**Children’s Hospital & Medical Center Chronic Pain Clinic Intake Questionnaire**

Directions: Please answer each of the following questions by writing in or choosing the best answer. Please mail these forms back to our office in order to be scheduled for an appointment:

**Children’s Hospital & Medical Center- Chronic Pain Clinic**

**8200 Dodge Street**

**Omaha, NE 68114**

Clinic Phone: 402-955-7170 (option 5 to reach clinic secretary)

Fax: 402-955-5596

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY’S INFORMATION**

**Mother**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Marital Status: | Single | Married | Separated | Divorced | Widowed | Remarried |
| Work: | Full-time | Part-time | Unemployed |  |  |  |

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Marital Status: | Single | Married | Separated | Divorced | Widowed | Remarried |
| Work: | Full-time | Part-time | Unemployed |  |  |  |

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BIRTH / DEVELOPMENTAL HISTORY**

Were there any problems during pregnancy? Yes No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was your child’s birth weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child have any complications during or after delivery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child have any problems noted at birth (ex: torticollis, birth defects, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns with your child’s development? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

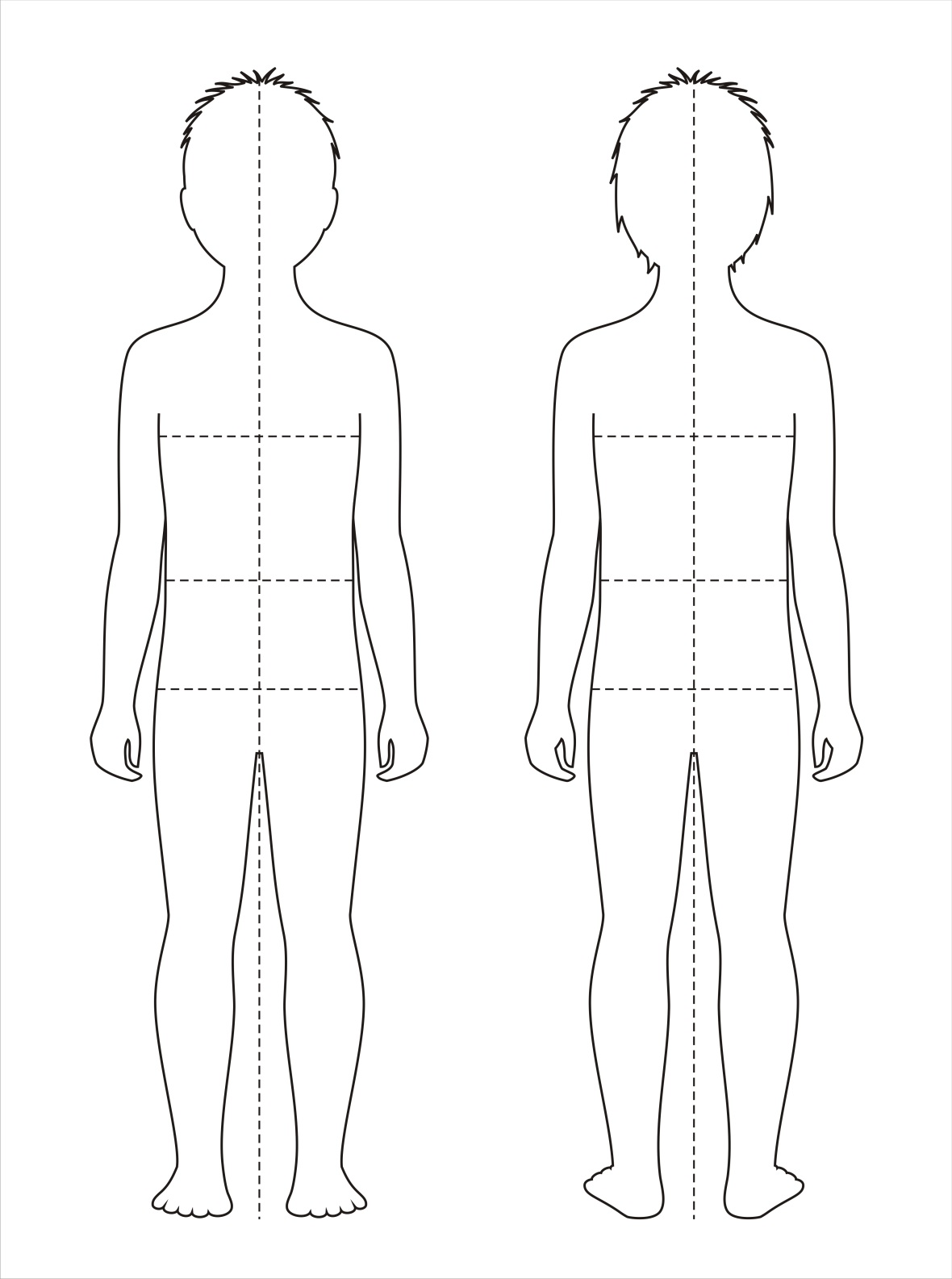
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAIN HISTORY**

