

Complex Pain Management Program

Patient Questionnaire- Initial Office Visit

Please have patient complete area below. Parent/Guardian may assist if needed.

Child's full name: _____ Date of birth: _____

Preferred name: _____ Preferred gender pronoun: _____

Age: _____ Sex: Male/Female

Your name: _____ Relationship to child: _____ Date: _____

Reason for Referral:

Briefly state the main concerns for which you are presently seeking help: _____

Symbols

-----numbness

0000 pins and needles

xxxx burning

///// stabbing

++++ aching

Choose 4 colors that represent your pain

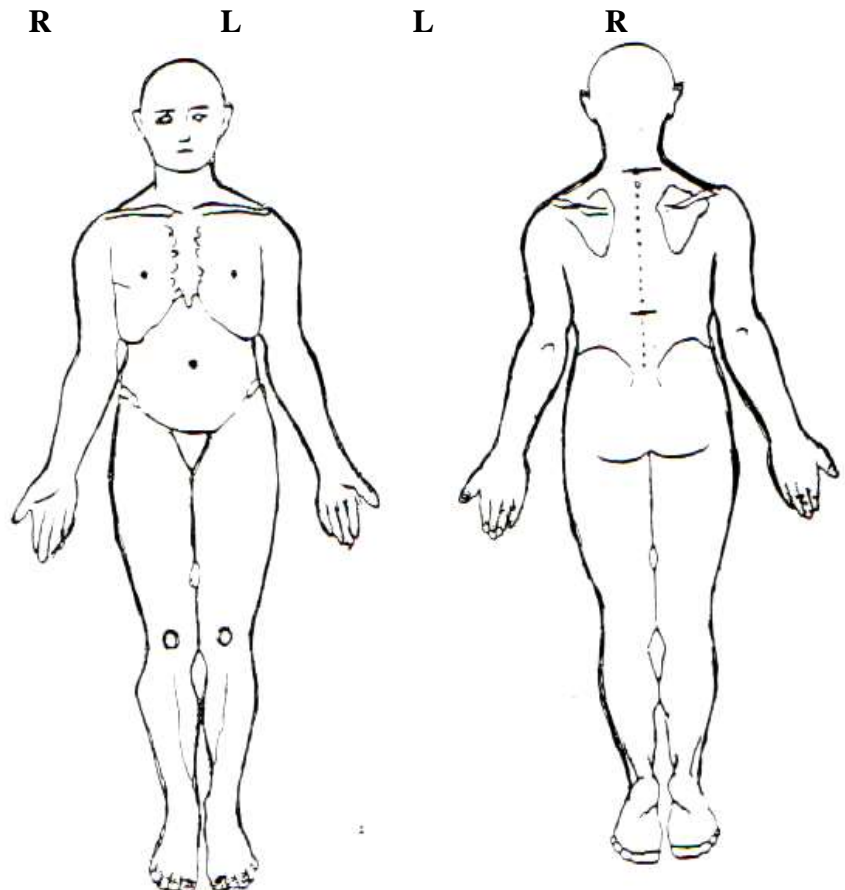
_____ small pain

_____ medium pain

_____ large pain

_____ worst pain

Where is your pain? Using the symbols or color system listed below, mark on the areas where you feel your pain. Show all affected areas. If you feel more than one sensation in same area, mark over the area with additional symbols that apply.



Why do you think you have pain? _____

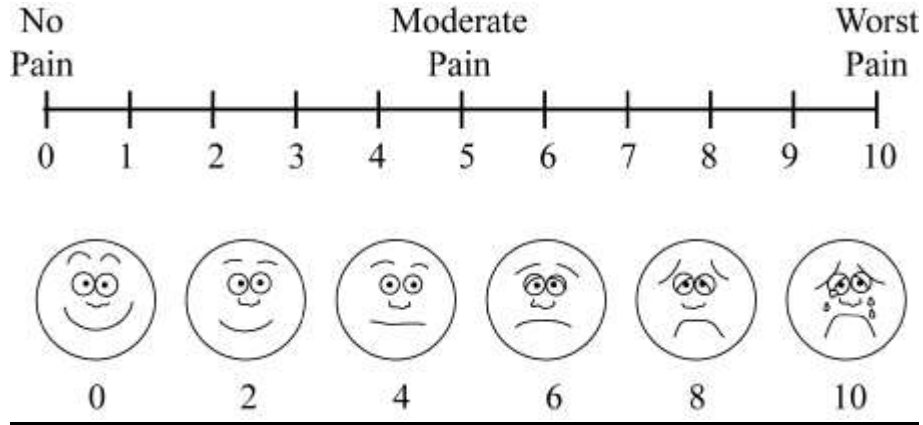
Is your pain usually WORSE during a certain time of day? Yes No

