

STORY / SUMMARY

NOTES

PLEASE ANSWER AS MANY QUESTIONS AS YOU CAN – THEY ARE ALL RELEVANT

Questions asking for an intensity number from 0 – 10, 0 =equals no pain, 10 equals the worse possible pain

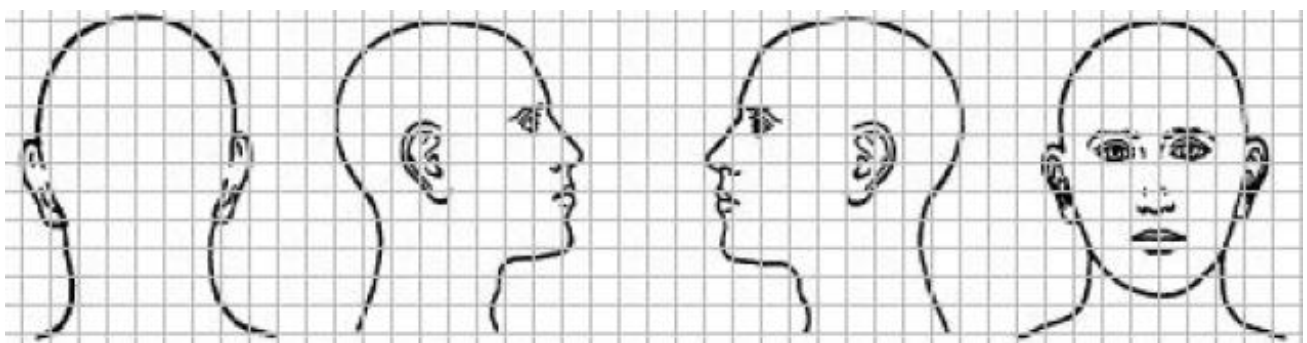
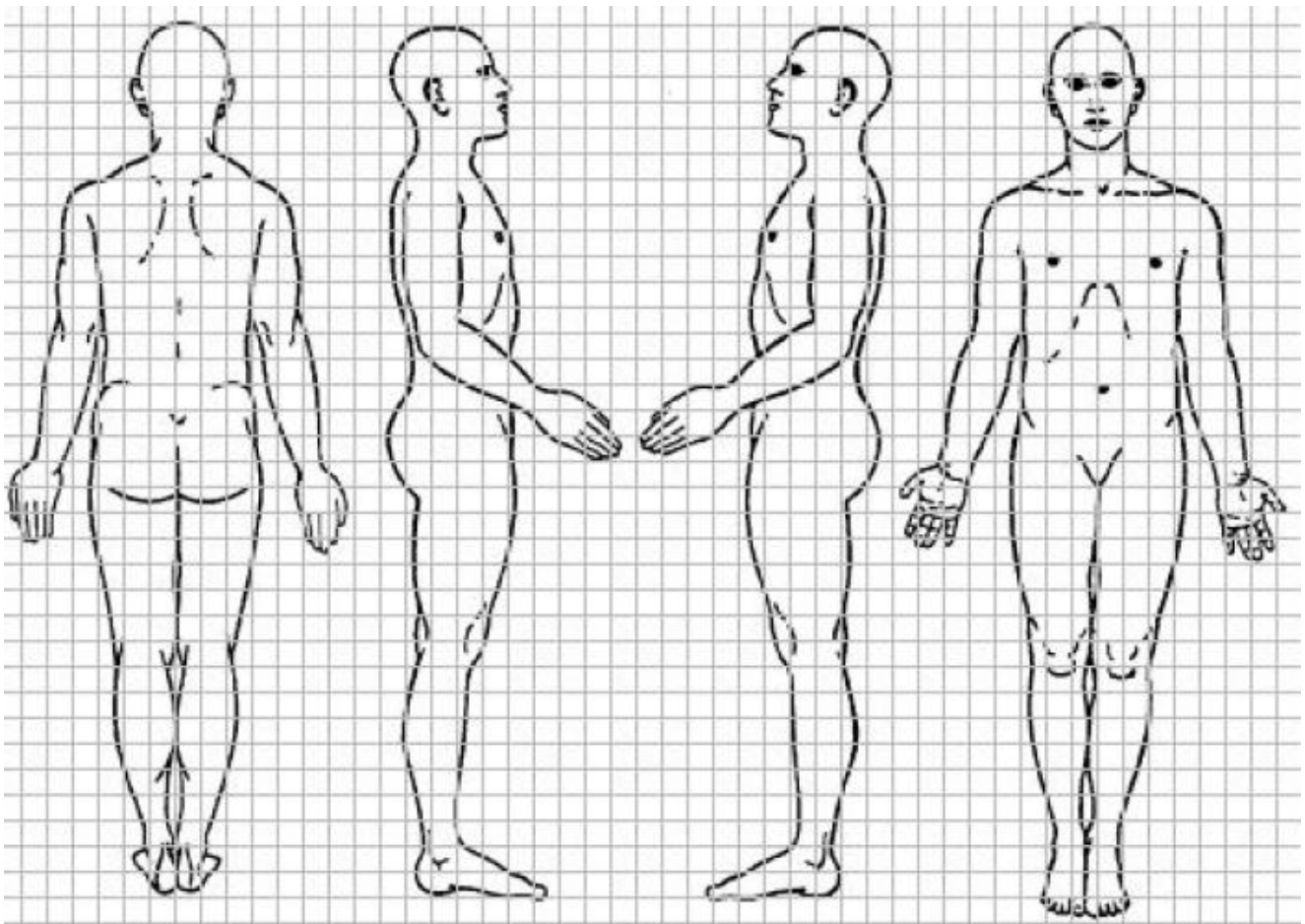
PAIN

