8	9	10

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

Please identify 2-3 goals that you would like to achieve. A goal is something you would like to achieve and you feel is possible over the next 2 weeks.

1. _____

2. _____

3. _____

To the best of your recollection, how many different healthcare providers have you seen in the **LAST 6 MONTHS** for your pain?

Number of times you have seen them (approximately)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10+**
General practice (i.e. family medicine, internal medicine):										
Medical specialists:										
Pain specialists:										
Surgical specialists:										
Psychologists, psychiatrists, or other mental health professionals:										
Physical therapists:										
Chiropractors										
Complimentary and alternative healthcare professionals (i.e naturopath, massage, accupuncture):										

Allergies: Are you allergic to any medication? ..... ☐ Yes ☐ No

If YES, please list them

Medication	**Reaction**

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

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

What over the counter (*non prescription)* medications or herbal preparations are you taking? (Eg Advil, Aleve, Tylenol, Benadryl)

Name of drug	**Strength**	**Number per day**

What ***pain*** medications are you taking eg Percocet, oxycodone, hydrocodone, gabapentin?

Name of drug	**Strength**	**Number per day**

What ***non-pain*** medications are you taking eg for high blood pressure, cholesterol, diabetes?

Name of drug	**Strength**	**Number per day**

Past Medical History: Have you had any of these conditions either now or in the past**?**

	Yes	No		Yes	No
No known Problems					
Alcohol Addiction			Heart Disease		
Anesthesia Reaction			Heart Failure		
Arthritis			High Blood Pressure		
Asthma			Kidney disease		
Cancer			Mental Health Disease		
COPD			Liver problems		
Diabetes			Stroke		
Drug Addiction			Thyroid Disease		
Acid reflux			Schizophrenia		
Stomach ulcer			Post Traumatic stress disorder		
Depression			Gout		
Panic disorder			HIV positive disease		
Bipolar disorder			Any unexplained weight loss of more than 10 pounds in the last 6 months		
Obsessive-compulsive disorder					

Review of systems: Do you suffer from

- ☐ Night sweats, unexplained falls
- ☐ Eye pain
- ☐ Sinus pain, ear pain, throat pain, pain on swallowing
- ☐ Chest pain, unable to lie flat at night because of shortness of breath
- ☐ Abdominal pain, nausea vomiting, diarrhea, constipation, bloating, black stools, an eating disorder
- ☐ Incontinence, burning urine, frequent urination
- ☐ Joint swelling,
- ☐ Breast pain, breast lumps, breast discharge
- ☐ Seizures, burning discomfort, numbness, poor balance, speech problems, headaches
- ☐ Tremor, palpitations, needing to drink a lot of water, chronic low blood pressure
- ☐ Prolonged bleeding after dental extraction, refused for blood donation

Social History

What is your marital status?

☐ Married ☐ Divorced/Separated ☐ Single ☐ Single but living with someone

Do you have any children? ..... ☐ Yes ☐ No

If yes, what are their ages? _____

Have you had a stress or change in a significant relationship within the past 12 months? ☐ Yes ☐ No

If yes, please explain: _____

Living Situation

☐ Live Alone ☐ With Family ☐ With Friends ☐ Homeless ☐ Other

Surgical History

Have you had surgeries?..... ☐ Yes ☐ No

IF YES, please list them with year of surgery

Name of surgery, example: spine fusion L5-S1	Year 2012

Tobacco Use

☐ No - Never ☐ No - Former Smoker ☐ Yes - Occasional smoker ☐ Yes - Smoke every day

If yes,

Ready to quit? ..... ☐ Yes ☐ No

Packs/Day ☐ 0.25 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2+

Alcohol Use

Do you drink alcohol? ..... ☐ Yes ☐ No

If yes,

Drinks per week: _____ Glasses of wine _____ Cans or bottles of beers _____ Shots of liquor

Recreational Drug Use (not prescribed to you)

Do you use recreational drugs? ☐ Yes ☐ No

If yes,

Drug Type?

☐ Benzodiazepines (Xanax, Ativan, Valium)
☐ Cannabis
☐ Cocaine
☐ Methamphetamine
☐ Opiates

Use per week ☐ 1 ☐ 2 ☐ 5 ☐ Other