The reason my child is attending this clinic is because of:

|  |  |  |  |
| --- | --- | --- | --- |
| Abdominal pain | Body pain | Joint pain | Pelvis pain |
| Arm pain | Chest pain | Leg pain | Other (Specify) |
| Back pain | Headaches | Neck pain |  |

Please mark as many locations on the figure below as needed to indicate your pain.



If you have pain in more than one place on your body, which part hurts the most? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the pain problem start? (month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

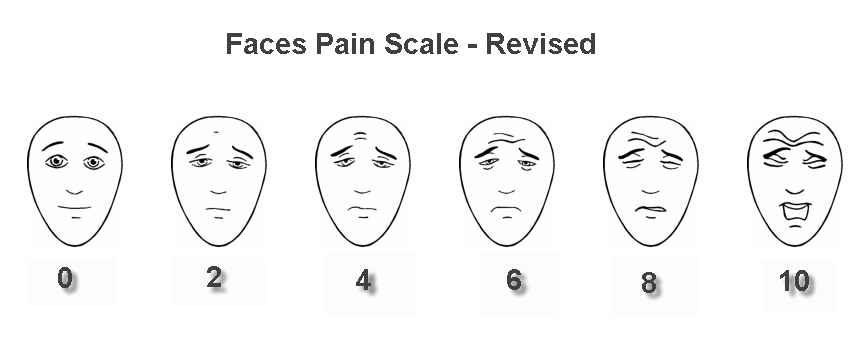
Which of the following best describes how the pain began (mark all that apply)

|  |  |  |
| --- | --- | --- |
| Motor vehicle accident | After a fall | Just began |
| Came on gradually | After an illness | After surgery |
| Other (Please explain) |  |  |

Mark all the words that describe your pain

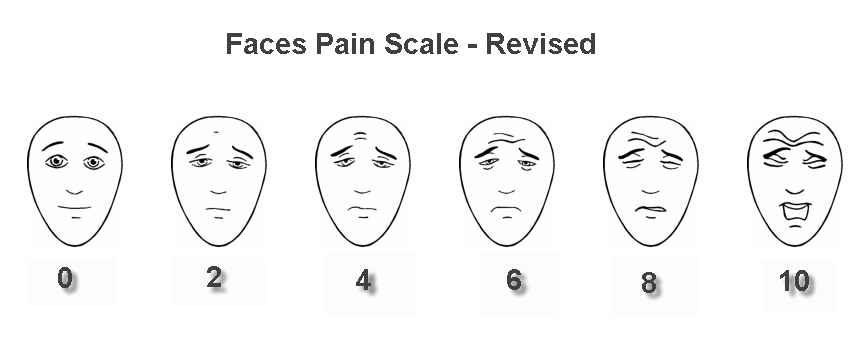
|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Aching | Dull | Miserable | Sharp | Stretching |
| Biting | Electric like | Pin and needles | Shooting | Throbbing |
| Burning | Grabbing | Pricking | Squeezing | Tingling |
| Cold | Horrible | Pounding | Sore | Unbearable |
| Cutting | Hot | Pulling | Stabbing | Other (Specify) |
| Deep | Itching | Scraping | Stinging |  |

