Complex Pain Management Program

Patient Questionnaire- Initial Office Visit

Please have patient complete area below. Parent/Guardian may assist if needed.

Child's full name: _____ Date of birth: _____

Age: _____ Sex: Male/Female

Your name: _____ Relationship to child: _____ Date: _____

Reason for Referral:

Briefly state the main concerns for which you are presently seeking help: _____

_____

_____

_____

_____

Where is your pain? Using the symbols or color system listed below, mark on the areas where you feel your pain. Show all affected areas. If you feel more than one sensation in same area, mark over the area with additional symbols that apply.

Symbols

-------numbness

0000 pins and needles

xxxx burning

////// stabbing

++++ aching

Choose 4 colors that represent your pain

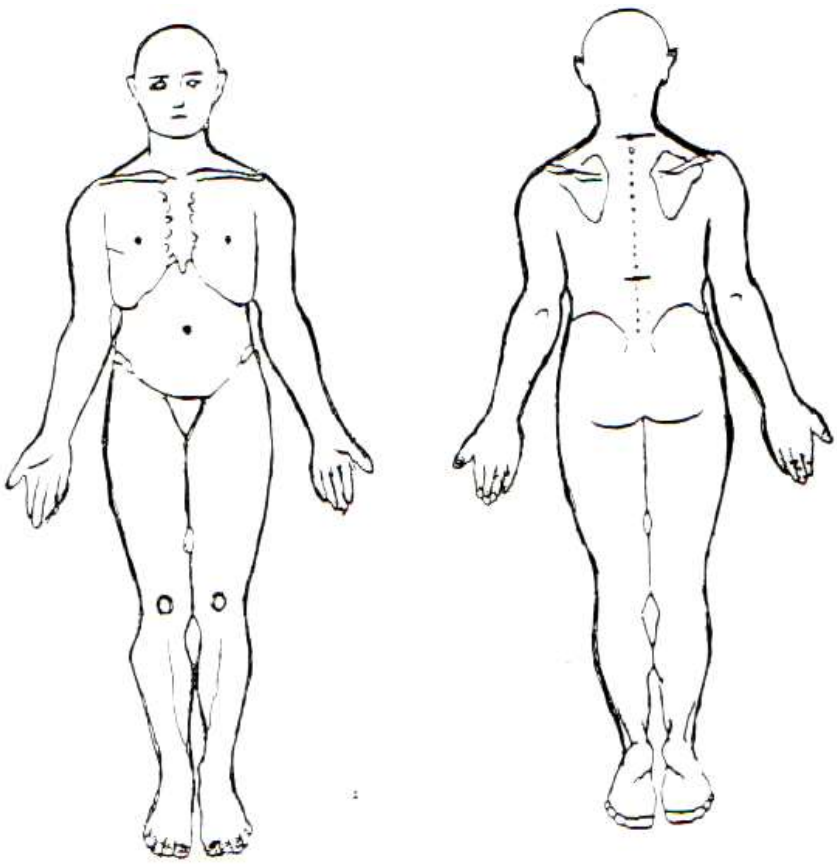
_____small pain

_____medium pain

_____ large pain

_____ worst pain

R **L** **L** **R**



Why do you think you have pain? _____

_____

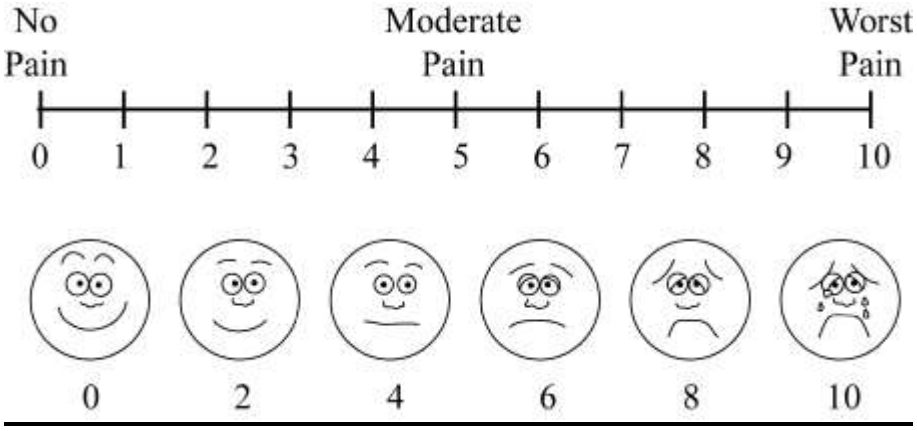
Is your pain usually WORSE during a certain time of day? ☐ Yes ☐No

