CONFIDENTIAL
BLAUSTEIN INTERVENTIONAL PAIN TREATMENT CENTER
***FOLLOW-UP* QUESTIONNAIRE**

JOHNS HOPKINS PAIN
M E D I C I N E

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Date: _____

Name:_____

Telephone #: _____ (*day*) _____ (*evening*)

Date of Birth: _____ Sex: M F

Primary Care Physician: Name:_____

Pain Related Information. Please answer all questions.

1) Describe the PAIN SINCE YOUR LAST VISIT (is it the same, getting worse or different?).

_____

_____

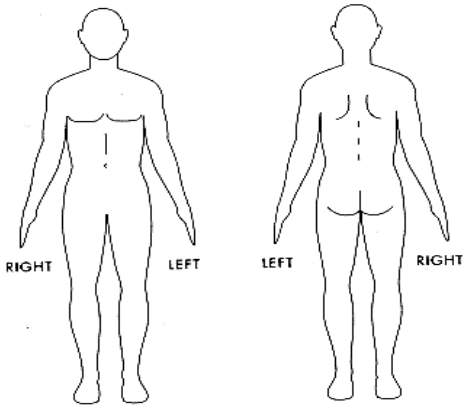
2) **Circle** all the things that make your pain ***worse****:*

sitting standing rest heat cold walking exercise sex touch other

3) **Circle** all the things that make your pain ***better****:*

sitting standing rest heat cold walking exercise sex touch other

4) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



5) I feel I have some form of pain now that requires medication each and every day Yes No

6) Did you take pain medications in the last 7 days? Yes No

7) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, toothaches). Have you had pain other than these everyday kinds of pain today? Yes No If YES, what kind?

8) Please rate your pain by circling the one number that best describes your pain at its **worst** in the **last 24 hours**.

0 1 2 3 4 5 6 7 8 9 10

No Pain *as bad as pain you can imagine*

9) Please rate your pain by circling the one number that best describes your pain at its **least** in the **last 24 hours**.

0 1 2 3 4 5 6 7 8 9 10

No Pain *as bad as pain you can imagine*

10) Please rate your pain by circling the one number that best describes your pain on the **average**.

0 1 2 3 4 5 6 7 8 9 10

No Pain *as bad as pain you can imagine*

11) Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10

No Pain *as bad as pain you can imagine*

12) In the last **24 hours**, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

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

No Complete *Complete Relief*

13) For each of the following words, circle 'Yes' or 'No' if that adjective applies to your pain.

Aching	Yes	No	Exhausting	Yes	No
Throbbing	Yes	No	Tiring	Yes	No
Shooting	Yes	No	Penetrating	Yes	No
Stabbing	Yes	No	Nagging	Yes	No
Gnawing	Yes	No	Numb	Yes	No
Sharp	Yes	No	Miserable	Yes	No
Tender	Yes	No	Unbearable	Yes	No
Burning	Yes	No			

14) **Circle** the one number that describes how, during the past week, pain has interfered with your:

A. **General Activity**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere *Completely interferes*

. **Mood**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere *Completely interferes*

C. **Walking Ability**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere *Completely interferes*

D. **Normal Work** (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere *Completely interferes*

E. **Relations with other people**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere *Completely interferes*

F. **Sleep**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere *Completely interferes*

G. **Enjoyment of life**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere *Completely interferes*

15) Circle the number between 0 and 10 which represents your present satisfaction regarding your sexual activity.

(**Greatly unsatisfied**) **0 1 2 3 4 5 6 7 8 9 10 (Greatly satisfied)**

DAILY ACTIVITIES:

16) Circle the number between 0 and 10 which represents your activity level.

(**inactive**) **0 1 2 3 4 5 6 7 8 9 10 (very active)**

Current Opioid Therapy, if applicable (for example, percocet, oxycontin, duragesic patch):

What percent relief do your opioids (*narcotics*) provide? (please give a number)_____%

Do you have any side effects from your opioids? (*circle those that apply*) no side effects, constipation, itching, dry mouth, nausea, erectile problems, menstrual change, vomiting, dizziness, sleepiness, lightheadedness, problems urinating, appetite change, tooth decay.

Are you any more functional from using the opioid? *(circle*) No Yes If so, how? _____

Are your opioids kept in a secure place? (*circle*) No Yes Where?_____

Do you feel that your mood has improved from opioid therapy? (*circle)* No Yes If so, how?

_____

Has your quality of life improved? *(circle*) No Yes If so, how?_____

Name of pharmacy listed on opioid bottle? _____

Physician Follow-up Notes:

Stamp:

Date: _____

Last intervention: _____

Duration of result: _____

Medication Changes: _____

_____

_____

Medication Side Effects: _____

_____

Opioids

Opioid Count: How many pills today? Incorrect and how?

Urine Drug Testing Results:

Physical exam: Ht _____ Wt _____ Temp_____ HR____ BP _____ RR_____O2 Sat _____Pain Score _____

Assessment:

Plan: