

Stanford University Medical Center  
**Stanford Pain Management Center**  
300 Pasteur Dr., Boswell Bldg., Room A408  
Stanford, CA 94305  
(650)723-6238 Fax: (650)725-7544  
Web site: <http://paincenter.stanford.edu>



Addressograph/Label or Patient Name and Medical Record Number

**Clinics – Pain Mgmt – New Patient Health Questionnaire**

Patient Name:

\_\_\_\_\_ Last First Middle Maiden

Address:

\_\_\_\_\_ Street City State Zip

Phone (Home) \_\_\_\_\_ Phone (Work or other) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

PCP Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician (if different than PCP): \_\_\_\_\_

Referring Physician Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Phone (toll free): \_\_\_\_\_ Member or Subscriber No. \_\_\_\_\_

Group No. \_\_\_\_\_ Employer Group Name (if applicable): \_\_\_\_\_

Workers Compensation Claim No. \_\_\_\_\_ Adjustor: \_\_\_\_\_

*If your insurance requires pre-authorization, you are responsible for securing the authorization before treatment has begun. We will be happy to assist by providing the insurance with the treatment plan, and other documentation.*

Secondary or additional Insurance: \_\_\_\_\_

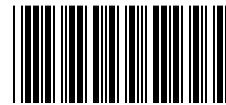
Phone (toll free): \_\_\_\_\_ Member or Subscriber No. \_\_\_\_\_

Group No. \_\_\_\_\_ Employer Group Name (if applicable): \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Attorney's Address: \_\_\_\_\_

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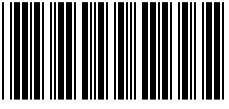


Addressograph/Label or Patient Name and Medical Record Number

**Clinics – Pain Mgmt – New Patient Health Questionnaire**

1. Distance from your home to Stanford Pain Clinic: \_\_\_\_\_ (approx. miles) \_\_\_\_\_ (driving time – minutes/hours)
2. Marital Status: Married, Separated, Widowed, Never Married, Living together
3. Your Age: \_\_\_\_\_ Number of Children: \_\_\_\_\_ Ages of Children: \_\_\_\_\_
4. Is there a specific question that you or your doctor wants answered today? \_\_\_\_\_  
\_\_\_\_\_
5. Where is your pain located (also please draw on the diagram on the next page)? \_\_\_\_\_  
\_\_\_\_\_
6. How long have you had your pain problem? \_\_\_\_\_
7. Briefly describe how your pain started:
  
8. Explain what you believe is the cause of your pain? Please try to be specific. \_\_\_\_\_  
\_\_\_\_\_
9. If your pain were 50% less tomorrow, what would you be doing differently? \_\_\_\_\_  
\_\_\_\_\_
10. How has your pain affected your life? \_\_\_\_\_
11. Describe your present pain (i.e. aching, throbbing, sharp, hot, cold, etc.)? \_\_\_\_\_
12. Describe the timing of your pain: Brief Constant Comes and goes Continuous  
Always there Appears and disappears Intermittent