**What level of pain do you typically have?** (Circle a number below)



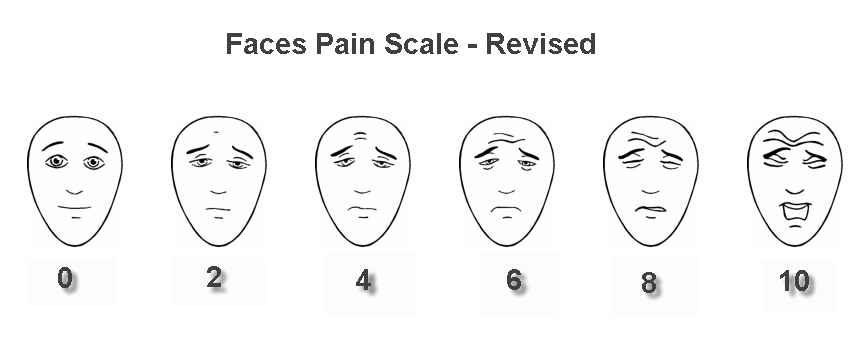
0 = no pain 10 = worst pain ever

**When your pain is at worst, how strong it is?** (Circle a number below)



0 = no pain 10 = worst pain ever

**When your pain is tolerable, how strong it is?** (Circle a number below)



0 = no pain 10 = worst pain ever

Since your pain started it has: Increased Decreased Stayed the same

Is your pain: Always there Comes and goes Is always there but sometimes gets worse

What affects your pain? (Check all that applies)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Makes it better** | **Makes it worse** | **Doesn’t change it** | **Didn’t try** |
| Activity/Movements |  |  |  |  |
| Standing |  |  |  |  |
| Walking |  |  |  |  |
| Running |  |  |  |  |
| Sitting |  |  |  |  |
| Bending |  |  |  |  |
| Lifting |  |  |  |  |
| Lying down/Rest |  |  |  |  |
| Stress/Emotions |  |  |  |  |
| Noise |  |  |  |  |
| Massaging or Rubbing |  |  |  |  |
| Cold |  |  |  |  |
| Heat |  |  |  |  |
| Other (please describe) |  |  |  |  |

What treatments have you tried for your pain? (Check all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Makes it a little better** | **Makes it a lot better** | **Doesn’t change it** | **Didn’t try** |
| Acupuncture |  |  |  |  |
| Biofeedback/Relaxation |  |  |  |  |
| Massage |  |  |  |  |
| PT/OT |  |  |  |  |
| TENS unit |  |  |  |  |
| Chiropractic |  |  |  |  |
| Osteopathic |  |  |  |  |
| Herbal remedies |  |  |  |  |
| Nerve blocks |  |  |  |  |
| Medications |  |  |  |  |

How does pain affect any of these activities? (Check all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **A little** | **Very** | **Extremely** |
| Attending school |  |  |  |  |
| Energy / being tired |  |  |  |  |
| Eating / appetite |  |  |  |  |
| Housework or chores |  |  |  |  |
| Playing or seeing friends |  |  |  |  |
| Schoolwork |  |  |  |  |
| Sleeping |  |  |  |  |
| Working at a job |  |  |  |  |
| Other favorite activity |  |  |  |  |

**MEDICATIONS**

What medications are you currently taking for pain? Grade effectiveness 0 = not effective 10 = very effective

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose** | **How often** | **How effective** | **Side-effects** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

What other medications have you tried to help your pain?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose** | **How often** | **Why did you stop** | **Side-effects** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Does your child use any substance? Caffeine Alcohol Tobacco Other illicit products

Do you have any allergies to medications? Yes No

Allergic to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL PROBLEMS**

Please mark each serious medical problem your child has had below:

|  |  |  |  |
| --- | --- | --- | --- |
| Birth injury | Emotional / Behavioral problems | Lung disease / Asthma | Vision problems |
| Blood disorder / cancer | Head injury | Liver disease | Other serious illness (*please specify*) |
| Colic | Heart disease | Rheumatologic disease |  |
| Diabetes | Kidney disease | Seizures / epilepsy |  |

Has your child had surgeries? No Yes, please explain:

Does your child have a history of injury? No Yes, please explain:

**SPECIALTY PROVIDERS**

Please provide the medical provider’s name and specialty area for each specialist that your child is *currently* working with:

Please provide the medical provider’s name and specialty area for each specialist that your child *has seen in the past*:

**FAMILY HISTORY**

Please mark each medical problem that your child’s relatives have:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Mother** | **Father** | **Grandmother** | **Grandfather** | **Siblings** |
| Fibromyalgia |  |  |  |  |  |
| Rheumatoid Arthritis |  |  |  |  |  |
| Headache |  |  |  |  |  |
| Chronic pain |  |  |  |  |  |
| Inflammatory bowel disease / syndrome |  |  |  |  |  |
| Early death (accident, medical, suicide) |  |  |  |  |  |
| Obsessive compulsive disorder (OCD) |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Bipolar disease |  |  |  |  |  |
| Anxiety |  |  |  |  |  |
| Panic attacks |  |  |  |  |  |
| Other (please specify) |  |  |  |  |  |

Has anyone in your family had pain problems like your child? No Yes, please explain:

**SCHOOL PATTERNS**

What is your current school grade: \_\_\_\_\_\_\_\_\_\_ School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Had you ever repeated a grade? No Yes (Grade? \_\_\_\_\_\_\_\_\_\_)

Are you enrolled in any special education services? No Yes

If yes, please select:

|  |  |
| --- | --- |
| Regular classroom with additional services | Individual Health Plan (IHP) |
| Homebound instruction | Self-contained classroom |
| 504 Plan | Other : |
| Individual Education Plan (IEP) |  |

This Academic School Year:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s grade this year | |  | Mostly A’s | Mostly B’s | Mostly C’s | Mostly D’s | Failing |
|  | | | | | | | |
| How many school days have you **missed** so far this year due to pain? | | | | | | | |
| 0 | 1 – 5 | 6 - 10 | 11 - 15 | 16 - 20 | 21 - 30 | 31 – 40 | > 40 |
|  | | | | | | | |
| How many school days were you **late** so far this year due to pain? | | | | | | | |
| 0 | 1 – 5 | 6 - 10 | 11 - 15 | 16 - 20 | 21 - 30 | 31 – 40 | > 40 |
|  | | | | | | | |
| How many school days did you **leave early** this year due to pain? | | | | | | | |
| 0 | 1 – 5 | 6 - 10 | 11 - 15 | 16 - 20 | 21 - 30 | 31 – 40 | > 40 |

Last Academic School Year:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s grade this year | |  | Mostly A’s | Mostly B’s | Mostly C’s | Mostly D’s | Failing |
|  | | | | | | | |
| How many school days did you **miss** last year due to pain? | | | | | | | |
| 0 | 1 – 5 | 6 - 10 | 11 - 15 | 16 - 20 | 21 - 30 | 31 – 40 | > 40 |
|  | | | | | | | |
| How many school days were you **late** last year due to pain? | | | | | | | |
| 0 | 1 – 5 | 6 - 10 | 11 - 15 | 16 - 20 | 21 - 30 | 31 – 40 | > 40 |
|  | | | | | | | |
| How many school days did you **leave early** last year due to pain? | | | | | | | |
| 0 | 1 – 5 | 6 - 10 | 11 - 15 | 16 - 20 | 21 - 30 | 31 – 40 | > 40 |

**CURRENT SLEEP PATTERNS**

At what time do you go to bed at night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what time do you wake up in the morning? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any naps? Yes No

Do you wake up at night? Yes No

Do you have difficulty (check all that apply)

|  |  |  |
| --- | --- | --- |
| Falling asleep | Staying asleep | Waking up in the morning |
| Restless sleep | Snoring | Daytime sleepiness |

How much does pain affect your sleep?

0 1 2 3 4 5 6 7 8 9 10

No Severe

Problem Problem

**EXTRA-CURRICULAR ACTIVITIES**

Please indicate the activities in which your child normally participates.

|  |  |  |
| --- | --- | --- |
|  |  | If yes state activity |
| Sports | No Yes |  |
| Clubs as school, student government | No Yes |  |
| Dance | No Yes |  |
| Groups (religious, scouting, etc.) | No Yes |  |
| Baby-sit, neighborhood yard work, etc. | No Yes |  |
| Job | No Yes |  |

**MISCELLANEOUS**

In the last year, did your family experience any of the following events?

|  |  |
| --- | --- |
| Change in residency or move | Death of family member or friend |
| Change in who is living at home | Financial stress |
| Change in school | Legal issues / concerns |
| Change in parent’s job or schedule | Major illness of family member or friend |
| Divorce or separation | Other major life event (please explain) |

How is your pain impacting your life and your family?

What are you goals/expectations for this clinic visit? What do you expect the Chronic Pain Clinic to Provide?

Person answering the questionnaire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_