PAIN MANAGEMENT INITIAL EVALUATION

Patient name: ________________________________

Date of Birth: ___________ Date: ______________

How long have you been having SEVERE problems with pain? _______________________

Was it the result of an injury or accident? _____ If so, what happened?

____

Where is your pain MOST SEVERE most of the time? _______________________________

Timing of Pain:

How often do you have your pain? (please check one)

[ ] Constantly/continuous. Present most of the time.

[ ] Intermittently. The pain comes and goes for periods of time.

Pain Quality:

How would you describe the pain? (choose as many adjectives as are applicable)

[ ] burning [ ] sharp [ ] cutting [ ] throbbing [ ] cramping [ ] numb

[ ] dull, aching [ ] pressure [ ] pins & needles [ ] shooting [ ] electric-like

Does the pain radiate anywhere? Where? ____

____

Rate your Pain Intensity:

"0" = No pain **"10" = worst pain imaginable**

Circle the number below that best describes the **WORST** your pain level gets:

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

Circle the one number that best describes the **BEST** your pain level gets:

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

RELIEVING AND AGGRAVATING FACTORS

Activity	*Helps Pain*	*Worsens Pain*
Sitting		
Standing		
Walking		
Driving		
Bending		
Turning		
Twisting		
Stretching		
Looking up		
Looking Down		
Lying on back		
Reclining		
Laying on side		
Support w/pillows		
Ice application		
Heat application		
Changing position		
Distraction		
Relaxation/meditation		
Doing something pleasant or fun		
Resting		

PREVIOUS PAIN TREATMENTS:

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

Treatment	Description	Last time tried
Chiropractic		
Physical Therapy		
Biofeedback		
Acupuncture		
Dry Needling		
Psychotherapy		
Massage therapy		
Ketamine infusion		
INJECTIONS:		
Joint		
Spine		
Radio Frequency Ablation		
Trigger Point		
SPINE SURGERY:		
Other:		

MEDICATIONS:

Check any medications you have EVER been on or are CURRENTLY taking:

NSAIDs	**Muscle Relaxant**	**Adjuncts**	**Short-Acting Opiates**	**Long-Acting Opiates**	**Migraine**
Tylenol	*Flexeril /cyclobenzaprine*	*Gabapentin /Neurontin*	*Tramadol*	*Tramadol ER*	*Topamax*
Ibuprofen	*Tizanidine /Zanaflex*	*Lyrica*	*Hydrocodone*	*MS Contin*	*Propranolol*
Naproxen	*Baclofen*	*amitriptylene*	*Vicodin*	*Morphabond*	*Maxalt*
Meloxicam	*Robaxin /methocarbamol*	*Nortriptyline*	*Norco*	*Embeda*	*Imitrex /sumatriptan*
Celebrex	*Norflex /orphenadrine*	*Cymbalta/duloxetine*	*Percocet*	*Avinza*	*Amerge*
Etodolac	*Skelaxin /metalazone*	*Savella*	*Oxycodone*	*Oxycontin*	*Zomig*
Nabumetone	*soma*	*Lidocaine*	*Oxymorphone /opana*	*XTampza ER*	*Relpax*
Diclofenac		*CBD*	*Dilaudid*	*Nucynta ER*	*Amovig*
Voltaren gel		*marijuana*	*Hydromorphone*	*Opana ER*	*Emgality*
Flector patch		*Gralise*	*Nucynta*	*Exalgo ER*	*Ajovy*
toradol		*Horizant*	*Codeine Tylenol #3,#4*	*Fentanyl*	*Botox*
		tegretol	*Levorphanol*	*Butrans*	*Fioricet*
			Subsys	*Belbuca*	
			morphine	*Suboxone*	
				methadone	
				Hysingla ER	

Have you been given/prescribed a form of Narcan to use in case of emergency? ____Yes _____No

SSRI/NSRI	**Mood**	**Atypical**	**Benzo**	**Sleep**
Celexa/citalopram	*Tegretol*	*Abilify*	*Klonopin/clonazepam*	*Ambien*
Effexor	*Trileptal*	*Rexulti*	*Librium*	*Doxepin*
venlafaxine	*oxcarbazepine*	*zyprexa*	*Restoril*	*Restoril*
Lexapro/escitalopram	*Depakote/divalproex*	*Risperdal*	*Serax/oxazepam*	*Trazodone*
Paxil/paroxetine	*Lamictal/lamotrigine*	*Geodon*	*Tranxene*	*Remeron*
Trintellix	*lithium*	*Haldol*	*Valium/diazepam*	*Sonata*
Zoloft/sertraline		*Invega*	*Xanax/alprazolam*	*Lunesta*
Fetzima		*Latuda*	*Ativan/lorazepam*	*Rozarem*
Pristiq/desvenlafaxine		*Seroquel*		Mirtazepine
Prozac/fluoxetine		*Vraylar*		
Vibryd/vilazodone				
Wellbutrin/bupropion				

Pain Catastrophizing Scale

Listed below are 13 statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

O - not at all

1 - to a slight degree 2 -

to a moderate degree 3

- to a great degree

4- all the time

For each item please rate how you think/feel when you are in pain...