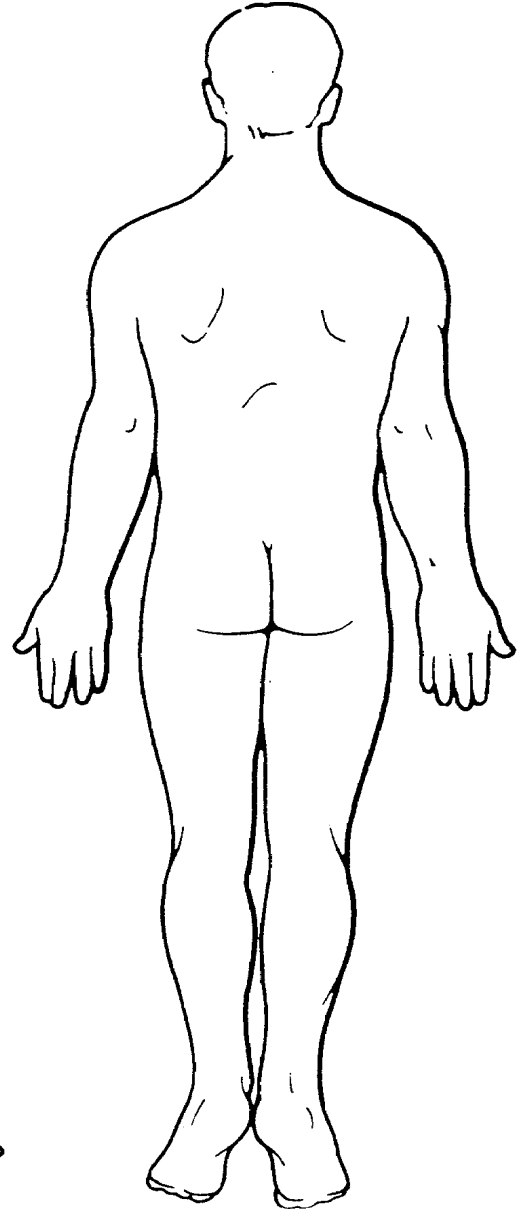
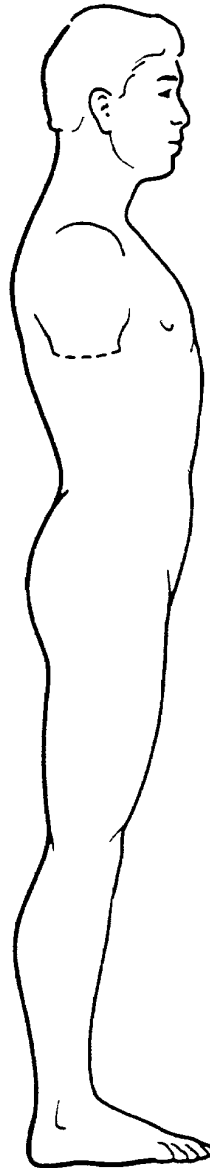
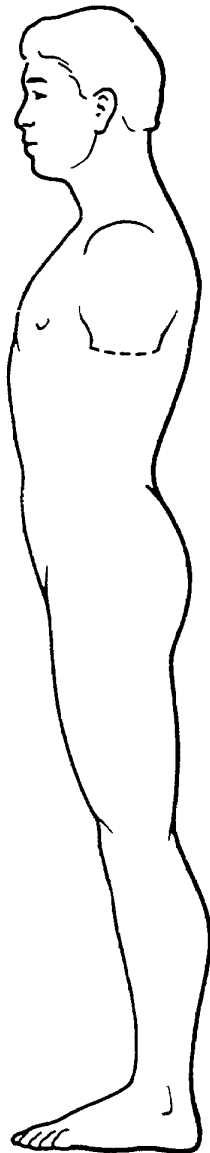
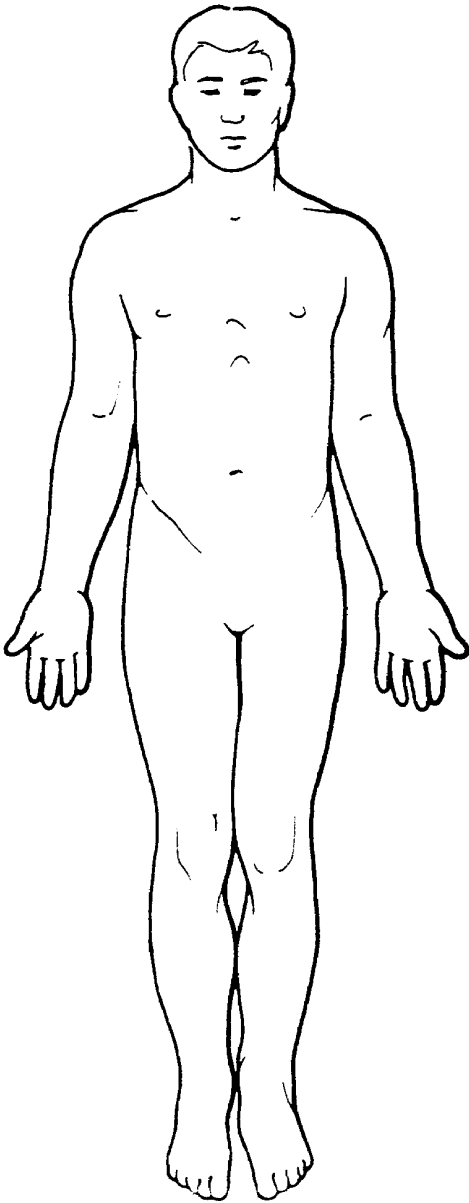
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MRN: \_\_\_\_\_

**Pain Location**

Mark on the drawing below the exact spot where your pain is located. Use a solid black dot (●). If the pain starts at that spot and radiates elsewhere (travels to another part of your body), draw a line from the spot where the pain starts to where it ends. If it is a whole area that hurts, shade in that area with a pencil.

