Pathia Pain Management
Treating Pain, Restoring Function, Building Resilience

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Provider No: 425791AL

Initial Patient Questionnaire

Section 1 – Patient Information

Title: □ Mr □ Mrs □ Ms □ Miss	**Family name (surname):**	**Given name(s):**
Gender: □Male □Female	**Date of birth:**	**Today's date:**

Residential address:
Street

City/Suburb Postcode State

Contact details: Home phone: Work phone:
Mobile: Email:

Country of Birth: □ Australia □ New Zealand □Other (please specify)

Do you require an interpreter? □ Yes □ No
If you answered yes, please specify the language:

Are you hearing or sight impaired? □ Yes □ No

Do you require help with written or spoken communication? □ Yes □ No

Height (in cm):	**Weight (in kg):**

Are you of Aboriginal, Torres Strait Islander or Maori origin? (more than one may be ticked)

□ No
□ Yes, Torres Strait Islander
□ Yes, Aboriginal
□ Yes, Maori

Which of the following best describes your current work status? (more than one may be ticked)

□ Full time paid employment
□ Part time paid employment (hrs)
□ Retired
□ Unemployed due to pain
□ Unemployed (not pain related)
□ Home duties
□ On leave from work due to pain
□ Studying (e.g. school, uni)
□ Voluntary work
□ Retraining
□ At work- limited hours and/or duties

Does your pain affect the number of hours you are able to work or study? □ Yes □ No

Does your pain affect the type of work you are able to do? □ Yes □ No

How did your main pain begin?

□ Injury at home
□ After surgery
□ Related to another illness
□ Injury at work/school
□ Motor vehicle crash
□ No obvious cause
□ Injury in another setting
□ Related to cancer
□ Other

How long has the main pain been present? (tick one box only)

□ Less then 3 months
□ 12 months to 2 years
□ More than 5 years
□ 3 to 12 months
□ 2 to 5 years

Which statement best describes your pain? (tick one box only)

□ Always present (always the same intensity)
□ Always present (level of pain varies)
□ Often present (pain free periods last less than 6 hours)
□ Occasionally present (pain occurs once to several times per day, lasting up to an hour)
□ Rarely present (pain occurs every few days or weeks)

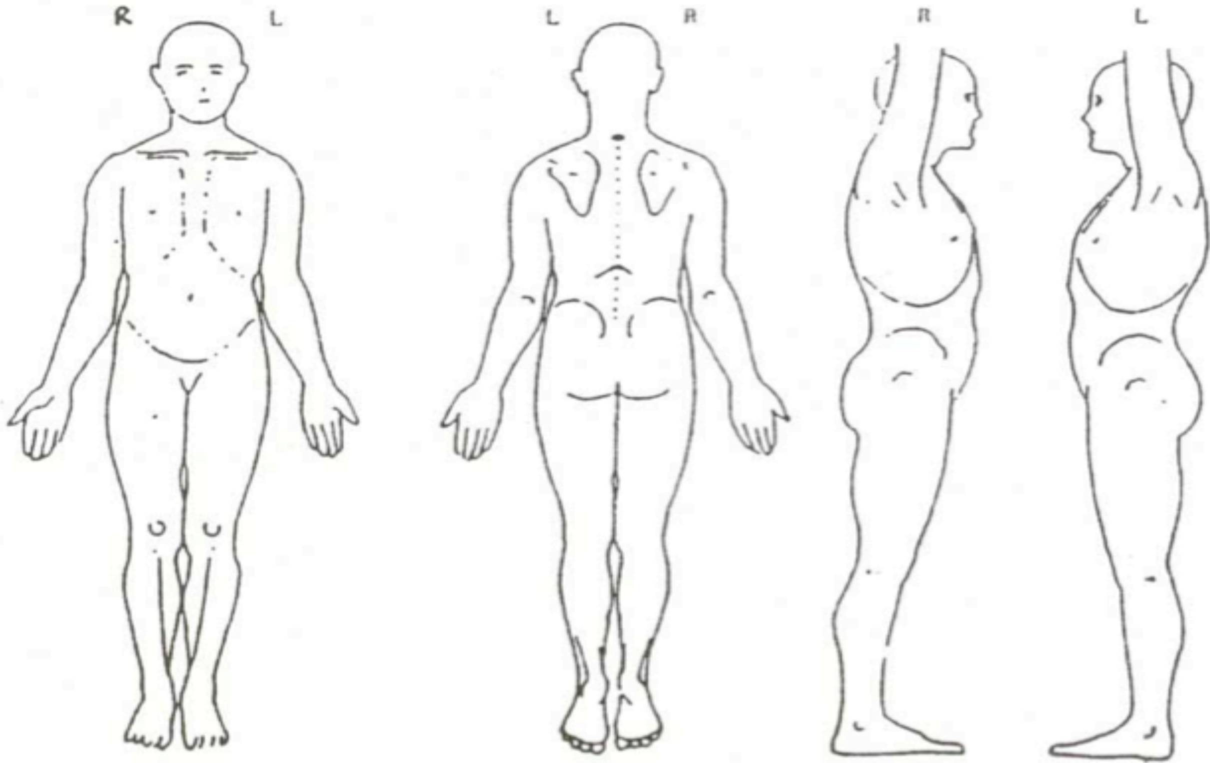
Do you have any of the following medical conditions?		
□ Heart disease	□ Ulcer or stomach disease	□ Anaemia or other blood disease
□ High blood pressure	□ Kidney disease	□ Osteoarthritis, degenerative arthritis
□ Lung disease	□ Depression/ anxiety	□ Rheumatoid arthritis
□ Diabetes	□ Cancer	□ Stroke or other neurological condition
□ Other medical problems (please specify)		

