northern health
the northern way of caring

University Hospital of Northern British Columbia

Patient Pain Questionnaire

 PATIENT LABEL

Please complete this form and return to your referring physician. Once your physician receives this package, a referral will then be forwarded to the UHNBC Pain Clinic.

Date:____________________

Address: ______________________________ Phone #: ______________ Cell #: ____________

Primary care physician: ____________________ Referring physician (if different):__________________

Height:____________ Weight (lb): ____________ Is this pain related to: ☐ WCB ☐ ICBC ☐ Medical/legal

1. Reason you were referred: ____

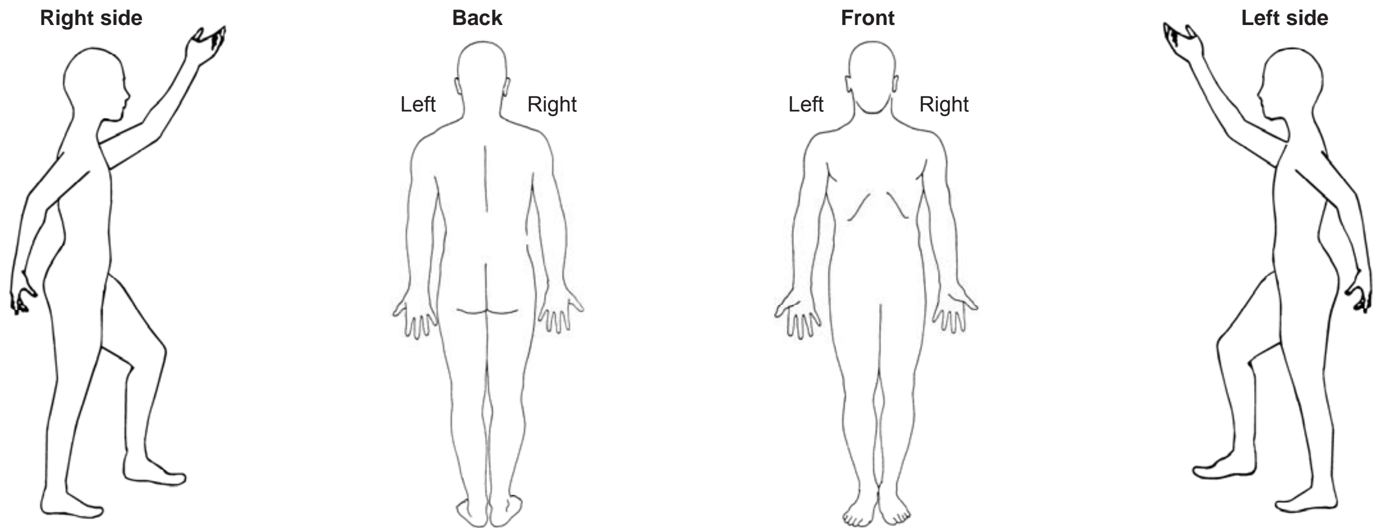
____

2. When did your pain first start? ____

3. How did your pain begin? ____

4. Where is the location of your worst pain? ____

5. Please use the diagram below to indicate where your **most painful area** is located. Shade in this area darkly and shade in your less painful areas lightly.



6. Which best describes your pain? ☐ Aching ☐ Burning ☐ Cold ☐ Dull ☐ Electric ☐ Sharp ☐ Stabbing ☐ Tingling ☐ Other:______________________________

7. Associated symptoms: ☐ None

   ☐ New weakness (where)? ______________________________

   ☐ New numbness (where)? ______________________________

8. When do you feel your pain is the worst? ☐ Morning ☐ Noon ☐ Night

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9. What makes your pain worse (e.g., walking, sitting lying down, bending over)? ______________________

10. What makes your pain better (e.g., walking, sitting lying down, bending over)? ______________________

11. Does it wake you from sleep? ☐ Yes ☐ No

12. Is your pain getting: ☐ Worse ☐ Better ☐ Same

13. Allergies to food, medication, or contrast dye: ______________________

14. Please list all your current medications, including over the counter medications, below:

Medication	Strength/dose	Total daily dose (how many/day)	Is it effective?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

15. What treatments have you had in the past for your pain? Please check all that apply.

Treatment	Helpful	Not helpful	Comments
☐ Spinal surgery			
☐ Steroid injections/nerve blocks			
☐ Acupuncture			
☐ Chiropractor			
☐ Massage			
☐ Relaxation therapy			
☐ Counselling			
☐ Physiotherapy			

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16. Past medical history

Do you have or have you ever had (check all that apply):

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Kidney problems
☐ Yes ☐ No Sleep apnea
☐ Yes ☐ No Infectious disease
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Heart problems
☐ Yes ☐ No Seizures
☐ Yes ☐ No Respiratory problems (COPD/asthma)
☐ Yes ☐ No Nervous system disorder
☐ Yes ☐ No Musculoskeletal disorder
☐ Yes ☐ No Cancer → Type: ______________________________ In remission: ☐ Yes ☐ No

Other: ______________________________

17. Social history

Do you have a history of:

☐ Smoking → How many per day? ______________________________
☐ Alcohol use → How many per day/week/month? ______________________________
☐ Substance use → Which substance and how often? ______________________________
☐ Marijuana use → How much? ______________________________

18. Do you have a history of: ☐ Depression ☐ Anxiety ☐ Psychological disorder (specify):______________

19. Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disability

20. Describe your current or past occupation: ______________________________

21. Have you had any medical imaging on your **spine** done in the past 24 months (i.e., x-ray, CT scan, MRI)?

☐ No ☐ Yes → Please fill out table below.

Image type	Where it was taken	Date

Thank you for completing this questionnaire. It will help us to better understand your pain problem.