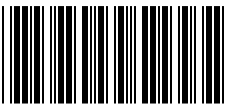
Next to the places on the drawing where you showed pain, put an “E” if the pain is external (on the outside surface). If the pain is internal (inside the body) mark it with an “I.” If the pain is both internal and external,



mark “E.I.”

**Left**

**Right**

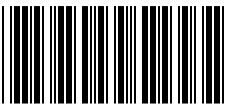


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MRN: \_\_\_\_\_

**Past Medications** (Medications you have previously tried for pain) Please check appropriate box

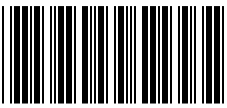
YES, TRIED	NOT TRIED	NAME OF MEDICATION	STILL TAKING (if known)	IF STOPPED WHY	
				Side effects	Not Effective
		<b><i>Pain Killers</i></b>			
		Actiq			
		Codeine, Tylenol #3,#4			
		Fentanyl patches (Duragesic)			
		Hydrocodone (Vicodin, Lortab, Norco)			
		Hydromorphone (Dilaudid)			
		Methadone			
		Morphine (MS Contin, Avinza, Kadian)			
		Meperidine (Demerol)			
		Oxycodone (Percocet, Oxycontin)			
		Propoxyphene (Darvon)			
		Stadol			
		Duloxetine (Cymbalta)			
		Pregabalin (Lyrica)			
		Other			
		<b><i>Anti Seizure Medicines</i></b>			
		Carbamazepine (Tegretol)			
		Gabapentin (Neurontin)			
		Lamotrigine (Lamictal)			
		Levetiracetam (Keppra)			
		Oxycarbazepine (Trileptal)			
		Tiagabine (Gabatril)			
		Topiramate (Topamax)			
		Zonisamide (Zonegram)			
		<b><i>Muscle Relaxants</i></b>			
		Baclofen			
		Carisprodol (Soma)			
		Clonazepam (Klonopin)			
		Cyclobenzaprine (Flexeril)			
		Diazepam (Valium)			
		Metaxolone (Skelaxin)			
		Methocarbamol (Robaxin)			
		Tizanidine (Zanaflex)			
		Other			
		<b><i>Anti-Depressants</i></b>			
		Amitriptyline (Elavil)			
		Bupropion (Wellbutrin)			
		Citalopram (Celexa)			
		Desipramine			
		Duloxetine (Cymbalta)			



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MRN: \_\_\_\_\_

YES TRIED	NOT TRIED	NAME OF MEDICATION	STILL TAKING (if known)	IF STOPPED WHY	
		<b><i>Anti-Depressants</i></b>		<b>Side Effects</b>	<b>Not Effective</b>
		Flouxetine (Prozac)			
		Hyp. Perforatum (St. John's Wort)			
		Lexapro			
		Mitrazepine (Remoron)			
		Nefazadone (Serzone)			
		Nortriptyline (Pamelor)			
		Paroxetine (Paxil)			
		Sertraline (Zoloft)			
		Trazadone (Deseryl)			
		Venlafaxine (Effexor)			
		Other			
		<b><i>Anti-Anxiety</i></b>			
		Alprazolam (Xanax)			
		Chlordiazepoxide (Librium)			
		Diazepam (Valium)			
		Lithium (Eskalith)			
		Lorazepam (Ativan)			
		OlazepineZyprexa)			
		Phenelzine (Nardil)			
		Risperidone (Risperdal)			
		Other			
		<b><i>Sleep</i></b>			
		Temazepam (Restoril)			
		Triazolam (Halcion)			
		Zaleplon (Sonata)			
		Zolpidem (Ambien)			
		<b><i>Anti-inflammatories</i></b>			
		Celecoxib (Celebrex)			
		Ibuprofen (Motrin, Advil)			
		Mobic			
		Naprosyn (Aleve)			
		Relafen			
		Rofecoxib (Vioxx)			
		Valdecoxib (Bextra)			



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MRN: \_\_\_\_\_

**Narcotic (opioid) medication (vicodin, percocet, darvocet, morphine, fentanyl, methadone)**

Have you been given opioid (narcotic) medication for your pain NO YES  
If YES, have they improved your activity or general level of function? NO YES

If you answered NO to last question, how did the opioid (narcotic) affect your pain level (please choose one):  
 "just take the edge off"  somewhat helpful  quite a bit  very much

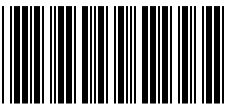
Are you taking your pain medications any differently than prescribed by your doctor (i.e. taking more than prescribed, changing the dosing frequency, not taking them, etc.)  NO  YES  
If yes, why:

Are you having any problematic side effects? NO YES  
If so, please describe:

Have you or your doctor ever felt that you had a problem with narcotics? NO YES  
Have you felt you should cut down on your alcohol or drug use?  NO  YES  
Have people annoyed you by criticizing your alcohol or drug use? NO  YES  
Have you ever felt bad or guilty about your alcohol or drug use? NO  YES  
Have you had a drink or used drugs first thing in the morning to steady your nerves or get rid of hangover? (eye opener) NO  YES

**Have you ever had any of the following treatments for your pain problem and what was the result?**  
Please check the appropriate box and give comments.

