Patient Initial Visit Questionnaire (PIVQ)

Your family doctor's expertise is indispensable, especially if you are already taking pain medications. We are a specialized interventional pain clinic and we pride ourselves in taking a different approach. We are trying to avoid pharmacological treatment (pills). Medical research indicates that long term opioid treatment for non- malignant chronic pain is unnecessary, and more often than not, could be harmful. We apologize that we can not offer prescription medications as we simply don't have enough resources for this huge undertaking. We will delegate that to your family doctor if it is deemed necessary. We also count on your family doctor to provide us with your latest investigation reports. We value the family physician role as a crucial team player. Having no family doctor could potentially delay the process of seeing you at SWOPI.

Patient information:

Date this form is filled (DD/MM/YYYY):		
Name (First Last):		
DOB (DD/MM/YYYY):		
Health Card Number:		
WSIB Claim # (if applicable):		
Weight Height	*Weight:*	*Height:*
Home Address		
Mailing Address (if different):		
Best Telephone Number to reach you:		
Are we allowed to communicate your health information with your Next of Kin (only when necessary):	*Yes:* ☐	*No:* ☐
Next of Kin (First Last):	Phone number:	Relationship:

Family Doctor (First Last):	Phone Number:	Fax Number:
Address:		

Referring Physician: (First Last):	Phone Number:	Fax Number:
Address:		

Pharmacy Name:	Phone Number:	Fax Number:
Address:		

Pain Questionnaire:

Where do you feel the pain currently (if you have multiple pain sites, please arrange sites in order of priority to treat from most to least urgent):

Neck (front/ back)	Headache (front/ back/ sides)	Facial Pain (where exactly)
Chest Wall (Front/ Left/Right)	Middle Back	Lower Back
Abdomen	Pelvis	Leg (Right/ Left)
Arm (Right/ Left)	I have pain all over my body	

The following questions pertain to the most painful area (will call it Primary Pain Problem), if you have more than one area of pain):

1) Please rate your pain in the last 24 hours (referring to the most painful area).

Average: 1-2-3-4-5-6-7-8-9-10	Worst: 1-2-3-4-5-6-7-8-9-10
Least: 1-2-3-4-5-6-7-8-9-10	Right Now: 1-2-3-4-5-6-7-8-9-10

2) When did the primary pain problem start? For how long have you been dealing with it?

3) Is your pain getting: Worse/ better/ the same/ comes and goes (intermittent, but consistently present/ comes and goes and sometimes completely disappears?

4) How would best describe best the primary pain problem:
Dull aching/ nagging/ grinding/ shooting/ burning/ stabbing/ ill defined/ heavy/ tight /sharp/ colicky/ spasmodic/ throbbing/ bounding/ cramping

5) Do you have any of the following features associated with your pain:
Extreme sensitivity to touch (with cloths or blankets), sudden heat or cold feeling/ pins/ needle/ numbness/ tingling/ bluish colour in the painful area/ shooting pain down the: Right Left Leg Arm

6) What relieves your main pain problem?
Medications/ rest/ meditation/ relaxation/ hot shower. Swimming/ exercise/ sleeping/ Injections/ THC or Marijuana/ Street drugs/ bending forward/ stretching/ sitting/ lying down/ yoga/ chiropractor/ physiotherapy/ Massage therapy/ Acupuncture/ Herbal medications/Naturopathic treatment/ medication infusions/ others. Please elaborate and add details.

7) Which of the following have you tried, but **DID NOT** relieve your pain:
Medications/ rest/ meditation/ relaxation/ hot shower. Swimming/ exercise/ sleeping/ Injections/ THC or Marijuana/ Street drugs/ bending forward/ stretching/ sitting/ lying down/ yoga/ chiropractor/ physiotherapy/ Massage therapy/ Acupuncture/ Herbal medications/Naturopathic treatment/ medication infusions/ others…please elaborate and add as many details as possible; which medications/ doses? Which injections? Where were these done?

8) What worsens you pain:
Standing/ Sitting/ Walking/ running/ lifting heavy objects/ work/ stress/ reading/ climbing stairs/ going down stairs/ house work/ gardening/ driving/ turning your head to one side/ looking up or down.

9) Do you have any of these features:
Night fever/ Night sweating/ Chills/ Unintentional Weight loss/ Previous history of cancer/ Loss of control of bowel or urine/ numbness in the crutch area/ extreme or progressive weakness affecting walking (foot drop/frequent tripping/ falls/ loss of balance) or affecting upper limb functions (dropping objects/ carrying grocery).

10) Is your pain suddenly worsened when you cough or sneeze? Yes /No

Impact of Pain:

1) How many times in the last 12 months have you visited ER for:
a) Your primary pain problem
b) Other pain problems, what are those?

2) How many times in the last 12 months have you visited ER for:
a) Your primary pain problem
b) Other pain problems, what are those?

3) How many times in the last 12 months did you visit or attempt to visit your Family Doctor for:
a) Your primary pain problem
b) Other pain problems, what are those?

4) How many times in the last 12 months have you missed work because of the primary pain problem?

5) Please rate the following from 1 to 10 ONLY IF you think these functions have been impaired by your primary pain problem. Leave it blank if your pain does not affect this function.

Sleep Quality: 1-2-3-4-5-6-7-8-9-10	Mood: 1-2-3-4-5-6-7-8-9-10
Ability to Work: 1-2-3-4-5-6-7-8-9-10	Ability to Walk: 1-2-3-4-5-6-7-8-9-10
Ability to Cope with Activities of Daily Life (ADLs) and Self Care : 1-2-3-4-5-6-7-8-9-10	Relationship with Others: 1-2-3-4-5-6-7-8-9-10
Overall Enjoyment of Life: 1-2-3-4-5-6-7-8-9-10	

Impact of Injury:

In your opinion, did your pain problem arise as a result of an accident?

