

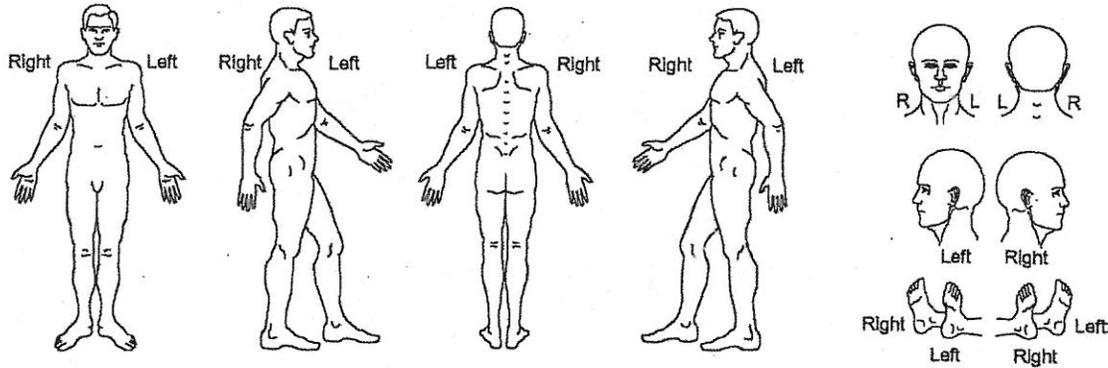
# Mountain Post Pain Clinic

## New Patient Self-Assessment Form

Date: \_\_\_\_\_ Patient's name: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

**1. Location and Quality:** Mark the chart below over the corresponding area with an 'S' for sharp pain, 'B' for burning pain, 'A' for aching pain, 'P' for pins/needles, 'T' for tingling, 'D' for dull pain.



**2. Intensity/Severity:** Please circle the level of your pain. Scale used:  
1- Little or no pain---10 worst pain you've felt.

Present:            1       2       3       4       5       6       7       8       9       10

Worst pain gets: 1       2       3       4       5       6       7       8       9       10

Best pain gets: 1       2       3       4       5       6       7       8       9       10

Acceptable level of pain: 1 2 3 4 5 6 7 8 9 10

**3. Onset:** When did your pain begin? Is there a known cause of your pain?

\_\_\_\_\_

**4.** Did the pain get worse during a deployment?

\_\_\_\_\_

**5.** What makes your pain worse? \_\_\_\_\_

**6.** What relieves your pain? \_\_\_\_\_

**7.** Do you have morning stiffness? \_\_\_\_\_ **8.** Do long car rides cause pain? \_\_\_\_\_

**9.** Does it hurt more to bend forwards or backwards? \_\_\_\_\_

**10.** Do you wake at night from pain? \_\_\_\_\_ **11.** How many hours do you sleep at night? \_\_\_\_\_

**Current Medications** (include vitamins and birth control pills, if applicable)

\_\_\_\_\_

Meds tried: \_\_\_\_\_ Why stopped? \_\_\_\_\_

Treatments tried: \_\_\_\_\_ Why stopped? \_\_\_\_\_

## General Health Review

Family Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, alcohol abuse, chronic pain, as well as psychiatric illnesses, etc)

---

---

Personal Surgical History: \_\_\_\_\_

---

Social History: Marital Status: \_\_\_\_\_ Job (MOS): \_\_\_\_\_  
Stress level 0-10: \_\_\_\_\_ How happy are you? 0-10 \_\_\_\_\_  
Do you presently smoke or use tobacco in any form? Yes \_\_\_\_\_ No \_\_\_\_\_  
If not, did you **ever** use tobacco products in any form? Yes \_\_\_\_\_ No \_\_\_\_\_  
How many packs/cans do (did) you use a day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Allergies (include medication, latex and/or food allergies)

---

## PATIENT HISTORY

Past and present (Please circle any that apply):

### Cardiovascular/Heart

Heart disease/angina  
Elevated Cholesterol  
Arrhythmia/Pacemaker  
Valve problem/murmur  
Rheumatic fever  
High Blood pressure  
Heart failure

### Respiratory/Lungs

Lung disease/COPD  
Asthma/Wheezing  
Short of breathe  
Cough  
Coughing blood  
Chest pain  
Obstructive sleep apnea

### Kidney/Bladder/Urethra

Kidney disease  
Kidney stones  
Blood in urine  
Urinary tract infection  
Bladder Pain  
Painful voiding  
Bladder cancer

### Gastrointestinal/Stomach

Blood in stools  
GERD/Ulcers  
Pancreas/Liver disease  
Gallstones  
Change in bowels

### Hematology/Blood

Blood Clots  
Bleed/Bruise easily  
Leukemia/anemia/sickle  
Enlarged lymph nodes  
Prior blood transfusion

### Constitutional/Systematic

Weight loss or gain  
Fever/chills  
Malaise  
Fatigue  
Nausea/vomiting

### Endocrine

Low Testosterone  
Thyroid  
Diabetes  
Pituitary disorder

### Musculoskeletal

Gout  
Arthritis  
Back/neck/hip/knee/shoulder  
Herniated Disc  
Joint replacement

### Neurologic

Traumatic brain injury  
Weakness/Numbness  
Seizures  
Migraines  
Multiple Sclerosis

### Skin

Rash or itching  
Melanoma  
Dryness  
Lumps

### Ear/Nose/Throat/Eyes

Sinus problems  
Hearing Loss  
Glaucoma/cataracts  
Seasonal allergies

### Psychiatry

Depression  
Panic/anxiety  
Memory disturbance  
Post Traumatic Stress Disorder

Any other illnesses that are not listed? \_\_\_\_\_

---

Physician: Mental Health consult? \_\_\_ Exercise Handout? \_\_\_ Narcotic agreement? \_\_\_

# BECK DEPRESSION INVENTORY

Source: Aaron T. Beck

Read over the statements grouped with each letter, A through U. Pick out the statement within each group that best describes the way you feel today, that is, right at this moment. Circle the number next to the statement that you have chosen in each group. If two or more statements in a group describe the way you feel equally well, circle each one. Be sure to read over all of the statements in each group before you decide on one.

## A.) Sadness

- 0 I do not feel sad.
- 1 I feel blue or sad.
- 2a I am blue or sad all the time and I can't snap out of it.
- 2b I am so sad or unhappy that it is quite painful.
- 3 I am so sad or unhappy that I can't stand it.

## B.) Pessimism

- 0 I am not particularly pessimistic or discouraged about the future.
- 1 I feel discouraged about the future.
- 2a I feel I have nothing to look forward to.
- 2b I feel that I won't ever get over my troubles.
- 3 I feel that the future is hopeless and that things cannot improve.

## C.) Sense of failure

- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2a I feel I have accomplished very little that is worthwhile or that means anything.
- 2b As I look back on my life all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person (parent, husband, wife).

## D.) Dissatisfaction

- 0 I am not particularly dissatisfied.
- 1a I feel bored most of the time.
- 1b I don't enjoy things the way I used to.
- 2 I don't get satisfaction out of anything anymore.
- 3 I am dissatisfied with everything.

## E.) Guilt

- 0 I don't feel particularly guilty.
- 1 I feel bad or unworthy a good part of the time.
- 2a I feel quite guilty.
- 2b I feel bad or unworthy practically all the time now.
- 3 I feel as though I am very bad or worthless.

## F.) Expectation or punishment

- 0 I don't feel I am being punished.
- 1 I have a feeling that something bad may happen to me.
- 2 I feel I am being punished or will be punished.
- 3a I feel I deserve to be punished.
- 3b I want to be punished.

Self-dislike

- 0 I don't feel disappointed in myself.
- 1a I am disappointed in myself.
- 1b I don't like myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

H.) Self-accusations

- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself for my faults.
- 3 I blame myself for everything bad that happens.

I.) Suicidal ideas

- 0 I don't have any thoughts of harming myself.
- 1 I have thoughts of harming myself but I would not carry them out.
- 2a I feel I would be better off dead.
- 2b I feel my family would be better off if I were dead.
- 3a I have definite plans about committing suicide.
- 3b I would kill myself if I could.

J.) Crying

- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now. I can't stop it.
- 3 I used to be able to cry but now I can't cry at all even though I want to

K.) Irritability

- 0 I am no more irritated now than I ever am.
- 1 I get annoyed or irritated more easily than I used to.
- 2 I feel irritated all the time
- 3 I don't get irritated at all at the things that used to irritate me.

L.) Social withdrawal

- 0 I have not lost interest in other people.
- 1 I am less interested in other people now than I used to be.
- 2 I have lost most of my interest in other people.
- 3 I have lost all my interest in other people and don't care about them at all.

M.) Indecisiveness

- 0 I make decisions about as well as ever.
- 1 I try to put off making decisions.
- 2 I have great difficulty in making decisions.
- 3 I can't make decisions at all anymore

N.) Body image change

- 0 I don't feel I look any worse than I used to.
- 1 I am worried that I am looking old or unattractive.
- 2 I feel that there are permanent changes in my appearance and they make me look unattractive.
- 3 I feel that I am ugly or repulsive-looking.

