Patient Interval Questionnaire

Patient Name:_____Date of Birth:_____Date of Visit:_____

Do you have or trying to open a work injury claim? ____Yes ___No Date of Injury_____
Automobile accident? ___Yes___No Date of Injury **Are you/is there any possibility you may be pregnant?** ___Yes___No
Do you have any type of DSHS/Apple Health/ or Community Plan coverage? ___Yes___No

I hereby authorize my insurance benefits to be paid directly to Northwest Pain Management Associates, realizing I am responsible to pay any balance due and I hereby authorize the release of the pertinent medical information to insurance carriers. I hereby attest that the information I have provided is true and correct.

Patient Signature _____

PRIMARY CARE PHYSICIAN NAME:_____ **PHONE:**_____

1. Have there been any significant changes in your health or pain control since your last visit? ___Yes ___No
2. Have you had any interventional procedures performed or are any scheduled? ___Yes ___No
   If you have had a procedure, did you receive any benefit?_____
3. **When Do You Sleep? (Circle All That Apply):**
   Evening: 8pm 9 10 11 12 1am 2 3 4 5 6 7 8 Morning: 9am 10 11 12 1pm 2 3 4 5 6 7
   Longest period of continuous sleep:_____hrs Do you feel rested?___Yes ___No Do you snore?___Yes___No

4. If you are taking pain medication, what is your pain level with medications?

No Pain										Worst Pain Possible
0	1	2	3	4	5	6	7	8	9	10

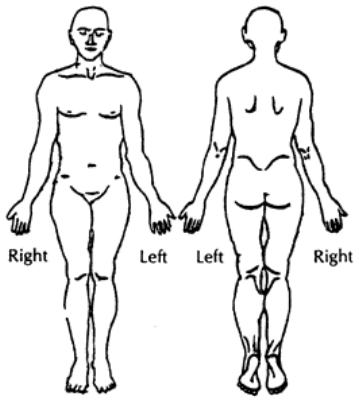
5. What is your pain level WITHOUT medications?

No Pain										Worst Pain Possible
0	1	2	3	4	5	6	7	8	9	10

6. Activity Scale

Bed ridden	Limited self-care/chores	Light duty work	Home chores	Full time work	All activities
5%	20%	50%	70%	90%	100%

Mark the location of your pain:



Height:_____
Weight:_____

7. What makes your pain worse?_____
8. What do you do to improve your pain?_____
9. NOT using the word pain, what are your goals?_____
   Are we helping you meet your goals? ___Yes___No
10. Do you feel depressed? ___Yes___No Do you have trouble with sweating? ___Yes ___No
11. Is constipation a problem? ___Yes___No Do you have less than three bowel movements a week? ___Yes ___No
    Do you use alcohol, if so how much and how often?_____Do you use tobacco products? ___Yes___No
12. Medication allergies and reactions:_____
13. **Since your last visit have you had <u>ANY</u> additions or changes in medications prescribed by other providers? (Including increases or decreases and / or strength). ____Yes ____No**
14. **List any benzodiazepine class medications you are taking (Xanax, Ativan, Valium, etc.):**_____

Please list ALL medications and supplements from all sources.

Medication	Dosage	Number per day	Benefits/ Side effects

PHARMACY NAME:_____ **LOCATION:** **PHONE:**_____