PATIENT PRE-CONSULTATION QUESTIONNAIRE

To evaluate your pain condition and facilitate the physician encounter, please complete the questionnaire. Although you can skip questions, detailed information is necessary for diagnosis and plan of care.

Name: _____ Date: _____
First Middle Last DD/MM/YY

Health Card #: _____ Expiry Date: _____ WSIB (if active): _____

Date of Birth: _____ Age: _____ Gender: ☐ M ☐ F ☐ X Height: _____ Weight: _____

Home Address: _____
Street # Apt # Street Name

_____
City Province Postal Code Country

Home Phone: (_____) _____ Mobile Phone: (____)_____

Family Doctor: _____ Phone: (___)_____ Fax:(___)_____

Please list below if you have other physicians within your circle of care:

Doctor: _____ Phone: (___)_____ Fax: (___)_____

Doctor: _____ Phone: (___)_____ Fax: (___)_____

Doctor: _____ Phone: (___)_____ Fax: (___)_____

Doctor: _____ Phone: (___)_____ Fax: (___)_____

Pharmacy: _____ Phone: (____)_____ Fax: (____)_____

Address: _____
Street # Street Name Province Postal Code

If your pain is related to a car accident and you have an ongoing active claim, please answer the following:

a. Not applicable ☐

b. Date of accident: _____

c. If you have an active lawsuit regarding your injury, please provide the following information:

   Lawyers name: _____ Firm: _____

   Phone: _____ Fax: _____

Communication Preferences:

Please indicate your preference(s) of communication from the practice (check all that apply):

☐ I consent to receiving communications about my appointments and practice-related issues by email _____ Initials

☐ I consent to receiving communications about my appointments and practice-related issued by text _____ Initials

☐ I prefer to receive communications by phone (when possible) _____ Initials

Outcome Measurement and Data Collection:

☐ I agree to complete outcome measurement forms/questionnaires to monitory my progress _____ Initials

☐ I consent to the **anonymized** use of my demographics and outcome measures for internal audit purposes, understanding that the data will not in any way expose my identity or personal health information. _____ Initials

AI Scribe:

☐ I hereby consent to the medical team to utilize AI tool to transcribe information _____ Initials

Code of Conduct:

☐ I agree to be respectful of the practice staff and clinicians and understand that disrespectful and/or disruptive behavior may result in my discharge from the practice. _____ Initials

☐ I agree to commit to attending my appointments on time and understand that there may be charges based on the practice policy for missed appointments, late arrival or cancelling within 48 hours for reasons other than the following:

- Medical illness requiring bed rest, isolation or hospitalization
- Family emergency
- Exceptional consideration

_____ Initials

Patient Full Name: _____

Signature: _____ Date: _____

Please tell us about your problem:

1. When did your current pain problem start? _____
2. Has your pain changed since it began? ☐ No change ☐ Worse ☐ Improved
3. How many times have you visited an emergency room or urgent care clinic in the past six months due to pain? _____
4. How many times have you visited your family doctor or specialists the past six months due to pain? _____
5. Check off everything that described the way your most severe pain feels:

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing
☐ Aching ☐ Tight ☐ Burning ☐ Cramping
☐ Other: _____

6. Which of the following symptoms do you experience? (Check only the ones that apply)
   - ☐ Bowel incontinence (soiling yourself)
   - ☐ Urinary incontinence (wetting yourself)
   - ☐ Night sweats
   - ☐ Unintended weight loss
   - ☐ Weakness resulting in falls/dropping things
   - ☐ Numbness, where? _____
   - ☐ Pins/Needles
   - ☐ Tingling
   - ☐ Shooting pain down the arm(s); which one? ☐ Right ☐ Left
   - ☐ Shooting pain down the leg(s); which one? ☐ Right ☐ Left
7. Check off everything that aggravates your pain:
   - ☐ Lifting ☐ Bending ☐ Standing ☐ Sitting
   - ☐ Climbing stairs ☐ Coughing ☐ Sneezing ☐ Turning head
   - ☐ Looking up ☐ Looking down ☐ Reading ☐ Thinking
   - ☐ Stress ☐ After Sleep ☐ Walking ☐ Other: _____
8. Check off everything that relieves your pain, even mildly or temporarily:
   - ☐ Medications ☐ Rest ☐ Sleep ☐ Exercises
   - ☐ Stretching ☐ PT ☐ Relaxation ☐ Injections
   - ☐ Massage ☐ Other: _____
9. Please check off and specify any major illness or surgeries you have had:
   - ☐ Depression ☐ HIV ☐ Hypertension
   - ☐ Heart attack/CHF ☐ Anxiety ☐ Kidney Failure
   - ☐ Sleep apnea ☐ Heart Surgery ☐ Blood disorder (specify) _____
   - ☐ Hepatitis B or C ☐ COPD ☐ Pacemaker or ICD
   - ☐ Cirrhosis ☐ Diabetes ☐ Other (specify)_____