No	Yes	Treatment Type	<u>Impr- oved</u>	<u>No Change</u>	<u>Worse</u>	<u>Comments</u>
		Physical therapy				
		Occupational Therapy				
		Aquatic/Pool therapy				
		Passive (heat, ice, gentle massage, ultrasound)				
		Mobilizations				
		Traction				
		Exercises/aerobic conditioning				
		TENS				
		Orthotics (i.e. corrective foot inserts)				
		Prosthetics (braces, supports, etc)				
		Chiropractic				
		Deep tissue Massage				
		Psychological counseling				
		Alcohol/Drug Detoxification				
		Accupuncture				
		Extended Bed Rest				
		Biofeedback or relaxation therapy				



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MRN: \_\_\_\_\_

No	Yes	Treatment Type	Impr- oved	No Change	Worse	Comments
		Radiation treatment				
		Trigger point injections				
		Epidural steroid injections				
		Facet joint injections				
		Nerve blocks				
		Spinal cord stimulation				
		Acupuncture				
		Acupressure				

**Medications** - List all you are **currently** taking and dosages (prescriptions, over the counter, herbal):

Medication	Dose	Frequency	Date Started	Prescribing Doctor

**Allergies** – Have you ever had and allergic reaction to any medication?

(an allergy means a rash, swelling, difficulty in breathing. It does NOT mean causing a stomach upset or dizziness)       YES       NO

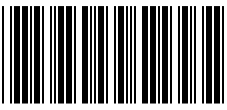
If YES please list them:

\_\_\_\_\_

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

*Please check YES or NO*

Yes	No		Yes	No	
		<b>Heart:</b>			<b>Lungs:</b>
		High blood pressure			Bronchitis
		High cholesterol			Asthma
		Angina			Shortness of Breath
		Heart attack			<b>Liver / Kidneys:</b>
		Congestive cardiac failure			Hepatitis
		Cardiac surgery			Liver problems
		Irregular heart beat			Kidney problems
		<b>Nervous system:</b>			Bladder problems
		Seizures			<b>Metabolic / Digestive:</b>
		Stroke			Diabetes: Insulin or Non-Insulin Dependent?
		Paralysis			Thyroid disease
		Peripheral neuropathy			Acid reflux



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MRN: \_\_\_\_\_

**Past Medical History** Have you had any of these conditions either now or in the past?  
*Please check YES or NO*

Yes	No		Yes	No	
		<b>Musculoskeletal:</b>			Stomach ulcer
		Arthritis			<b>Cancer:</b>
		Neck/back problems			Site:
		Artificial joints (replacement)			<b>Alcohol/Drug Dependency or Addiction</b>
		Other:			List:
		<b>Blood Disorder:</b>			<b>Psychological/Psychiatric:</b>
		Anemia			Depression/Anxiety
		Bruising			Panic Disorder
		Bleeding Problems			Post-Traumatic Stress Disorder
		<b>Immune Disorder:</b>			<b>Other Medical Problems (Please Describe):</b>
		HIV			
		Other:			

**Diagnostic Tests**

List any diagnostic tests (i.e. MRI, XRAY, EMG, etc.) you have had related to your pain problem including dates and results:

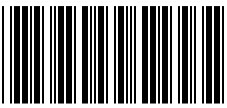
Date	Exam	Where performed	Results

**Surgical History**

Have you had any surgeries directly related to your pain problem(s)?  YES  NO  
(If yes, please complete the information below)

Name and year of surgery (i.e. lumbar fusion, abdominal surgery)

1.		Year:
2.		Year:
3.		Year:
4.		Year:
5.		Year:



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MRN: \_\_\_\_\_

Have you had other surgeries that weren't related to your pain?  
(e.g., appendectomy, tonsillectomy) YES NO (If yes, please complete the information below)

Name and year of surgery

1.		Year:
2.		Year:
3.		Year:
4.		Year:
5.		Year:

**ER visits**

In the past year have you been treated in the Emergency Room for your pain problem: YES NO  
If yes, please circle the number of times: 1 2-3 4-6 7-10 More than 10 times