1. **MAIN SITE OF PAIN (Now):** INTENSITY NOW (From 0 -10)

2. **IN THE PAST 3 MONTHS, ON AVERAGE, HOW INTENSE WAS YOUR PAIN?** (From 0 -10) ...

3. **DID THE PAIN START SOMEWHERE ELSE?** YES NO

3a. If it did, where did it start?



4. WHERE ELSE DO YOU HAVE PAIN? Nowhere else

(0 = No pain)

- | | | |
|----------|-------------|-----------------------------|
| 1) | Since | Intensity (from 0-10) |
| 2) | Since | Intensity (from 0-10) |
| 3) | Since | Intensity (from 0-10) |
| 4) | Since | Intensity (from 0-10) |
| 5) | Since | Intensity (from 0-10) |

5. HAVE YOU HAD THIS SAME PAIN BEFORE? YES NO

5a. IF 'YES', WHEN DID IT FIRST APPEARED?

5b. IF 'NO', WHEN DID IT START (this time)?

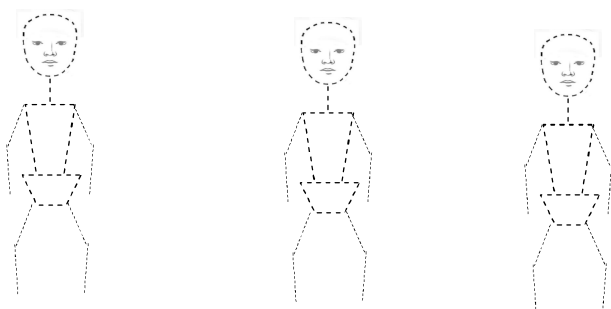
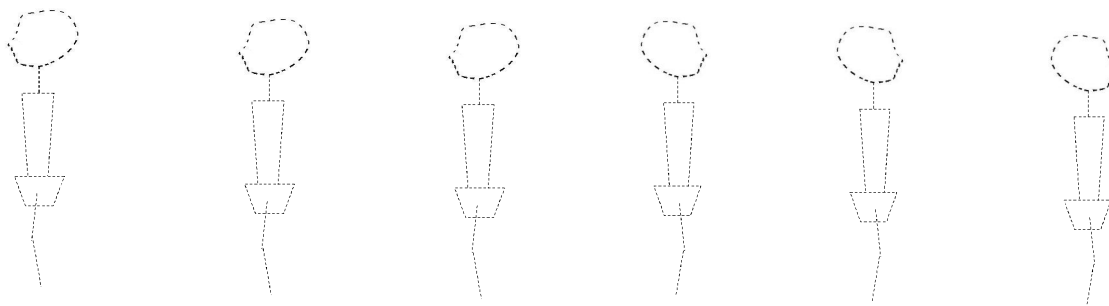
6. IS THE PAIN USUALLY BETTER: AT NIGHT? IN THE DAY? NEVER BETTER

7. BRIEFLY, WHAT DO YOU DO THAT MAKES THE CURRENT PAIN BETTER? (even if just a little):

8. WHAT ARE THE MAIN ACTIVITIES THAT YOU COULD DO BEFORE AND THAT YOU CANNOT DO NOW BECAUSE OF YOUR CURRENT PAIN?

- | | |
|----------|----------|
| 1) | 2) |
| 3) | 4) |

MOBILITY



9. PLEASE LIST ALL PAST AND PRESENT HEALTH ISSUES (physical and mental/emotional) AND INJURIES, WHICH HAVE REQUIRED GP INTERVENTION OR HOSPITAL VISIT

CONDITION	DATE	CONDITION	DATE
1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

MAIN CONDITION

10. SINCE THE PAIN/CONDITION STARTED, HAVE YOU OR SOMEONE ELSE NOTICED ANY CHANGES IN YOUR MOOD? YES NO

10a. If 'YES', how has your mood been affected?