Section 2 – Heath Service use		
1	How many times in the past 3 months have you seen a general practitioner in regard to your pain?	times
2	How many times in the past 3 months have you seen a medical specialist (e.g. orthopedic surgeon) in regard to your pain?	times
3	How many times in the past 3 months have you seen health professionals other than doctors (e.g. physiotherapist, chiropractor, psychologist) in regard to your pain?	times
4	How many times in the past 3 months have you visited a hospital emergency department in regard to your pain? Include all visits regardless of whether or not you were admitted to the hospital emergency department	times
5	How many times in the past 3 months have you been admitted to hospital as an inpatient because of your pain?	times
6	How many diagnostic tests (e.g. x-rays, scans) have you had in the last 3 months relating to your pain?	tests

Section 3 – Medication use			
List all the medications you are taking (include all prescription & over–the–counter medicines)			
Medicine name (as on the label)	Medicine strength (as on the label)	How many do you take per day?	How many days per week do you take this medication?

Section 4 – BPI +

1. On the diagram below shade in the areas where you feel pain. Put an X on the area that hurts most.



2. Rate your pain by circling the one number that best describes the following: (circle one of the numbers on the scale nest to each item, where 0= *No pain*, and 10= *Pain as bad as you imagine)*

a) Your pain at its worst in the last week?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain bad as you can imagine
b) Your pain at its least in the last week?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain bad as you can imagine
c) Your pain on average?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain bad as you can imagine
d) How much pain do you have right now?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain bad as you can imagine

3. During the past week, how much has pain interfered with the following: (circle one of the numbers on the scale nest to each item, where 0= *does not interfere*, and 10= *Completely interferes*)											
a) Your general activity?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
b) Your mood?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
c) Your walking ability?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
d) Your normal work (both outside home & housework)	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
e) Your relations with other people?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
f) Your sleep?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
g) Your enjoyment of life?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes

Please list the names of health professional you are currently seeing (e.g. physiotherapist, chiropractor, psychologist, naturopath)

Name	Type of treatment	Suburb/Town	Permission to contact Y/N
e.g. John Brown	*Exercise physiologist*	*Waratah*	*Y*

Please list any operations you have had relating to your pain problem(s):

Type of operation	Date	Surgeon

Do you think you need more medication, or stronger medication that you are currently taking?

□ agree strongly □ agree □ unsure
□ disagree □ disagree strongly

In the last week have you had side effects from pain medications or treatment? Please circle the number that best shows how severe the side effects have been.

0	1	2	3	4	5	6	7	8	9	10
No side effects										Severe side effects

Please list any additional medications (other than those listed in Section 3) you have taken in the past **for your pain and indicate whether or not they were helpful**

Medication Name	Dose	How often	Benefits *(tick)*				Side effects
			Marked	Moderate	Slight	None	

Please tick if you are a:

□ smoker □ non-smoker □ ex-smoker

If you smoke, please tick how many cigarettes you smoke in a normal day:

□ Less than 5 □ 5-14 □ more than 15

Please tick how many days of the week you drink alcohol:

□ Less than 1 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7

If you currently drink alcohol, please tick how many *standard* drinks you usually have on these days:

□ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 8-15 □ more than 15

Do you ever drink alcohol to relieve your pain? □ No □ Yes

How many cups or glasses of caffeinated drinks (i.e. Tea/coffee/caffeinated or energy drinks) do you have per day?

□ 0 □ 1-3 □ 4-5 □ 6-7 □ more than 8

Your story

If you wish to, this section is reserved for you to tell ***your*** story. This may be the story of your pain and how it affects you and your lifestyle, or what you do now to limit your pain's effect on your life.

† Modified Brief Pain Inventory, reproduced with acknowledgement of the Pain Research Group, The University of Texas MD Anderson Cancer Centre USA
* Nicholas MK (1989)
^ Sullivan MJL (1995)
# Lovibond SH & Lovibond PF (1995)