Clinic Visit Questionnaire

Weight	___________
BP	___________
Pulse	___________

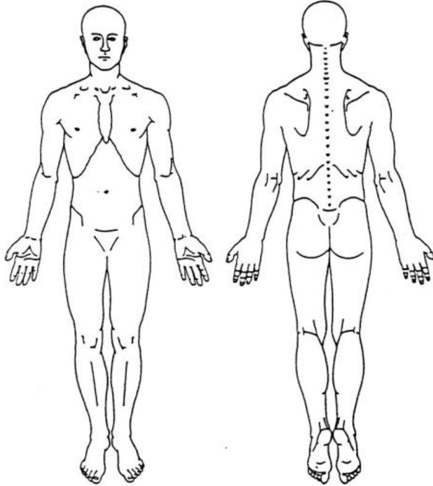
To be completed by clinic

Name ____

Date _________________ Phone # _______________________

Today I'm seeing: ____

SHADE IN THE AREAS OF YOUR DISCOMFORT:



CIRCLE YOUR RESPONSE:

How intense is your pain right now?

0 1 2 3 4 5 6 7 8 9 10

In the last week, your least pain?

0 1 2 3 4 5 6 7 8 9 10

In the last week, your highest pain?

0 1 2 3 4 5 6 7 8 9 10

In the last week, your average pain?

0 1 2 3 4 5 6 7 8 9 10

Since your last visit, is your pain…

Much worse Worse Same Some better Much improved

HOW WOULD YOU DESCRIBE YOUR PAIN TODAY? *(circle all that apply)*

Burning	Cold	Stinging	Tingling	Shooting	Aching
Dull	Throbbing	Sharp	Stabbing	Sore	
Constant	Off & On	Exhausting	Vicious	Punishing	

HAVE THERE BEEN ANY CHANGES IN THE QUALITY OR LOCATION OF YOUR PAIN? No Yes

OVERALL, HOW MUCH HAS YOUR PAIN IMPROVED SINCE STARTING TREATMENT HERE?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

CIRCLE ANY PROBLEMS OR MEDICATION SIDE EFFECTS YOU HAVE HAD SINCE YOUR LAST VISIT:

Nausea Vomiting Constipation Diarrhea Appetite Changes Drowsiness

Chest Pain Itching Vision changes Headaches Fever Dizziness Irritability

Depression Anxiety Concentration or Memory Difficulties

HAVE YOU HAD ANY MEDICAL OR DENTAL VISITS SINCE YOUR LAST VISIT? No Yes

(*If "yes", please list reason and name of provider, any new health issues*)

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND WHAT THEY ARE FOR:

(Continue form on other side)

Clinic Visit Questionnaire

What is the impact of pain on your…

	(0 = *pain has no impact* ……..…. 10 = *pain completely controls*)										
Mood (e.g., anxiety, depression)	0	1	2	3	4	5	6	7	8	9	10
Relationships with others	0	1	2	3	4	5	6	7	8	9	10
Walking	0	1	2	3	4	5	6	7	8	9	10
Working	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of life	0	1	2	3	4	5	6	7	8	9	10
Housework/Chores	0	1	2	3	4	5	6	7	8	9	10
Hobbies/Fun	0	1	2	3	4	5	6	7	8	9	10

How many hours of a 24-hour day are you typically:

Up and active ____________ Resting ____________ Sleeping at night ____________

How long does it take you to fall asleep at night? _______________

Is your sleep interrupted? …..……………………… No Yes

Do you feel rested when you wake up in the morning? No Yes

What do you do when you wake up during the night? ____

What activities are you doing? (shopping, fishing, working, housework, etc.)

What does resting mean for you? (watching TV, reading, relaxation CD, computer, napping, etc.)

Are you doing a Walking or Stretching or Pool program regularly? No Yes
(*If yes, please explain below how many hours per week of physical activity and what types of exercise you get.*)

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*Have you attended any of the 6 pain education classes? No Yes (*If yes, how many?*) ______

*Have you seen Dr. Doleys or Dr. Cianfrini within the past year? No Yes

Check *all* of the following that apply to you since your last clinic visit:

____ I have taken my medicine exactly as prescribed

____ I have skipped or forgotten medicine doses

____ I have used recreational drugs (e.g., pot)

____ I have taken more medicine than prescribed

____ I have used alcohol

____ I have smoked cigarettes
(*If so, how many packs per day?*) ______

Please list the 1-3 most important thing(s) to discuss with your doctor today: