Southwest Pain Management
Patient Interval Questionnaire

Patient Name: _____ DOB: _____Date form completed: _____ Date of Visit:_____
If you have multiple insurances please list insurance we are seeing you under today:_____

Are you or might you possibly be pregnant? Yes/No **Are you breastfeeding?** Yes/No

Pain Score with meds:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	(0 = no pain, 10 = worst pain)
Pain Score without meds:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	(0 = no pain, 10 = worst pain)
Pain Score right now:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	(0 = no pain, 10 = worst pain)

Status of your pain: __ changing __improving __fluctuating __resolved __stable __worse
_____
Pain radiates to: __none __left arm __right arm __left ankle __right ankle __left calf __ right calf __left foot __right foot __left thigh __right thigh __other:_____
Descriptors: __ache _burning __deep __diffuse __discomforting __dull __localized__numbness __piercing __sharp __shooting __stabbing __superficial __throbbing __other:_____
Aggravated by: __Nothing __ascending stairs __bending __changing positions __ coughing __daily activities __descending stairs __defecation __extension __flexion __jumping __lifting __lying/rest __pushing __running __sitting __sneezing __standing __twisting __ walking __rolling over in bed __other: _____
Relieved by: __nothing __exercise __heat __ice __injection __lying down __massage __movement __OTC medications __pain medications __physical therapy __spontaneously __stretching __rest __sitting __other: _____

Smoker Status: Current every day smoker Current some days smoker Never smoked Former smoker
Do you use alcohol: No/Yes If yes list frequency/amount: _____ Involved in a 12-step program? Yes/No
Do you use marijuana or any other recreational drugs: Yes/ No If yes list type/frequency:_____
__ I have a card for medicinal marijuana
Advanced Directives: __none __Do Not Resuscitate __Living Will __ Other Directive: _____
Quality of Life Scale (Select the **ONE** answer that best describes the quality of your life without medications – **THEN** Select the **ONE** answer that best describes the quality of your life with medications)

Without Meds	**With Meds**	***If you have had a procedure in the last 60 days Please address*** »»»»»»»»»»»	**Procedure Before**	**After**
____	____	Stay in bed all day. Feel hopeless and helpless about life	____	____
____	____	Stay in bed at least half the day. Have no contact with outside world	____	____
____	____	Get out of bed but don't get dressed. Stay at home all day	____	____
____	____	Get dressed in the morning. Minimal activities at home. Contact with friends via phone, email	____	____
____	____	Do simple chores around the house. Minimal activities outside of home two days a week	____	____
____	____	Struggle but fulfill daily home responsibilities. No outside activity. Not able to work/volunteer	____	____
____	____	Work/volunteer limited hours. Take part in limited social activities on the weekend	____	____
____	____	Work/volunteer for a few hours daily. Can be active at least five hours a day. Can make plans to do simple activities on weekends	____	____
____	____	Work/volunteer for at least six hours daily. Have energy to make plans for one evening social activity during the week. Active on weekends	____	____
____	____	Work/volunteer/be active eight hours daily. Take part in family life. Outside social activities limited	____	____
____	____	Go to work/volunteer each day. Normal daily activities each day. Have a social life outside of work. Active part in family life.	____	____

Pain Intensity and Interference
In the Last Month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [That is, your usual pain at times you were in pain.]

No Pain										**Pain as bad as it could be**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10 where 0 is "no Interference" and 10 is "unable to carry on any activities"?

No Interference										**Unable to carry on any activities**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Have you had **any** procedures performed by SPM in the last 60 days? □ No □ Yes If yes, List: _____
Do you feel the procedure reduced your pain level? Y/N Were you able to increase your activities? Y/N
Percent pain reduction in pain treated _____% Percent reduction in overall pain _____%