**Health care visits**

In the past three months, how many times have you been to your regular health care provider or specialist for your pain problem (MD, ARNP, PA, PT)?  
Please circle the number of visits: 1 2-3 4-6 7-10 More than 10 times

In the past three months how many times have you seen an alternative health care provider for your pain problem (Chiropractor, homeopath, naturopath, acupuncturist)?  
Please circle the number of visits: 1 2-3 4-6 7-10 More than 10 times

**Sleep History**

Can you estimate the average number of hours you sleep per night? \_\_\_\_\_  
Can you estimate the average number of hours you sleep during the daytime? \_\_\_\_\_

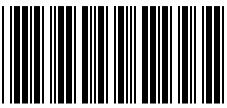
On the worst night during the last two weeks, how badly did your pain affect your sleep?

- Not affected at all
- I didn't lose any sleep but needed pain medication
- It interfered with my sleep, and as a result, I slept for more than 4 hours
- It interfered with my sleep, and as a result, I slept for 2-4 hours
- It interfered with my sleep, and as a result, I slept less than 2 hours

If you have difficulty sleeping is it related more to:

- Getting to sleep initially
- Maintaining sleep throughout the night
- Both

- Have you been told you snore a lot? YES NO
- Have you been told you often gasp for breath at night? YES NO
- Are you a restless sleeper? YES NO
- Do you often have problems with restlessness of your legs keeping you awake? YES NO
- Do you feel tired or fatigued during the day? YES NO
- Do you take naps more than twice a week or fall asleep inappropriately during the day? YES NO



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MRN: \_\_\_\_\_

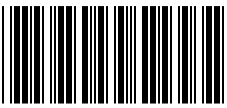
**Social History**

- Did you have a happy childhood? NO YES
- Have you ever been sexually and or physically abused? NO YES
- Do you currently feel threatened in your environment? NO YES
- Have you ever seriously considered or attempted suicide? NO YES
- Do you have a suicide plan at the moment? NO YES
- Have you ever been psychiatrically hospitalized? NO YES
- If your pain is from a traumatic event, do you ever experience distressing dreams about the event?  
N/A NO YES
- Have you ever participated in psychotherapy? NO YES
- Are you currently participating in psychotherapy? NO YES
- If YES to the above, through which provider(s)?

- Do you smoke? YES NO
- If yes, how much per day?
- If you are a former smoker when did you stop?
- Do you drink alcohol? YES NO
- If yes, how many drinks per day?
- If yes, how many drinks per week?
- If yes, do you drink to intoxication or binge drink?
- If yes, do you drink to decrease your pain?
- In the past 10 years have you ever tried street drugs? YES NO
- Have you or anyone around you ever felt you had a problem with alcohol or drugs? YES NO
- Have you ever received alcohol or drug treatment?

**Family History**

<u>Family Member</u>	<u>Age (or age at death)</u>	<u>Sex</u>	<u>Living</u>	<u>Medical Problems</u>
Grandparents	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Father	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Mother	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Siblings	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Children	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____



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MRN: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Do you have any problems/symptoms in the following areas? Check “Yes” or “No”. If “Yes”, give an explanation

<b>Yes</b>	<b>No</b>		<b>Patient Comments</b>	<b>Physician Comments</b>
		Eyes		
		Ears/Nose/Mouth/Throat		
		Respiratory (lungs/breathing)		
		Cardiovascular (heart/blood vessels/circulation)		
		Gastrointestinal (stomach/intestines)		
		Constitutional (weight loss/gain, fever/chills/fatigue)		
		Genitourinary (genitals/sexual function/kidney/bladder)		
		Neurological (brain/nervous system)		
		Integumentary (skin areas and/or breasts)		
		Psychiatric (emotions/mood/memory)		
		Musculoskeletal (bones/joints/muscles)		
		Endocrine (hormones/metabolism/thyroid)		
		Allergic/Immunologic (allergies/immune system)		
		Hematologic/Lymphatic (blood or bleeding problems; lymph nodes or “swollen glands”)		

Form Completed by: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

***Instructions to Attending Physician***

*Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key findings must be summarized in your progress notes; however, the questionnaire may be referenced for additional details.*

Attending MD (Sign): \_\_\_\_\_ Print Name: \_\_\_\_\_ Pager: \_\_\_\_\_ Date: \_\_\_\_\_

Also Reviewed By: \_\_\_\_\_ Print Name: \_\_\_\_\_ Pager: \_\_\_\_\_ Date: \_\_\_\_\_