If yes, When? Morning Midday Evening Night

What makes your pain worse? _____

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

If yes, When? Morning Midday Evening Night



Choose the number which best describe the intensity of your pain by placing an x on the line.
0= NO PAIN 10=WORST PAIN IMAGINABLE

Your pain right now..... 0 1 2 3 4 5 6 7 8 9 10

Your pain at its worst..... 0 1 2 3 4 5 6 7 8 9 10

Your pain at its least..... 0 1 2 3 4 5 6 7 8 9 10

The worst toothache you ever had 0 1 2 3 4 5 6 7 8 9 10

The worst headache you ever had 0 1 2 3 4 5 6 7 8 9 10

What is an acceptable pain level 0 1 2 3 4 5 6 7 8 9 10

Do you have any of the following symptoms with you pain?

vomiting sweating noise sensitivity nausea blurred vision dizziness

light sensitivity numbness/tingling irritability feeling faint rapid heart beat

anxiety rapid breathing loud heart beat depression

Realistic goals or expectations from treatment at SLCH Complex Pain Program: _____

If your pain were to be better managed, how would your life be different: _____

Have you had any of the following tests to evaluate your pain? (Please provide details)

X-Rays _____

MRI _____

CT scan _____

Myelogram _____

Nerve and Muscle Tests _____

Listed below are treatments used in pain management. Please indicate those treatments you have had and whether or not they were helpful to you.

<u>Treatments</u>	<u>Facility/Date</u>	<u>Was it Helpful?</u>
<input type="checkbox"/> Surgery related to pain _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Injections _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Physical Therapy _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Psychological Treatments _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Relaxation Training _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Biofeedback _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chiropractor _____		<input type="checkbox"/> Yes <input type="checkbox"/> No

Other illnesses for which you are currently being treated: Yes / No _____

Current Medications: Yes / No (if yes, please list):

<u>Name of Medication</u>	<u>Dosage</u>	<u>Name of Prescribing Physician</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Previous Pain Medications</u>	<u>Dosage</u>	<u>Date stopped/Reason for discontinuing</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies:

Difficulties following doctor's advice in taking medicine or other treatment? Yes / No (describe):

Personal Health History

Please check all conditions which you currently have.

Constitution

- Activity change
- Appetite change
- Chills
- Excessive sweating
- Fatigue
- Fever

- Weight change
- _____ OTHER

HENT

- Congestion
- Dental problem
- Drooling
- Ear discharge
- Ear pain
- Facial swelling
- Hearing loss
- Mouth sores
- Nosebleeds
- Postnasal Drip
- Runny nose
- Sinus Pain
- Sinus pressure
- Sneezing
- Sore throat
- Ringing in ears
- Trouble swallowing
- Voice changes
- _____ OTHER

BREAST

- Tenderness
- Redness
- Lumps
- _____ OTHER

Eyes

- Eye discharge
- Eye itching
- Eye pain
- Eye redness
- Light sensitivity
- Visual disturbance

_____ OTHER
RESPIRATORY

- Apnea
- Chest tightness
- Choking
- Cough
- Shortness of breath
- Stridor
- Wheezing

_____ OTHER
CARDIOVASCULAR

- Chest pain
- Leg swelling
- Palpitations

_____ OTHER
GI

- Abdominal distention
- Abdominal pain
- Rectal bleeding
- Constipation
- Diarrhea
- Nausea
- Rectal pain
- Vomiting
- _____ OTHER

Endocrine

- Cold intolerance
- Heat intolerance
- Frequent thirst
- Excessive dilute urine
- _____ OTHER

GU

- Difficulty urinating
- Painful intercourse
- Painful urination
- Bedwetting
- Flank pain
- Frequency
- Genital sore
- Blood in urine
- Menstrual problem
- Pelvic Pain
- Urgency
- Urine decreased
- Vaginal bleeding

_____ OTHER
MUSCULOSKELETAL

- Joint pain
- Back pain
- Gait problem
- Joint swelling
- Muscle pain
- Neck pain
- Neck Stiffness
- _____ OTHER

SKIN

- Pale appearance
- Color Change
- Rash
- Wound
- _____ OTHER

Allergy/ Immunology

- Environmental allergies
- Food allergies
- frequent infections
- _____ OTHER

Neurological

- Dizziness
- Headaches
- Facial asymmetry
- Light-headedness
- Numbness
- Seizures
- Speech difficulty
- Syncope
- Tremors
- Weakness
- _____ OTHER

HEMATOLOGIC

- Enlarged lymph nodes
- Bruises easily
- _____ OTHER

PSYCHIATRIC

- Agitation
- Behavior problem
- Confusion
- Decreased concentration
- Mood Changes
- Hallucinations
- Hyperactivity
- Nervous / Anxious
- Self – injury
- Sleep disturbance
- Suicidal ideation
- _____ OTHER

Please have parent/child complete this portion of form:

History of Behavioral Health Problems	Circle One	Child/family member
Attention Problems (e.g., ADD or ADHD)	Yes / No	
Learning Problems or Disabilities	Yes / No	
Depression or Postpartum Depression	Yes / No	
Bipolar Disorder / Manic Depression	Yes / No	
Anxiety or Obsessive-Compulsive Disorder	Yes / No	
Anger management problems	Yes / No	
Alcohol use/abuse	Yes / No	
Illicit drug use/ abuse	Yes / No	
Antisocial / criminal behavior	Yes / No	
Difficulty falling asleep	Yes/No	
Nightmares	Yes/No	
Risky Behaviors	Yes/No	

Please list any counselors, psychotherapists, psychologists and psychiatrists you have seen:

<u>Age</u>	<u>Provider Name</u>	<u>Service</u> (Testing, treatment, medication)	<u>Helpful</u>
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No

Previous medications to manage mood or behavior problems: Yes / No (describe): _____

Psychiatric hospitalizations: Yes / No (describe): _____

Family Information:

Names of child's legal guardians: _____

Relationship to child: _____

Highest grade completed by mother: _____ highest grade completed by father: _____

Mother's occupation: _____ Father's occupation: _____

Parents' marital status: Married Divorced Separated Deceased Never Married

If the child's parents are married, how long have the parents been married? _____

If separated or divorced, age of child at the time: _____ Dates of any remarriages: _____

Frequency of visitation with non-custodial parent: _____

Please list all the members of your immediate family (include any half or step-siblings):

Name	Age	Relationship to child	living within household Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No

Do you have any concerns regarding your child's early development? Yes / No (describe): _____

Educational History:

Name of current school: _____ Phone: _____

Grade: _____ Teacher: _____ Present letter grades: _____

Skipped grades: Yes / No which ones? _____ Reason: _____

Repeated grades: Yes / No which ones? _____ Reason: _____

	Circle One	Ages	Describe
Early Education Intervention	Yes / No		
Occupational Therapy	Yes / No		
Physical Therapy	Yes / No		
Speech Therapy	Yes / No		

Has a psychologist ever tested your child? Yes* / No When & why? _____

**Please have a copy of the results mailed to our office.*

Does your child currently receive any special education, enrichment or resource services? Yes* / No (describe): _____

****If your child receives any special education services, please enclose a copy of your child's current Individual Education Plan (IEP) or have it sent by the school.***

Teachers report current concerns about your child's performance in these areas:

Reading	_____	Attention/concentration	_____
Spelling	_____	Behavior	_____
Math	_____	Social skills	_____
Writing	_____	Emotional adjustment	_____

Has your child ever received detention, been suspended or expelled? Yes / No (describe): _____

Previous schools attended

Dates attended (begin - end)

Briefly describe any problems occurring during your child's attendance at these previous schools:

How much has pain interfered with your school attendance?

No interference 0 1 2 3 4 5 6 7 8 9 10 Extreme interference

How much has pain interfered with your performance (e.g., grades) at school?

No interference 0 1 2 3 4 5 6 7 8 9 10 Extreme interference

Social History:

Describe any problems your child may have with peers (e.g., bullied, teased, no friends, poor social skills, aggressive, bossy, shy): _____

Is your child involved in any clubs, sports, or other organized activities? Yes / No (please list): _____

Please list some of your child's personal strengths and talents: _____

Please check any of the following stressful events that apply to your child or family and describe:

- Relocations: _____
- Job changes: _____
- Deaths: _____
- Chronic health problems: _____
- Major illnesses: _____
- Marital problems: _____
- Someone significant moving out of the area: _____
- Experiencing a traumatic event: _____
- Witnessing a traumatic event: _____
- Physical or sexual abuse or neglect: _____
- Division of Family Services (DFS) involvement: _____
- Legal issues: _____
- Other: _____

Please attach any additional remarks you may wish to make regarding your child. Thank you for taking the time to complete this information form.



Department of Anesthesiology
Divison of Pediatric Anesthesiology and Pain Management

PERMISSION TO OBTAIN AND RELEASE INFORMATION

I hereby authorize Washington University to transfer, release or obtain information on:

(Name of Patient) _____ **(Date of Birth)**

To exchange written and or verbal information with:

(Name of School) _____ **(Phone Number)**

Information to include but not limited to medical and or related health records and information, psychological evaluations, or school work reports, and educational information.

I certify that I am the parent and legal guardian of the above mentioned child or that I am the student of majority age and have the authority to sign this release.

(Signature of Parent / Guardian)

(Relationship to child)

(Signature of student)



DOB:

DOS:

Consent to Hospital Treatment and/or Admission and Assignment of Benefits, Financial Responsibilities

I know that I have the right to make decisions about my child's medical treatment. I consent to have the doctors and other healthcare workers at St. Louis Children's Hospital provide medical treatment to my child. I understand the medical treatment is provided by physicians and health care workers who may be employees of St. Louis Children's Hospital, Washington University School of Medicine, or other individuals who are allowed to provide care at the Hospital. I also understand the physicians and health care workers may be fellows, residents or students in training and that the individuals caring for my child are collectively called "the staff."

I also consent to taking and storing photographs, videos and other electronic images of my child for the purposes of treating my child and providing education and I understand that reasonable efforts will be made to protect the identity of my child.

If I receive Medicare or Medicaid, I agree the information I gave to apply for payment is correct. I have been given a paper listing my rights as a Medicare or Medicaid patient. I know I can ask for a review of my/my child's record to find out about any payments or charges I may owe if Medicare or Medicaid will not cover my child's charges.

If I receive Medicare, Medicaid or other insurance benefits, I know I am responsible to know what my insurance covers and that I can call my insurance plan if I have questions. I also understand I am responsible for any deductibles, co-insurance, and any non-covered charges. I know that I may receive separate bills for services provided by healthcare workers who are not employed by the Hospital – like Washington University or other individuals allowed to provide care at the Hospital.

I authorize direct payment to St. Louis Children's Hospital of all insurance benefits and I authorize release of my/my child's personal health information as may be required for my insurance plan to pay such benefits. I understand that I am responsible, subject to BJC's Financial Assistance Policy, for portions of my child's hospital bill not covered by insurance.

I also agree that I have received the Admission Packet, or Toolkit, if this information applies to me, or if not, I have access to signs and/or brochures which contain information about:

- Advance Directives: What are they? Where can I get one? Do we need one?
- Privacy of my health care information and who may have access to my information
- How the Hospital handles personal valuables
- Visiting Hours, Visitor Policies and Behavior Rules
- What Rights and Responsibilities I/we have as a patient or family member and who to contact if I/we have questions.

I have read this whole form, or had it read and explained to me, and I had the opportunity to ask questions.

Signature of Person Consenting to Treatment

Relationship to Patient

Date

Signature of Guarantor if different than above

CH 1135 Approved by HIMFC 6/23/2015

