Date: _____

Dr. H. M. Finestone – Pain Questionnaire

Bruyere #: _____

Bruyere Continuing Care, Elisabeth-Bruyere Hospital

TOH #: _____

Hello,

Before seeing you I would appreciate you filling this form out, the best you can, to help both you and I more! Don't worry if you need to leave any questions blank.

Main reason for seeing me – in just ONE sentence tell me your problem, eg. "my back hurts", or "my feet are numb and I can't walk" etc.

_____
_____
_____

Past Medical History: Tick off the boxes that apply to you:

1. Stroke/ Heart Risk Factors: ☐ High blood pressure ☐ Diabetes ☐ High cholesterol

☐ Atrial fibrillation

☐ Smoking

If you have quit smoking, when did you quit? Date: _____

How many packs of cigarettes did you smoke/day and how many years were you a smoker? _____

2. ☐ Thyroid disease [insert box] Cancer [insert box] Other disease? [insert line for text]

[insert box] Other disease? [insert line for text] [insert box] Other disease? [insert line for text]

3**. Surgeries**: Eg. joints, stomach, head, other

1. _____ 2. _____

3. _____ 4. _____

4. **Previous Painful Conditions**: – List other pains you may have had in the past (eg. hand, back, neck, stomach, pelvic, pain related to periods, headaches) and any details about treatment for the pain and how is it today?

Pains that you have had:

1. _____

2. _____

3. _____

Medication: I. List all the medications you are on NOW

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

II. List any medications that you USED to be on, but didn't work

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Allergies: 1. _____ 2. _____ 3. _____

What happened during the allergic reaction?

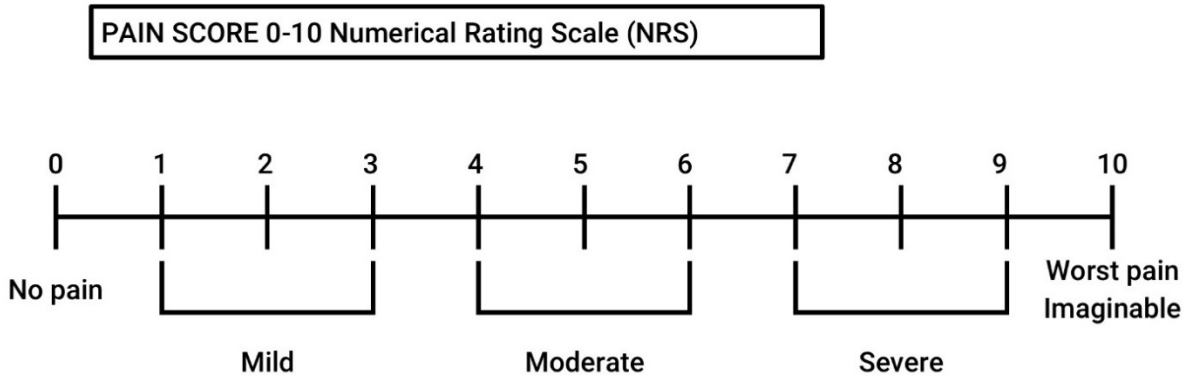
_____

History: Tell me 1. Where is your pain? 2. When did it start? (date) 3. What does it feel like? 4. What did you do about it? (eg. medications, treatments, therapies, other doctors…) Try to be as clear as you can.

_____
_____
_____
_____
_____
_____

_____
_____
_____
_____
_____
_____

Pain score- Rate your pain with this scale:



Social: this section allows me to better understand you and how the pain may be affecting you

1. Where were you born? How many siblings did you have? _____

2. Did you or family members have any alcohol or drug problems? _____

3. Did you or family members experience any abuse? _____

4. Are you working? On disability? On a pension? _____

Therapies you have had: describe what was done, when, where

1. Physiotherapy _____

2. Massage therapy _____

3. Chiropracty _____

4. Acupuncture, Raki, yoga, other _____

5. Osteopathy _____

6. Pain clinic _____

7. Drug rehabilitation _____

Goals: I. what would be the best thing that could happen with your pain? Eg. “it would go away”, “it would get 50% better”, “I could cope with it better”…

_____
_____
_____

II. What treatment do you think you need? Eg. a test, a referral to another medical doctor, surgery, more medication…

_____
_____
_____

That's it for now. We'll discuss some or all of the information you've given me and see if we can make some sense out of it. I will be doing a physical examination and possibly ordering other tests as well.

Thank you!

Hillel M. Finestone, MDCM, FRCPC,

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