If yes, When? ☐Morning ☐Midday ☐Evening ☐Night

What makes your pain worse? _____

Is your pain BETTER during a certain time of day? ☐ Yes ☐ No

If yes, When? ☐Morning ☐Midday ☐Evening ☐Night



Choose the number which best describe the intensity of your pain by placing an x on the line.
0= NO PAIN 10=WORST PAIN IMAGINABLE

Your pain right now…….	0 1 2 3 4 5 6 7 8 9 10
Your pain at its worst……..	0 1 2 3 4 5 6 7 8 9 10
Your pain at its least……	0 1 2 3 4 5 6 7 8 9 10
The worst toothache you ever had	0 1 2 3 4 5 6 7 8 9 10
The worst headache you ever had	0 1 2 3 4 5 6 7 8 9 10
What is an acceptable pain level	0 1 2 3 4 5 6 7 8 9 10

Do you have any of the following symptoms with you pain?

☐vomiting ☐sweating ☐noise sensitivity ☐nausea ☐ blurred vision ☐dizziness

☐light sensitivity ☐numbness/tingling ☐irritability ☐ feeling faint ☐rapid heart beat

☐anxiety ☐rapid breathing ☐ loud heart beat ☐ depression

Realistic goals or expectations from treatment at SLCH Complex Pain Program: _____
_____
_____

Have you had any of the following tests to evaluate your pain? (Please provide details)

X-Rays _____
MRI _____
CT scan _____
Myelogram _____
Nerve and Muscle Tests _____

Listed below are treatments used in pain management. Please indicate those treatments you have had and whether or not they were helpful to you.

Treatments	Facility/Date	Was it Helpful?
☐ Surgery related to pain	_____	☐ Yes ☐ No
☐ Injections	_____	☐ Yes ☐ No
☐ Physical Therapy	_____	☐ Yes ☐ No
☐ Psychological Treatments	_____	☐ Yes ☐ No
☐ Relaxation Training	_____	☐ Yes ☐ No
☐ Biofeedback	_____	☐ Yes ☐ No
☐ Chiropractor	_____	☐ Yes ☐ No

Other illnesses for which you are currently being treated: Yes / No _____
_____

Current Medications: Yes / No (if yes, please list):

Name of Medication	Dosage	Name of Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Pain Medications	Dosage	Date stopped/Reason for discontinuing
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies:
_____

Difficulties following doctor's advice in taking medicine or other treatment? Yes / No (describe):
_____

Personal Health History

Please check all conditions which you currently have.

Constitution
___Activity change
___Appetite change
___Chills
___Excessive sweating
___Fatigue
___Fever
___Weight change
_____OTHER

HENT
___Congestion
___Dental problem
___Drooling
___Ear discharge
___Ear pain
___Facial swelling
___Hearing loss
___Mouth sores
___Nosebleeds
___Postnasal Drip
___Runny nose
___Sinus Pain
___Sinus pressure
___Sneezing
___Sore throat
___Ringing in ears
___Trouble swallowing
___Voice changes
_____OTHER

BREAST
___Tenderness
___Redness
___Lumps
_____OTHER

Eyes
___Eye discharge
___Eye itching
___Eye pain
___Eye redness
___Light sensitivity
___Visual disturbance
_____OTHER

RESPIRATORY
___Apnea
___Chest tightness
___Choking
___Cough
___Shortness of breath
___Stridor
___Wheezing
_____OTHER

CARDIOVASULAR
___Chest pain
___Leg swelling
___Palpitations
_____OTHER

GI
___Abdominal distention
___Abdominal pain
___Rectal bleeding
___Constipation
___Diarrhea
___Nausea
___Rectal pain
___Vomiting
_____OTHER

Endocrine
___Cold intolerance
___Heat intolerance
___Frequent thirst
___Excessive dilute urine
_____OTHER

GU
___Difficulty urinating
___Painful intercourse
___Painful urination
___Bedwetting
___Flank pain
___Frequency
___Genital sore
___Blood in urine
___Menstrual problem
___Pelvic Pain
___Urgency
___Urine decreased
___Vaginal bleeding
_____OTHER

MUSCULOSKELETAL
___Joint pain
___Back pain
___Gait problem
___Joint swelling
___Muscle pain
___Neck pain
___Neck Stiffness
_____OTHER

SKIN
___Pale appearance
___Color Change
___Rash
___Wound
_____OTHER

Allergy/ Immunology
___Environmental allergies
___Food allergies
___ frequent infections
_____OTHER

Neurological
___Dizziness
___Facial asymmetry
___Light-headedness
___Numbness
___Seizures
___Speech difficulty
___Syncope
___Tremors
___Weakness
___OTHER

HEMATOLOGIC
___Enlarged lymph nodes
___Bruises easily
_____OTHER

PSYCHIATRIC
___Agitation
___Behavior problem
___Confusion
___Decreased concentration
___Mood Changes
___Hallucinations
___Hyperactivity
___Nervous / Anxious
___Self – injury
___Sleep disturbance
___Suicidal ideation
_____OTHER

Please have parent/child complete this portion of form:

History of Behavioral Health Problems	Circle One	Child/family member
Attention Problems (e.g., ADD or ADHD)	Yes / No	
Learning Problems or Disabilities	Yes / No	
Depression or Postpartum Depression	Yes / No	
Bipolar Disorder / Manic Depression	Yes / No	
Anxiety or Obsessive-Compulsive Disorder	Yes / No	
Anger management problems	Yes / No	
Alcohol use/abuse	Yes / No	
Illicit drug use/ abuse	Yes / No	
Antisocial / criminal behavior	Yes / No	
Difficulty falling asleep	Yes/No	
Nightmares	Yes/No	
Risky Behaviors	Yes/No	

Please list any counselors, psychotherapists, psychologists and psychiatrists you have seen:

Age	Provider Name	Service (Testing, treatment, medication)	Helpful
____	_____	_____	Yes / No
____	_____	_____	Yes / No
____	_____	_____	Yes / No

Previous medications to manage mood or behavior problems: Yes / No (describe): _____
_____

Psychiatric hospitalizations: Yes / No (describe): _____

Family Information:

Names of child's legal guardians: _____

Relationship to child: _____

Highest grade completed by mother: _____ highest grade completed by father: _____

Mother's occupation: _____ Father's occupation: _____

Parents' marital status: ☐Married ☐Divorced ☐Separated ☐ Deceased ☐ Never Married

If the child's parents are married, how long have the parents been married? _____

If separated or divorced, age of child at the time: _____ Dates of any remarriages: _____

Frequency of visitation with non-custodial parent: _____

Please list all the members of your immediate family (include any half or step-siblings):

Name	Age	Relationship to child	living within household
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes/ No
_____	_____	_____	Yes / No

Do you have any concerns regarding your child's early development? Yes / No (describe): _____
_____
_____

Educational History:

Name of current school: _____ Phone: _____

Grade: _____ Teacher: _____ Present letter grades: _____

Skipped grades: Yes / No which ones? _____ Reason: _____
Repeated grades: Yes / No which ones? _____ Reason: _____

	Circle One	Ages	Describe
Early Education Intervention	Yes / No		
Occupational Therapy	Yes / No		
Physical Therapy	Yes / No		
Speech Therapy	Yes / No		

Has a psychologist ever tested your child? Yes* / No When & why? _____
_____

Please have a copy of the results mailed to our office.

Does your child currently receive any special education, enrichment or resource services? Yes* / No (describe): _____

If your child receives any special education services, please enclose a copy of your child's current Individual Education Plan (IEP) or have it sent by the school.