What accident?

Where and when did it happen?

Is WSIB involved?

Is there a litigation related to the accident?

Name of your personal injury lawyer if applicable (First Last):

Legal firm:	Phone:	Fax:

Are you on disability income? For how long? Is it related to the accident?

Are you currently involved in any sort of litigation's? What is the impact of that on your pain Problem?

Medical History:

Please tell us of you have any of the following:

1) Are you currently pregnant or could you be currently pregnant?

2) Hypertension (high blood pressure) / heart attacks/ stents/ congestive hear failure/ leaky or tight valves/ cardiomyopathy/ pulmonary hypertension/ aneurysms

3) Asthma COPD other respiratory problems

4) Sleep Apnea (do you have a CPAP machine)

5) Kidney problems: Renal failure, polycystic kidney/ single kidney

6) Liver problems: Fatty liver/ cirrhosis/ liver failure

7) Diabetes: For how long? On insulin? Last Hb A1C? Adequate control? Prediabetes (susceptible)

8) Thyroid problems: Increased or decreased functions/ nodule/ enlargement/ cancer/ inflammation

9) Rheumatoid arthritis/ osteoarthritis/ psoriatic arthritis/ lupus/ mixed collagen disorders/ autoimmune diseases

10) Do you have any history of cancer? What cancer? When? In remission? Active treatment still going on?

11) Have you ever been treated with chemotherapy or radiation therapy?

12) Do you have HIV? Hepatitis B or C?

13) Do you have leukemia/ multiple myeloma or lymphoma?

14) Do you have any bleeding tendency (bleed or bruise easily?) / hemophilia/ Von Willibrand factor deficiency?

15) Have you been diagnosed with:
Depression/ bipolar depression/ Anxiety/ Mood disorders/Schizophrenia/ Borderline personality disorder/ Antisocial personality disorder/ Dementia? Or any other mental health issues?

16) In the last 5 years, have you been under the care of a psychiatrist/ psychologist/ or have you been admitted to a mental health institution?

Surgical History:

Please list all surgeries that you have had especially:
Spine surgery/ head and neck surgery/ hernia repair/ thoracic (chest) surgery/ breast surgery / abdominal surgery.

Medications:

Please list all current/ active medications (Please also note that you MUST HAVE an up-to-date medication list from your pharmacist) on your first visit to SWOPI.

Name of Medication	**Dose and Time**

Are you currently taking blood thinners:
Plavix (clopidogrel) / Xarelto (Rivaroxaban)/ Eliquis (Apixaban) / Pradaxa (Dabigatran)/ Heparin/ Low Molecular Weight Heparin Injections/ Warfarin (Coumadin)/ Brilinta (Ticagrelor)/ No to all

Allergic Reactions:

Please list all the medications that you are allergic to:

Other food / environmental allergy/ LATEX allergy:

Are you allergic to contrast dyes (CT or radiology contrast material)?

Social History:

Smoking history:
Active/ Current/ Previous / Remote. How many packs? Years?

Alcohol:
Active/ Current/ Previous / Remote. How many drinks per week? How long?

Smoked Marijuana:
How many joints/ grams? And for how long?

Have you used any of the following whether currently or previously:
Cocaine/ Amphetamine/ Heroin/ Prescription Opioids/ Benzodiazepines/ Crystal Meth/ Hallucinogens or Psychedelic Drugs

Who do you live with?

How do you describe your relationship with your family? Do you have good social support network? Family/ friends?

What is your highest level of education?

Are you currently employed?

If not, are you seeking to join the work force in the future?

If you are working: are you generally happy / or generally miserable unhappy at work

Do you work night shifts? Often/ seldom/ regularly/ never

Body Weight Problems:

Have you ever had a significant weight problem (more than 30 lb to loose)? What was done to overcome this problem?

Have you had Anorexia or Bulimia Nervosa?

Do you have a problem with:
Binge eating/ emotional eating/ eating at night/ portion control/ eating junk or unhealthy food/ eating frequently or at erratic schedules?

Insurance information:

Name of insurance company if applicable:

Name of Policy Holder:

Plan Number: Client ID Number:

Please indicate what is covered:

- ☐ Prescription Medications
- ☐ Botox (DIN 01981501)
- ☐ Viscous Supplements/ Hyaluronic Acid BIN# 11157612, 909270, 11335331, 1557132 or 11018085
- ☐ Psychology Services
- ☐ Acupuncture
- ☐ Naturopathy
- ☐ Physiotherapy

Accident Insurance (if claim still open):

Claim #: Policy #: Date of accident (DD/MM/YYYY):

Insurance Company Name:

Agent Name (First Last): Phone: Fax:

Goals of Treatment:

It is crucial that you and your treating team at SWOPI develop goals of treatment. Chronic pain is by its very nature a persistent or recurrent problem. It is vital that these goals are realistic. In most cases, our aim should be reduction of pain by 50% or more, knowing that it is often unrealistic to aim for complete resolution of pain (however, it can happen at least for some time). Often times, even after initial success, the same pain would recur again especially when the root cause remains undealt with (as often is the case with most chronic pain interventions). This may dictate repetition of the initial treatment, devising a different approach or changing goals of care and adapting our daily activities and life style.

In your own words: describe your goals of treatment of the primary pain problem:

What would you do if this pain is decreased by 50% or completely gone:

Patient name: **Signature:**