_____ I worry all the time about whether the pain will end.

_____ I feel I can't go on.

_____ It's terrible and I think it's never going to get any better.

_____ It's awful and I feel that it overwhelms me.

_____ I feel I can't stand it anymore.

_____ I become afraid that the pain will get worse.

_____ I keep thinking of other painful events.

_____ I anxiously want the pain to go away.

_____ I can't seem to keep it out of my mind.

_____ I keep thinking about how much it hurts.

_____ I keep thinking about how badly I want the pain to stop.

_____There's nothing I can do to reduce the intensity of the pain.

_____ I wonder whether something serious may happen.

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Appendix C – Physical Functional Ability Questionnaire (FAQ5)

This tool has not been validated for research; however, work group consensus was to include it as an example due to the lack of other validated and easy-to-use functional assessment tools for chronic pain.

Name: ______________________

Date: ______________________

Date of Birth: ______________________

MR #: ______________________

Instructions: Circle the number (1-4) in each of the groups that best summarizes your ability.

Add the numbers and multiply by 5 for total score out of 100.

_______ **Self-care ability assessment**

1. Require total care: for bathing, toilet, dressing, moving and eating
2. Require frequent assistance
3. Require occasional assistance
4. Independent with self-care

_______ **Family and social ability assessment**

1. Unable to perform any: chores, hobbies, driving, sex and social activities
2. Able to perform some
3. Able to perform many
4. Able to perform all

_______ **Movement ability assessment**

1. Able to get up and walk with assistance, unable to climb stairs
2. Able to get up and walk independently, able to climb one flight of stairs
3. Able to walk short distances and climb more than one flight of stairs
4. Able to walk long distances and climb stairs without difficulty

_______ **Lifting ability assessment**

1. Able to lift up to 10 lbs. occasionally
2. Able to lift up to 20 lbs. occasionally
3. Able to lift up to 50 lbs. occasionally
4. Able to lift over 50 lbs. occasionally

_______ **Work ability assessment**

1. Unable to do any work
2. Able to work part-time **and** with physical limitations
3. Able to work part-time **or** with physical limitations
4. Able to perform normal work

_______ **Physical Functional Ability (FAQ5) Score**

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Return to Table of Contents

Physical Functional Ability Questionnaire (FAQ5) Information Sheet

The Physical Functional Ability Questionnaire (FAQ5) was developed as a clinical assessment tool for patients with chronic pain and disability issues. This tool can provide a "snapshot" of the patient's self-perception of his or her physical functional ability at one point in time, without reference to pain perception. The tool was developed for ease of use in a busy clinical practice. The time for a patient, or family member, to complete the questionnaire is usually one to two minutes, and scoring is easily completed within seconds. This tool is adaptable to electronic medical records (EMR) to allow tracking over time, and total and/or subset numerical scores may be entered into the EMR by support staff, medical clinician or patient.

All references to pain perception have been excluded, and all elements of physical function referenced by this questionnaire are directly observable or measurable, except for Work Ability. Self-Care Ability is the equivalent of Activities of Daily Living (ADLs), and Family and Social Ability is the equivalent of Instrumental Activities of Daily Living (IADLs). Movement Ability is easily observed indirectly by clinicians, and Lifting Ability could be simply tested by observing the patient lifting one or more reams of copy paper (each 500 sheet ream weighs about five pounds). Lifting Ability weight levels correlate with U.S. Department of Labor and Industry physical demand work levels and energy requirements: Sedentary – 10 pounds occasional/1.5 to 2.1 METs; Light – 20 pounds occasional/2.2 to 3.5 METs; Medium – 20-50 pounds occasional/3.6 to 6.3 METs; Heavy – 50 to 100 pounds occasional/6.4 to 7.5 METs.

Because this tool measures an individual's self-perception of physical function, it is not by itself a measure of impairment (any loss or abnormality of anatomical or physiological structure or function, permanent or temporary) or disability (inability to perform a major life activity, including work, because of an impairment). Disability is usually defined by an insurance company or governmental agency, such as the Veterans Administration or Social Security Administration.

The utility of the FAQ5 is greatest in several areas:

1. Establishing a simple baseline measure of physical function from which to begin a physical rehabilitation program.
2. Establishing a simple physical functional goal toward which to aim a physical rehabilitation program.
3. A periodic measure of progress (or lack of progress) toward a functional rehabilitation program goal.
4. Establishing a subjective baseline and framework against which objective findings of physical dysfunction may be compared during a clinical evaluation or assessment of patients claiming disability benefits.

Use of the FAQ5 global score (25-100) provides a simple numerical score for comparison of past or current perceptions with future goals. Most patients with chronic pain or those seeking disability benefits have initial scores in the range of 40 to 60. In patients with chronic pain and those seeking disability benefits, discordance is common between elements within the FAQ5, or between the FAQ5 and observed physical function. Discordances may provide clues to psychosocial risk factors, which can contribute to perpetuation of chronic pain and disability behaviors, that need to be addressed as part of a treatment and rehabilitation program. For example, discordance between the patient's perception of physically observable elements (ADLs, IADLs, movement and lifting) and self-perceived work capacity may indicate some degree of reluctance to return to work.

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Return to Table of Contents

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________________ **DATE:** ______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	____	+ ____	+ ____
	TOTAL:	____		

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	________
Somewhat difficult	________
Very difficult	________
Extremely difficult	________

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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