North Bay Regional Health Centre

Clinical Services
Pain Clinic Questionnaire
Tel: 705-474-8600 (3850)
Fax: 705-495-7983

Patient Name:_____
Health Card:_____
Address:_____
_____
Date of Birth:_____
(day) (month) (year)
Email: _____

Contact information:
Daytime phone: _____ Home phone: _____ Cell phone: _____
Who completed this form? ☐ Patient ☐ Other Name/Relationship: _____ Date:_____
Family Doctor: _____ Address: _____ Phone: _____
Sex: ☐ Male ☐ Female Allergies: ☐ Yes ☐ No Marital Status: _____ Preferred Language: _____
Age: _____ Height _____ Weight ____ Religion: _____ Name of the legal next of kin: _____
Are you or your spouse covered by any insurance plan other than OHIP? ☐ Yes ☐ No Name of company: _____
Are there unresolved legal/compensation issues related to your condition? ☐ Yes ☐ No WSIB Claim # _____
If so, Lawyer name and phone number _____ Disability Claim #: _____

	Yes	No	
1.	☐	☐	Are you working? ☐ full time ☐ part-time ☐ retired ☐ student Occupation:
2.	☐	☐	Does your spouse work? ☐ N/A ☐ full time ☐ part time ☐ retired ☐ student Occupation:
3.	☐	☐	Do you have children? Number of children: Ages:
4.	☐	☐	Do you drink alcoholic beverages (includes beer, wine, spirits)? If **yes**, how many drinks per week?
5.	☐	☐	Do you smoke any tobacco products? If yes, how much?
6.	☐	☐	Do you smoke marijuana? If **yes**, how much or how often?

Medical History

Indicate if you have or have had any of the following by putting a check mark in the box.
☐ cancer in the last 5 years ☐ hepatitis B or C ☐ HIV ☐ blood disorder: _____ ☐ kidney failure
☐ cirrhosis ☐ rheumatoid arthritis ☐ joint replacement: _____ ☐ spinal injury: _____ ☐ neuropathy
☐ anxiety ☐ depression ☐ addictions to _____ ☐ epilepsy/seizures ☐ sleep apnea ☐COPD
☐ hypertension/high blood pressure ☐ heart attack/heart disease ☐ heart surgery ☐ pacemaker or ICD
☐ other: _____

Pain History

Date Pain Began:

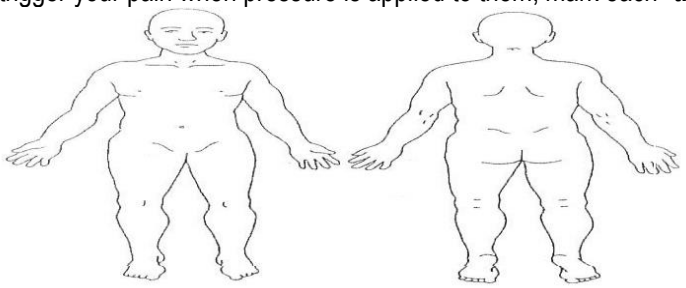
Describe your current pain and how it began:

	Yes	No	
7.	☐	☐	Has your pain changed since the time it first began? If **yes**, in what way?
8.	☐	☐	Have you visited an emergency room for your pain in the last 12 months? If **yes**, How many times:
9.	☐	☐	Have you visited your family doctor for your pain in the last 3 months?
10.	☐	☐	Have you been to another Pain Clinic? If **yes**, when and where?
11.	☐	☐	Have you tried anything on your own to relieve your pain? If **yes**, please describe what you did and how it worked
12.	☐	☐	Have you ever seen a psychologist or psychiatrist for your pain problem? If **yes**, please provide details about your treatment, such as when you had it, who provided it, the nature of treatment, and whether it was helpful.
13.	☐	☐	Have you ever seen a psychologist or psychiatrist for another problem? If **yes**, please specify when, for how long, by whom and describe the circumstances of the problem and the treatment.

Patient Name/J Number: _____

In what important ways has your life changed as a result of your pain problem?
What would you hope to gain from treatment at the Pain Management Clinic at the North Bay Regional Health Centre?

LOCATION OF PAIN: Please mark on the drawings below, the areas where you feel pain. Then, near the areas that you mark, put **E** if the pain is external (on the outside), or **I** if the pain is internal (on the inside). Put **EI** if the pain is both external and internal. Also, if you have one or more areas which can trigger your pain when pressure is applied to them, mark each "**trigger point**" with an **X**.



Medication information

14. ☐ ☐ Do you take any blood thinners (anticoagulants)?

Please describe in detail all medications that you are **now** taking for your pain problem **OR** ☐ I **do not** take any medications (include pills, patches, creams, puffers, eye drops, vitamins, herbals, and recreational drugs) or attach a MedsCheck Review list from your pharmacist.

Name of the Pharmacy you use:_____ Telephone Number: _____

Medication	Date Started	Dose (mg)	# per day	Reason	Does it help?			Do you have side effects?	
					Yes	Somewhat	No	Yes	No
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐

List all medications that you have taken in the **past** (you are no longer taking) for your pain problem.

Medication	When	How Long	Reason Discontinued	Did it help?			Did you have side effects?	
				Yes	Somewhat	No	Yes	No
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐

Treatment History

Have you had any of the following interventions for your pain problem?

Treatment	When month/year	By Whom	How Long (months)	Did it help?		
				Yes	Somewhat	No
Physiotherapy				☐	☐	☐
Massage				☐	☐	☐
Acupuncture				☐	☐	☐
Injections: Nerve Blocks				☐	☐	☐