BARNES-JEWISH Hospital
BJC HealthCare

Washington University in St. Louis
SCHOOL OF MEDICINE

PAIN MANAGEMENT CENTER
PATIENT HEALTH RISK HISTORY

PATIENT IDENTIFICATION

Please check (✔) the appropriate box(es) (☐) and fill in the blank(s) as needed.

Please complete the following questions and bring completed form with you for your new patient appointment.

Do you have an Advance Directive (Living will)?		Yes	No
If you answered no, would you like information about a living will?		Yes	No
Have you lost or gained 10 pounds or more in the last month? If yes, how much	Yes	No	Lost_____lbs Gain_____lbs
Are you satisfied with your current weight?	Yes	No	
How is your appetite?	Good	Fair	Poor
How do you rate your diet?	Good	Fair	Poor
Are you able to purchase and prepare balanced meals?	Yes	No	
Would you like to see a dietitian?	Yes	No	

Have you experienced any of the following problems recently?

Difficulty walking?	Yes	No
Difficulty getting dressed?	Yes	No
Falling?	Yes	No
Difficulty bathing/grooming?	Yes	No
Memory problems?	Yes	No
Eating or feeding problems?	Yes	No
Difficulty speaking?	Yes	No
Difficulty with activities of daily living: cooking, cleaning, shopping, driving?	Yes	No

Do you have concerns regarding any of the following?

Getting Medications?	Yes	No
Housing?	Yes	No
Transportation?	Yes	No
Would you like to speak with a social worker?	Yes	No
Do you use tobacco?	Yes	No
Specify type:	Amount/day	#of years:
Are you interested in quitting?	Yes	No
Would you like information on how to stop smoking?	Yes	No

Are you having pain today?	Yes / No	If Yes, specify location:
How often do you experience this pain?	Occasionally	Frequently Constantly
How does your pain feel?	☐ Aching	Burning Crushing Dull Sharp

Are you in a relationship with someone who makes you feel afraid, unsafe, or is hurting you?	Yes	No

Patient or Representative Signature: _____ **Date:**_____ **Time:** _____

Nurse Signature: _____ **Date:**_____ **Time:** _____

DO NOT WRITE BELOW THIS LINE

BJ 10-3343-2549 EF

BARNES-JEWISH Hospital BJC HealthCare

Washington University in St. Louis SCHOOL OF MEDICINE

PAIN MANAGEMENT CENTER (PMC)
PATIENT COMMUNICATION FORM

PATIENT IDENTIFICATION

Please (✓) the appropriate box(es) (☐) and fill in the blanks as needed

1. My patient health information may be discussed with the following family members or friends:

   NAME:_____ RELATIONSHIP: _____

   NAME:_____ RELATIONSHIP: _____

   NAME:_____ RELATIONSHIP: _____

2. You may leave medical information on voice mail at these numbers:

   HOME PHONE:_____

   CELL PHONE:_____

   Preferred Number to reach you ☐ Home ☐ Cell Other:_____

3. The following person(s) may pick up your prescriptions at the office:

   _____

   _____

4. What is your preferred pharmacy and phone number?

   _____

Patient/Responsible Adult:

_____ _____ Date: _____ Time: _____
SIGNATURE **REQUIRED** PRINTED NAME **REQUIRED**

RN: _____ _____ Date: _____ Time: _____
SIGNATURE **REQUIRED** PRINTED NAME **REQUIRED**

DO NOT WRITE BELOW THIS LINE

ORIGINAL - Chart
YELLOW - Log Book Front Desk

BJ 4-3343-1615 EF

BARNES-JEWISH Hospital BJC HealthCare

Washington University in St. Louis
SCHOOL OF MEDICINE

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

ADDRESSOGRAPH

Please check (✓) the appropriate box (☐) and fill in the blank(s) as needed.

Date: _____

Patient Name: _____ **Date of Birth:** _____

Please complete the questionnaire as fully as possible to assist us with your evaluation and treatment. Please read each question carefully and answer to the best of your ability. This information is part of your medical record, and will not be released without your permission.

Referring Physician: _____ Telephone Number: _____

Primary Care Physician: _____ Telephone Number: _____

PAIN HISTORY

Briefly describe your pain: _____

_____

_____

_____

_____

When did your pain first begin? (date): _____

Under what circumstances did the pain begin:

☐ Accident at work
☐ Accident at home
☐ Following surgery
☐ Pain just began
☐ At work, but not an accident
☐ Auto accident
☐ Following an illness
Other reason: _____

Briefly describe the circumstance(s) you checked: _____

_____

_____

Are you receiving compensation or disability payments now? ☐ Yes ☐ No
Are you involved in a lawsuit because of your pain or injury? ☐ Yes ☐ No
Have you contacted a lawyer because of your pain or injury? ☐ Yes ☐ No

What are your expectations from the Pain Center? _____

_____

_____

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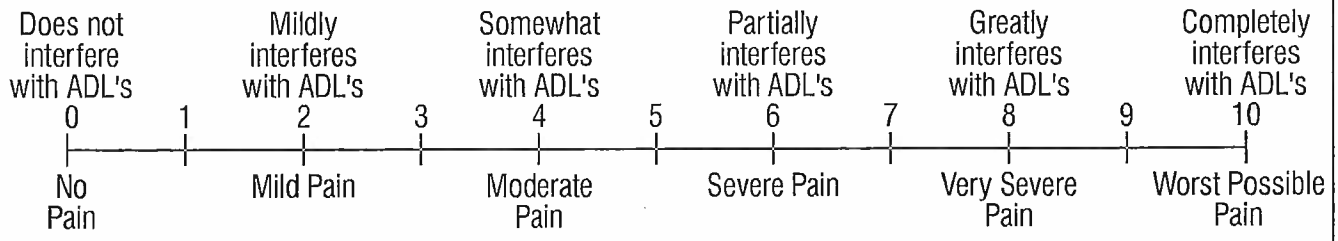
BARNES-JEWISH Hospital BJC HealthCare

Washington University in St. Louis
SCHOOL OF MEDICINE

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

Please answer the following questions on how your pain affects your activities of daily living (ADL)'s, using the ADL Pain Chart below.



PAIN INTENSITY

Check (✔) the box to indicate your pain level at the present time.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Check (✔) the box where your pain is at its worst.

☐ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Check (✔) the box where your pain is at its least.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Check (✔) the box of your average pain.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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BARNES-JEWISH Hospital BJC HealthCare

Washington University in St. Louis SCHOOL OF MEDICINE

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

PAIN INTENSITY

Which word (or words) best describe the patterns of your pain:

☐ Always present
☐ Comes and goes

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

If yes, when: ☐ Morning ☐ Midday ☐ Evening ☐ Night

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

If yes, when: ☐ Morning ☐ Midday ☐ Evening ☐ Night

QUALITY OF PAIN

Please describe your pain. Check (✔) all that apply:

	Yes	No		Yes	No
Throbbing			Heavy		
Shooting			Tender		
Stabbing			Splitting		
Cramping			Tiring-Exhausting		
Gnawing			Sickening		
Hot-Burning			Fearful		
Aching			Punishing-Cruel		

INCREASES/DECREASES PAIN

Please check (✔) How your pain reacts to the following:

	Better	Worse	No Change
Walking			
Lifting			
Bending			
Lying			
Weather/Temperature change			
Standing			
Sitting			
Stress/Worry			
Heat			
Ice			
Rest			
Medications			
Light touch			
Cough			
Sneeze			
Strain			
Other:			

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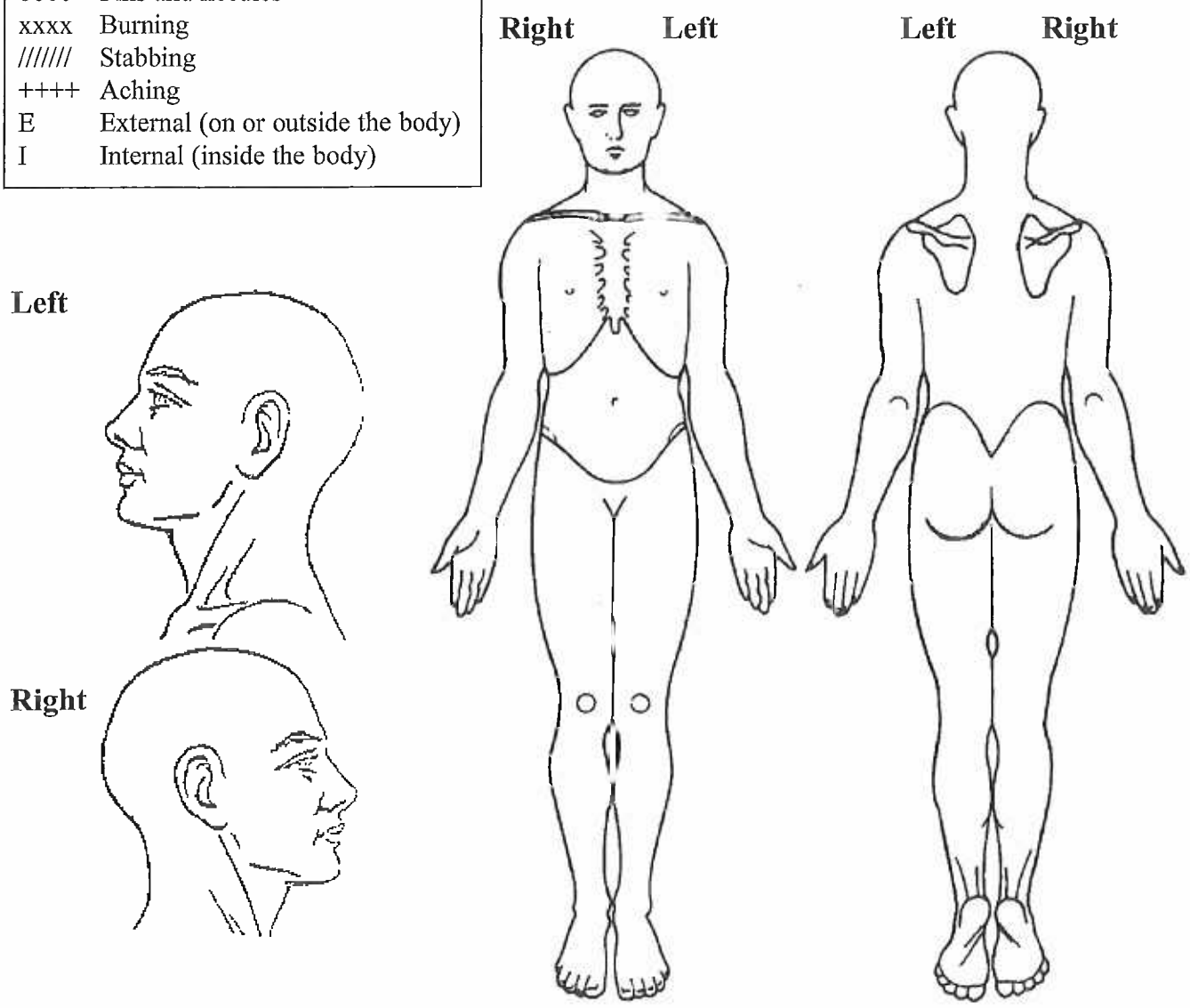
PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

Where is your pain?

Using the symbols listed below, mark on the drawings the areas where you feel pain. If you feel more than one sensation in the same area, mark over that area with additional symbols that apply. Show all affected areas.

SYMBOLS	
——	Numbness
0000	Pins and needles
xxxx	Burning
///////	Stabbing
++++	Aching
E	External (on or outside the body)
I	Internal (inside the body)



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BARNES-JEWISH Hospital BJC HealthCare

Washington University in St. Louis SCHOOL OF MEDICINE

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

LIFESTYLE CHANGES

During the past month, how much did pain interfere with the following activities?
Check (✔) the box for each of the questions that best describes your situation.

	Not at All	A Little Bit	Moderately	Quite a Bit	Extremely
Going to work	☐	☐	☐	☐	☐
Performing household chores	☐	☐	☐	☐	☐
Yard work or shopping	☐	☐	☐	☐	☐
Socializing with friends	☐	☐	☐	☐	☐
Recreation and hobbies	☐	☐	☐	☐	☐
Having sexual relations	☐	☐	☐	☐	☐
Physical exercise	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐
Appetite	☐	☐	☐	☐	☐

PRIOR TREATMENTS

Prior treatments for pain, check (✔) all the boxes that apply.

	Helpful	Not Helpful
☐ Surgery	☐	☐
☐ Nerve Block	☐	☐
☐ TENS/MENS	☐	☐
☐ Physical Therapy	☐	☐
☐ Occupational Therapy	☐	☐
☐ Biofeedback/Relaxation Therapy	☐	☐
☐ Acupuncture	☐	☐
Facility where it was performed?_____		
☐ Chiropractor	☐	☐
☐ Other Pain Center(s)	☐	☐
☐ Professional Psychological Support	☐	☐

Other:_____

DIAGNOSTIC TESTS

	Date	Facility
☐ MRI	_____	_____
☐ CAT SCAN	_____	_____
☐ XRAY	_____	_____
☐ EMG	_____	_____
☐ Nerve Conduction Study	_____	_____
Other:	_____	_____

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BARNES-JEWISH Hospital BJC HealthCare

Washington University in St. Louis
SCHOOL OF MEDICINE

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

Please check (✔) all conditions which you currently have.

MEDICAL HISTORY

Constitutional Symptoms
Fever ☐ Fatigue

Nutritional Assessment
Weight loss/gain
Poor appetite
Nutritional supplement use

Eyes
Eye Pain Blurred Vision
Glaucoma Eye Discharge
Glasses or Contacts
Light Sensitivity

Ears/Nose/Mouth/Throat
Ear Discharge Ringing or Pain
Hearing difficulty or aid
Nose Pain Nose Drainage
Nose Congestion
Nose Bleeds Sinus Infections
Dentures Jaw/Tooth Pain
Mouth Sores Sore Throat
Hoarseness

Cardiovascular
High blood pressure
Chest pain
Heart attack
Abnormal heart rhythm
Swelling of ankles
Mitral Valve Prolapse
Blood clot
Use of blood thinners

Respiratory
Painful breathing
Productive cough
Emphysema
Shortness of breath
Tuberculosis
Asthma

Gastrointestinal
Abdominal pain
Heartburn Hiatal hernia
Nausea and vomiting
Constipation Diarrhea
Ulcers
Liver, gallbladder problems, black, bloody stools

Genitourinary
Painful urination
Bladder infection
Difficult urination
Frequent urination
Blood in urine
Sexually transmitted disease

Musculoskeletal
Arthritis ☐ Swollen joints
Muscle pain

Integumentary (skin or breast)
Rash Itching
☐ Bruise easily Shingles
Skin cancer

Neurological
Headache Multiple sclerosis
Seizures Head injury
Stroke Tremors
Weakness/numbness/tingling
Dizziness ☐ Loss of coordination

Psychiatric
Memory loss ☐ Alzheimer's
Depression ☐ Anxiety/Panic Attacks
Alcoholism ☐ Thoughts of suicide
Irritability

Endocrine
Sweats Thyroid disease
Diabetes

Hematologic/Lymphatic
Leukemia Bruising
Bleeding disorder
Swollen glands
Hepatitis

Immunologic/Allergies
AIDS/HIV
Cancer: _____

PHYSICIAN ONLY
"All others negative"

FAMILY MEDICAL HISTORY

Has anyone in your family every had any of the following conditions? Please check all that apply.

	Father	Mother	Brother	Sister	Grandparent
Anxiety					
Cancer					
Chronic pain					
Depression/Mental Illness					
Diabetes					
Disability					
Drug Addition/Drug Abuse					
Heart disease					
High blood pressure					
Physical/Verbal Abuse					
Stroke					
Suicide					
Thyroid disease					
Cause of Death					

DO NOT WRITE BELOW THIS LINE

BARNES-JEWISH Hospital BJC HealthCare

Washington University in St. Louis SCHOOL OF MEDICINE

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

OTHER MEDICAL HISTORY/ PAST SURGERIES

Other Medical Conditions Now or Past	Surgeries	Date

Do you have any medical devices implanted in your body? ☐ Yes ☐ No
(i.e. pacemaker, portacath, pump, rods, prosthesis, stimulator etc.)_____

ALLERGIES

Allergies/Sensitivities	Reaction	Allergies/Sensitivities	Reaction

CURRENT PAIN MEDICATIONS

Date Started	Medication	Dose/How often do you take medication?	Benefit

Are you afraid of becoming addicted to your medications? ☐ Yes ☐ No
Are you on any blood thinners? ☐ Yes ☐ No

OTHER CURRENT MEDICATIONS

Date Started	Medication	Dose/How often do you take medication?

PREVIOUS PAIN MEDICATIONS

Previous Medication Taken for Pain (Important please contact your Physician or Pharmacy for Lists)

Medication	Dose	Reason Discontinued

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BARNES-JEWISH Hospital BJC HealthCare

Washington University in St. Louis SCHOOL OF MEDICINE

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

PSYCHOSOCIAL

Significant other:_____

Relationship: _____

Do you take care of other family members? ☐ Yes ☐ No

(i.e. parents, children, etc.) _____

Do you live alone? ☐ Yes ☐ No

Education Level:_____

Are you currently working? ☐ Yes ☐ No If no, why?_____

Previous/Current Occupation:_____

Do you smoke? ☐ Never ☐ Previously, but quit ☐ Daily ☐ Less than daily

Number of years smoking?_____ Number of packs per day?_____

Have you ever used recreational drugs? ☐ Yes ☐ No If yes, please indicate which drugs:

☐ Marijuana ☐ Heroin ☐ Ecstasy ☐ Cocaine ☐ Speed

☐ Crack ☐ Other:_____

Do you drink alcohol? ☐ Never ☐ Currently ☐ Daily ☐ Rarely

How much per week?_____

☐ Previously, but quit. When did you quit:_____

Have you ever been in a 12 step recovery program? ☐ Yes ☐ No

PSYCHOLOGICAL

Please check (✔) the box which describes how you have been feeling.

During the past month have you been tense or anxious?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

During the past month have you been depressed or discouraged?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

Hospital Admission for Mental Illness? ☐ Yes ☐ No

During the past month have you been irritable or upset?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

When you are in pain, how often is your husband/wife/other family supportive and encouraging?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

When you are in pain, how often does your husband/wife/other family ignore you or become angry?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

I have received the Patient Bill of Rights ☐ Yes ☐ No

Form completed by (Patient/Other):_____ _____

Signature Relationship

Date/Time:_____

DO NOT WRITE BELOW THIS LINE

BJ 6-3343-1780

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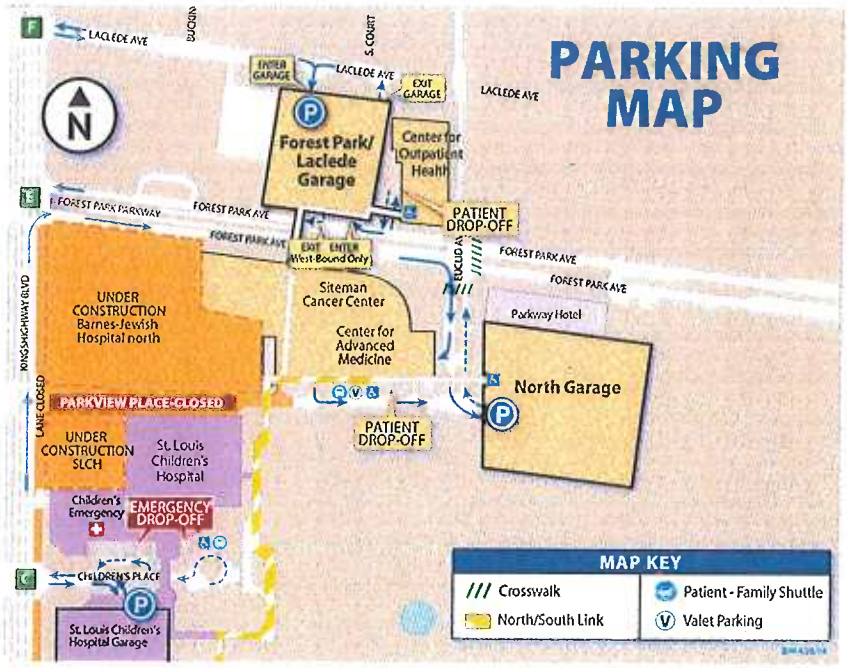

Directions to the Center for Advanced Medicine

4921 Parkview Place, St. Louis MO 63110

Traveling North on Kingshighway from Highway 40/Interstate 64:

From Highway 40/Interstate 64, take Exit 36 Kingshighway North. Proceed north on Kingshighway in the right lane to Forest Park Avenue. Turn right onto Forest Park Avenue and travel one block to Euclid. Turn right onto Euclid. Take the first right under the canopy for the CAM valet drop-off OR turn left for self-parking in the CAM North Garage.

Valet Parking and Drop-off:

A covered driveway is located at the entrance to the Center for Advanced Medicine on the corner of Euclid and Parkview Avenues. A valet parking charge of $ 2.00 will be added to your normal parking fee. Patients can be dropped off/picked up in the same area or more conveniently at the 3rd floor of the parking garage. Many reserved handicap parking spaces are available on every floor of the garage.

BARNES JEWISH Hospital BJC HealthCare | Washington University in St. Louis Physicians

NATIONAL LEADERS IN MEDICINE

To Our Patients:

The Pain Management Center is jointly operated by Washington University Physicians and Barnes Jewish Hospital. Therefore, your insurance will be billed for both a physician fee and a facility fee.

The Barnes Jewish Hospital billing may include other services received, for example radiology or laboratory in addition to facility.

For more information about the physician's charges, you can call Washington University Financial Services at (314) 273-0500 or 1-800-862-9980.

To speak with a BJC Financial Patient Services representative, please call 800-833-0604.

Thank You.

The Pain Management Center
4921 Parkview Place, Suite 14-C
Saint Louis, MO 63110
314-362-8820