- Anxious Angry/'snappy' 'Down'/depressed Panic Attacks
 Stressed Tearful Other

11. HAVE YOU CONSULTED YOUR GP ABOUT YOUR CURRENT PAIN/CONDITION?

YES NO

11a. IF 'YES', WHAT WAS THE DIAGNOSIS?

11b. IF 'YES', WHAT DID YOUR GP DO ABOUT IT?

.....

11c. IF 'YES', DID YOUR GP INTERVENTION HELP?: A LOT A LITTLE DIDN'T HELP

12. HAVE YOU TRIED ANY ALTERNATIVE WAYS TO DEAL WITH YOUR PAIN/CONDITION?

YES NO

12a. If you have, what have you tried?

.....

13. ARE YOU TAKING ANY PRESCRIBED MEDICATION FOR YOUR PAIN/CONDITION?

YES NO

13a. If 'YES', what prescribed medication/s are you taking for your current pain?

NAME	PURPOSE	DOSAGE	FREQUENCY
1

- 2.....
- 3.....
- 4.....
- 5.....

13b. Does your prescribed medication help make the pain/condition better?

YES A LITTLE NO

13c. Does your prescribed medication help make you feel better (in general)?

YES A LITTLE NO

13d. Do you suffer from side-effects from any of your prescribed medication?

YES A LITTLE NO

13e. Have you stopped taking any prescribed medication because of its side-effects?

YES NO

14. ARE YOU TAKING OVER THE COUNTER MEDICATION FOR YOUR CURRENT PAIN/CONDITION?

YES NO

14a. If 'YES', what over the counter medication/s are you taking for your current pain?

NAME	PURPOSE	DOSAGE	FREQUENCY
1.....
2.....
3.....

14b. Does your over the counter medication help make the pain better?

YES A LITTLE NO

14c. Does your over the counter medication help make you feel better (in general)?

YES A LITTLE NO

15. ARE YOU CURRENTLY TAKING MEDICATION FOR ANY OTHER CONDITIONS?

YES NO

15a. If 'YES', please list the other medication below:

NAME OF MEDICATION	PURPOSE	DOSAGE	HOW OFTEN?
1
2
3
4
5
6
7
8
9
10

16. HAVE YOU EVER HAD TREATMENT FOR OSTEOPOROSIS OR PAGET’S DISEASE OR HAVE YOU EVER TAKEN

- Actonel and Actonel + Ca ,
 - Alendronate sodium tablets (Fosamax and Fosamax + D),
 - Ibandronate sodium tablets (Boniva),
 - Etidronate disodium tablets (Didronel),
 - Tiludronate disodium tablets (Skelid, sanofi-aventis),
 - Pamidronate disodium injection (Aredia),
 - Zoledronic acid injection (Reclast and Zometa)
- OR ANY FORM OF BISPHTHONATES?

YES NO DON'T KNOW

17. ARE YOU CURRENTLY TAKING ANY KIND OF SUPPLEMENTS TO MAKE THE CURRENT PAIN/CONDITION BETTER?

YES NO

17a. If 'YES', what supplements are you taking for your current pain/condition?

NAME	PURPOSE	DOSAGE	WHEN
1
2
3

17b. Do your supplements help make the pain/condition better? YES A LITTLE NO

17c. Do your supplements help make you feel better (in general)? YES A LITTLE NO

18. ARE YOU CURRENTLY TAKING ANY KIND OF SUPPLEMENTS FOR ANY OTHER REASONS?

(Including vitamins, minerals, herbal remedies, etc) YES NO

18a. If 'YES', what supplements are you currently taking?

NAME	PURPOSE	DOSAGE	WHEN
1
2
3
4
5
6
7

19. HAVE YOU HAD ANY SIGNIFICANT EVENT(S) IN YOU LIFE IMMEDIATELY BEFORE YOUR CURRENT PAIN/CONDITION STARTED OR EVER?

(These can include bereavement, separation/divorce, loss of employment, difficult childhood, history of physical or emotional abuse, traumatic experience(s), etc)

NO UP TO 3 MONTHS BEFORE 3- 6 MONTHS BEFORE 6-12 MONTHS BEFORE

OTHER

What

When

- 1
- 2
- 3
- 4

20. ARE YOU ABLE TO WORK? YES A LITTLE NO NOT APPLICABLE

21. IF YOU ARE UNEMPLOYED, IS IT MAINLY BECAUSE OF YOUR CURRENT PAIN/CONDITION?

YES NO

22. IF YOU ARE EMPLOYED, HOW MANY DAYS OF WORK HAVE YOU MISSED BECAUSE OF PAIN DURING THE PAST 12 MONTHS? (Please tick one)

0 DAYS 1- 3 DAYS 3-7 DAYS 1-2 WEEKS 2-4 WEEKS 1-2 MONTHS
 2-4 MONTHS 4-6 MONTHS 6-8 MONTHS 8-10 MONTHS 10-12 MONTHS

23. DOES YOUR CURRENT PAIN/CONDITION PREVENT YOU FROM HAVING A GOOD SLEEP AT NIGHT?

YES NO

24. CAN YOU DO NORMAL HOUSE CHORES? YES A LITTLE NO

25. CAN YOU SOCIALISE? YES A LITTLE NO

26. DOES YOUR CURRENT PAIN/CONDITION NEGATIVELY AFFECT YOUR RELATIONSHIP WITH YOUR FAMILY OR PARTNER? YES A LITTLE NO

27. DOES YOUR CURRENT PAIN/CONDITION MAKE YOU WORRY ABOUT YOUR FUTURE?

YES A LITTLE NO

28. DO YOU SMOKE? YES NO

28a. IF 'YES' HOW MANY A DAY - ON AVERAGE?

29. DO YOU DRINK 4 OR MORE GLASSES OF WATER A DAY? (Coffee/tea/soft drinks do not count)

YES NO

30. DO YOU DRINK MORE THAN ONE CUP/MUG OF COFFEE A DAY? YES NO

31. DO YOU DRINK MORE THAN ONE DOSE OF ALCOHOL A DAY? (e.g. up to 1 large glass of wine,

1 dose of spirit, 1 bottle of beer, and so on) YES NO

32. ARE YOU AWARE OF ANY FOOD ALLERGIES OR INTOLERANCE YOU MAY HAVE?

YES NO

32a. IF 'YES' PLEASE LIST THEM HERE:

- | | |
|---------|---------|
| 1 | 4 |
| 2 | 5 |
| 3 | 6 |

33. DO YOU REGULARLY EAT POTATOES, TOMATOES AND/OR AUBERGINES (EGGPLANT)?

YES NO STOPPED

34. DO YOU REGULARLY CONSUME COW'S MILK, WHEAT, CORN, EGGS, BEEF, YEAST, OR

SOY? YES NO STOPPED

35. DO YOU REGULARLY EAT A LOT OF MEAT? (SPECIALLY RED)

YES NO STOPPED

36. DO YOU REGULARLY EAT FOOD MADE WITH WHITE FLOUR? (e.g. white bread, pasta, biscuits, cakes, pies and so on) YES NO STOPPED

37. DO YOU REGULARLY HAVE SUGAR? (This includes 'hidden' sugar in ready-made meals, pies, pastry, cakes, biscuits, marmalades, jam, sweets, soft drinks, etc) YES NO STOPPED

38. WHAT DO YOU HOPE TO ACHIEVE BY COMING TO THIS CLINIC? (THIS ARE YOUR 'GOALS')

1)

2)

3)

INTLIFE PAIN MANAGEMENT CIC – PERMISSION SLIP

REG No

Please note that YOUR CONFIDENTIALITY RIGHTS ARE PROTECTED IN EACH CASE

1. I give my permission to have my treatment details shared with my GP and other health care professionals: YES NO

2. I give my permission to have manual records retained by Intlife Pain Management for recording my treatment and progress: YES NO

3. I give my permission to have my details stored on Intlife Pain Management's computer database and accessed for evaluation purposes: YES NO

4. I give my permission to have my written comments on my experience of attending Intlife Pain Management used for evaluation purposes and/or publicity YES NO

5. I give my permission to be contacted for publicity purposes YES NO

Please print your name in CAPITAL LETTERS

Signature

Date