- O.) Work retardation
- 0 I can work about as well as before.
  - 1a It takes extra effort to get started at doing .
  - 1b I don't work as well as I used to.
  - 2 I have to push myself very hard to do anything.
  - 3 I can't do any work at all.
- P.) Insomnia
- 0 I can sleep as well as usual.
  - 1 I wake up more tired in the morning than I used to.
  - 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
  - 3 I wake up early every day and can't get more than 5 hours sleep.
- Q.) Fatigability
- 0 I don't get any more tired than usual.
  - 1 I get tired more easily than I used to.
  - 2 I get tired from doing anything.
  - 3 I get too tired to do anything.
- R.) Anorexia
- 0 My appetite is no worse than usual.
  - 1 My appetite is not as good as it used to be.
  - 2 My appetite is much worse now.
  - 3 I have no appetite at all anymore.
- S.) Weight loss
- 0 I haven't lost much weight, if any, lately.
  - 1 I have lost more than 5 pounds.
  - 2 I have lost more than 10 pounds.
  - 3 I have lost more than 15 pounds.
- T.) Somatic preoccupation
- 0 I am no more concerned about my health than usual.
  - 1 I am concerned about aches and pains or upset stomach or constipation.
  - 2 I am so concerned with how I feel or what I feel that it's hard to think of much else.
  - 3 I am completely absorbed in what I feel.
- U.) Loss of libido
- 0 I have not noticed any recent change in my interest in sex.
  - 1 I am less interested in sex than I used to be.
  - 2 I am much less interested in sex now.
  - 3 I have lost interest in sex completely.

Score \_\_\_\_\_



Patient Name/Last Four: \_\_\_\_\_  
Indication: \_\_\_\_\_

## Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

### Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

### Section 2: Personal Care (eg. washing, dressing)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, wash with difficulty and stay in bed

### Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

### Section 4: Walking\*

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than one mile
- Pain prevents me from walking more than one-half mile
- Pain prevents me from walking more than 100 yards
- I can only walk using a stick or crutches
- I am in bed most of the time

### Section 5: Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

### Section 6: Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain

- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

### Section 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

### Section 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

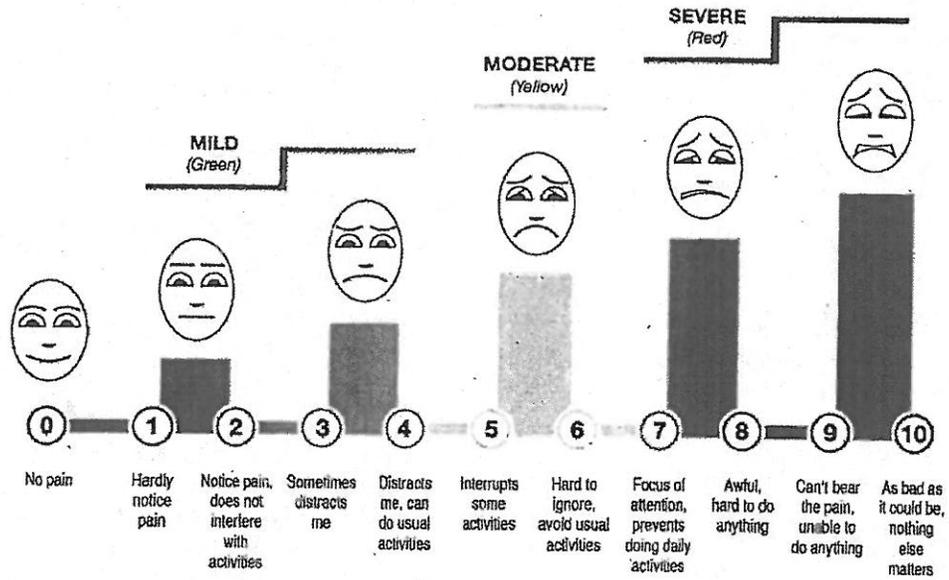
### Section 9: Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

### Section 10: Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment

## Defense and Veterans Pain Rating Scale



Using the pain rating scale above as your guide, please respond to each item below by marking one box per row.

v 2.0

1. What is your level of pain right now?  0  1  2  3  4  5  6  7  8  9  10

2. In the past 7 days, how intense was your pain at its worst?  0  1  2  3  4  5  6  7  8  9  10

3. In the past 7 days, how intense was your average pain?  0  1  2  3  4  5  6  7  8  9  10

4. Choose the one number that describes how, during the past 24 hours, pain has interfered with your ACTIVITY.  
 0  1  2  3  4  5  6  7  8  9  10  
 Does not interfere Completely interferes

5. Choose the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:  
 0  1  2  3  4  5  6  7  8  9  10  
 Does not interfere Completely interferes

6. Choose the one number that describes how, during the past 24 hours, pain has interfered with your MOOD.  
 0  1  2  3  4  5  6  7  8  9  10  
 Does not interfere Completely interferes

7. Choose the one number that describes how, during the past 24 hours, pain has interfered with your STRESS:  
 0  1  2  3  4  5  6  7  8  9  10  
 Does not interfere Completely Interferes

# Opioid Risk Tool Patient Form

Mark each box that applies.

**1. Family History of Substance Abuse:**

**Female**

**Male**

Alcohol

Illegal Drugs

Prescription Drugs

**2. Personal History of Substance Abuse:**

Alcohol

Illegal Drugs

Prescription Drugs

**3. Age (mark box if between 16-45)**

**4. History of Preadolescent Sexual Abuse**

**5. Psychological Disease**

Attention Deficit Disorder,  
Obsessive-Compulsive Disorder,  
Bipolar, Schizophrenia

Depression