Teachers report current concerns about your child's performance in these areas:

Reading	_____	Attention/concentration	_____
Spelling	_____	Behavior	_____
Math	_____	Social skills	_____
Writing	_____	Emotional adjustment	_____

Has your child ever received detention, been suspended or expelled? Yes / No (describe):
_____

Previous schools attended Dates attended (begin - end)

_____ _____
_____ _____
_____ _____

Briefly describe any problems occurring during your child's attendance at these previous schools:
_____

Social History:

Describe any problems your child may have with peers (e.g., bullied, teased, no friends, poor social skills, aggressive, bossy, shy): _____
_____

Is your child involved in any clubs, sports, or other organized activities? Yes / No (please list): _____
_____
_____

Please list some of your child's personal strengths and talents: _____
_____
_____
_____

Please check any of the following stressful events that apply to your child or family and describe:

- o Relocations: _____
- o Job changes: _____
- o Deaths: _____
- o Chronic health problems: _____
- o Major illnesses: _____
- o Marital problems: _____
- o Someone significant moving out of the area: _____
- o Experiencing a traumatic event: _____
- o Witnessing a traumatic event: _____
- o Physical or sexual abuse or neglect: _____
- o Division of Family Services (DFS) involvement: _____
- o Legal issues: _____
- o Other: _____

Please attach any additional remarks you may wish to make regarding your child. Thank you for taking the time to complete this information form.

Washington University in St. Louis

Department of Anesthesiology
Divison of Pediatric Anesthesiology and Pain Management

PERMISSION TO OBTAIN AND RELEASE INFORMATION

I hereby authorize Washington University to transfer, release or obtain information on:

_____ _____
_____ _____
(Name of Patient) **(Date of Birth)**

To exchange written and or verbal information with:

_____ _____

(Name of School) **(Phone Number)**

Information to include but not limited to medical and or related health records and information, psychological evaluations, or school work reports, and educational information.

I certify that I am the parent and legal guardian of the above mentioned child or that I am the student of majority age and have the authority to sign this release.

_____
(Signature of Parent / Guardian)

_____
(Relationship to child)

_____
(Signature of student)

Children's HOSPITAL • ST. LOUIS BJC HealthCare

Washington University in St. Louis SCHOOL OF MEDICINE

DOB: DOS:

Consent to Hospital Treatment and/or Admission and Assignment of Benefits, Financial Responsibilities

I know that I have the right to make decisions about my child's medical treatment. I consent to have the doctors and other healthcare workers at St. Louis Children's Hospital provide medical treatment to my child. I understand the medical treatment is provided by physicians and health care workers who may be employees of St. Louis Children's Hospital, Washington University School of Medicine, or other individuals who are allowed to provide care at the Hospital. I also understand the physicians and health care workers may be fellows, residents or students in training and that the individuals caring for my child are collectively called "the staff."

I also consent to taking and storing photographs, videos and other electronic images of my child for the purposes of treating my child and providing education and I understand that reasonable efforts will be made to protect the identity of my child.

If I receive Medicare or Medicaid, I agree the information I gave to apply for payment is correct. I have been given a paper listing my rights as a Medicare or Medicaid patient. I know I can ask for a review of my/my child's record to find out about any payments or charges I may owe if Medicare or Medicaid will not cover my child's charges.

If I receive Medicare, Medicaid or other insurance benefits, I know I am responsible to know what my insurance covers and that I can call my insurance plan if I have questions. I also understand I am responsible for any deductibles, co-insurance, and any non-covered charges. I know that I may receive separate bills for services provided by healthcare workers who are not employed by the Hospital – like Washington University or other individuals allowed to provide care at the Hospital.

I authorize direct payment to St. Louis Children's Hospital of all insurance benefits and I authorize release of my/my child's personal health information as may be required for my insurance plan to pay such benefits. I understand that I am responsible, subject to BJC's Financial Assistance Policy, for portions of my child's hospital bill not covered by insurance.

I also agree that I have received the Admission Packet, or Toolkit, if this information applies to me, or if not, I have access to signs and/or brochures which contain information about:

- Advance Directives: What are they? Where can I get one? Do we need one?
- Privacy of my health care information and who may have access to my information
- How the Hospital handles personal valuables
- Visiting Hours, Visitor Policies and Behavior Rules
- What Rights and Responsibilities I/we have as a patient or family member and who to contact if I/we have questions.

I have read this whole form, or had it read and explained to me, and I had the opportunity to ask questions.

Signature of Person Consenting to Treatment	Relationship to Patient	Date

Signature of Guarantor if different than above

CN 1135 Approved by HIMFC 6/23/2015