☐ Please check this box if you feel not comfortable to answer questions about your habits and proceed to #10; otherwise, continue:

☐ Recreational Drugs ☐ Cigarettes ☐ Cannabis ☐ Other: _____

☐ Alcohol (specify) _____ ounces/week. Type (specify) _____

Does anything of it helps to reduce pain? ☐ Yes ☐ No

☐ Alcohol helps

☐ Recreational drugs or cannabis help

☐ Food, sugary products, chewing gum help

10. Please list your drug allergies

_____ _____

_____ _____

_____ _____

11. List **ALL** medications you are currently taking (you may attach a list):
Note: Are you taking any strong blood thinners, such as Plavix, Ticlid, Pradaxa, coumadin/Warfarin or Xarelto/Rivaroxaban? ☐ Yes (please specify in table below) ☐ No

Name	Doses Taken	Times Taken Per Day	For What Condition?

12. List 3 **realistic** goals that you wish to be able to do if your pain was better controlled. For example, return to work, increase walking level, play with children, use less medications, etc.

a. _____

b. _____

c. _____

PLACE X ABOVE THE NUMBERS BELOW

1) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

No pain — Pain as bad as you can Imagine

2) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

No relief — Complete relief

3) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

Does not interfere — Completely interferes

B. Mood

Does not interfere — Completely interferes

C. Walking Ability

Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework)

Does not interfere — Completely interferes

E. Relations with other people

Does not interfere — Completely interferes

F. Sleep

Does not interfere — Completely interferes

G. Enjoyment of life

Does not interfere — Completely interferes

OFFICE USE:
PDI /70

Over the last 2 weeks, how often have you been bothered by the following problems? *(Circle to indicate your answer)*	1	2	3	4
0-2 (n) 3-5 (ml) 6-8 (mo) 9-12 (s)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	◯	◯	◯	◯
2. Not being able to stop or control worrying	◯	◯	◯	◯
3. Little interest or pleasure in doing things	◯	◯	◯	◯
4. Feeling down, depressed, or hopeless	◯	◯	◯	◯

Circle the response that indicates how much you have been bothered by that problem in the past month		0	1	2	3	4
>4		Not at all	A little bit	Moderately	Quite A Bit	Extremely
PCL1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	◯	◯	◯	◯	◯
PCL4	Feeling very upset when something reminded you of a stressful experience from the past?	◯	◯	◯	◯	◯

Please rate how confident you are that you can do the following things at present, despite the pain. To indicate your answer, circle one of the numbers on the scale under each item, where 0 = not at all confident and 4= completely confident.

Remember, this questionnaire is not asking whether or not you have been doing these things, but rather how confident you are that you can do them at present, despite the pain.

	0	1	2	3	4
1. I can do some form of work, despite the pain (''work'' includes housework and paid and unpaid work).	◯ Not at all confident	◯	◯	◯	◯ Completely confident
2. I can live a normal lifestyle, despite the pain.	◯ Not at all confident	◯	◯	◯	◯ Completely confident

Please indicate the degree to which this thought comes to your mind:

"When I feel pain, it is terrible, and I feel it is never going to get any better"

0	1	2	3	4
Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
○	○	○	○	○

''I keep thinking about how badly I want the pain to stop''

Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
○	○	○	○	○

"I become afraid that the pain may get worse''

Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
○	○	○	○	○

''I anxiously want the pain to go away''

Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
○	○	○	○	○

>7

This is a list of feelings other patients have used to express their condition. Please circle the numbers that best describe how you feel about each statement

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
1. I'm afraid I might injure myself if I exercise.	○	○	○	○
2. If I were to try to overcome it, my pain would increase.	○	○	○	○
3. My body is telling me I have something dangerously wrong.	○	○	○	○
4. People aren't taking my medical condition serious enough.	○	○	○	○
5. My accident/problem has put my body at risk for the rest of my life.	○	○	○	○
6. Pain always means I have injured my body.	○	○	○	○
7. Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening.	○	○	○	○
8. I wouldn't have this much pain if there wasn't something potentially dangerous going on in my body.	○	○	○	○
9. Pain lets me know when to stop exercising so that I don't injure myself.	○	○	○	○
10. I can't do all the things normal people do because it's too easy for me to get injured.	○	○	○	○
11. No one should have to exercise when he/she is in pain.	○	○	○	○
	1	2	3	4

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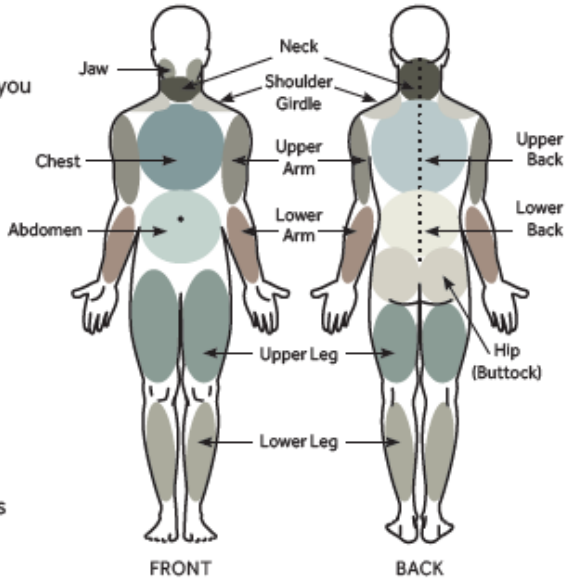
Pain Diagram

Please check the boxes below for each area in which you have had pain or tenderness **during the past 7 days**.

- ☐ Shoulder girdle, left
- ☐ Shoulder girdle, right
- ☐ Upper arm, left
- ☐ Upper arm, right
- ☐ Lower arm, left
- ☐ Lower arm, right
- ☐ Hip (buttock) left
- ☐ Hip (buttock) right
- ☐ Upper leg left
- ☐ Upper leg right
- ☐ Lower leg left
- ☐ Lower leg right
- ☐ Jaw left
- ☐ Jaw right
- ☐ Chest
- ☐ Abdomen
- ☐ Neck
- ☐ Upper back
- ☐ Lower back
- ☐ None of these areas

WPI score: _____



Symptom Intensity

For each symptom listed below, use the following scale to indicate the intensity of the symptom **during the past 7 days**.

	No problem	Slight or mild problem	Moderate problem	Severe problem
Points	0	1	2	3
A. Fatigue	☐	☐	☐	☐
B. Trouble thinking or remembering	☐	☐	☐	☐
C. Waking up tired (unrefreshed)	☐	☐	☐	☐

During the **past 6 months** have you had any of the following symptoms?

	Points	0	1
A. Pain or cramps in lower abdomen		☐ No	☐ Yes
B. Depression		☐ No	☐ Yes
C. Headache		☐ No	☐ Yes

SS score: _____

Have the symptoms listed on this sheet, and pain been present at a similar level for **at least 3 months**?

☐ No ☐ Yes

TOTAL score: _____

During the past 7 days, how much have you been bothered by any of the following problems?	Not at all	A little bit	Somewhat	Quite a bit	Very much
1. Stomach or bowel problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. Back pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. Pain in your arms, legs, or joints	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. Headaches	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. Chest pain or shortness of breath	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. Dizziness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. Feeling tired or having low energy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. Trouble sleeping	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

0 to 3 (n); 4 to 7 (l); 8 to 11 (m); 12 to 15 (h); 16 to 32 (vh)