Fax/Email to
Mississauga Pain Clinic

DATE: _____

FAX: 905-858-3527
EMAIL: jppainclinic@yahoo.ca

RE: _____

# of Pages including the cover sheet: _____

Notes/Comments:

From (Patient name): _____

Mississauga Pain Clinic

To be filled out by patient

Suite 220, 6855 Meadowvale Town Centre Circle, Mississauga, ON L5N 2Y1
T: (905) 858-8512, F: (905) 858-3527, jppainclinic@yahoo.ca

DATE:

Name:

Address:

Phone:
Alternate:

Health Card #:
Version code:

Date of Birth:

Height: Weight:

Where is your pain?
☐ low back pain ☐ low back pain with leg pain
☐ neck pain neck ☐ pain with arm pain
☐ headache
☐ pain all over my body, other type of pain:
Specify:_____

How long have you had the above pain?
☐ Days ☐ Weeks ☐ Months ☐ Years
Are you currently seeing a pain specialist?
If YES, name of doctor _____ or NO

Do you have an open MVA claim? Yes: ☐ No: ☐
Do you have a lawyer involved in case? Yes: ☐ No: ☐
Do you have an extended health insurance? Yes: ☐ No: ☐
Name of insurance plan: _____
Are you on a disability plan? Yes: No
Are you a WSIB patient? Yes: ☐ No: ☐
Is your WSIB still open? Yes: ☐ No: ☐
Are you working? Yes ☐ No: ☐
When was the last time you worked? Date:_____
Are you self-employed? ☐ Yes ☐ No
Do you have any ongoing medical litigation? ☐ Yes ☐ No

What is your goal with respect to pain management (put down number)?
1: strongly disagree, 2: disagree, 3: neutral, 4: agree, 5: strongly agree

I want to go back to work: ___.
I want to do more daily at home (better life style): ____
I just want pain relief: ____.
I am here because my insurance or WSIB asked me to come. ____.
I want to settle my court case. ___.

Allergy: _____

Medications for pain: _____ Medication that you **used** in the past for pain:
_____ _____
_____ _____
_____ _____

Medications for other medical problems: _____
_____
_____

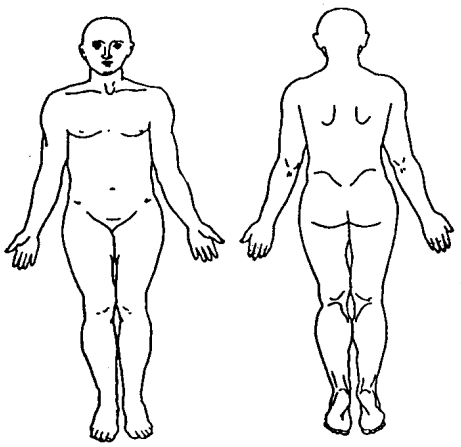
Do you have the following medical problems?

☐ Peptic ulcer disease ☐ Kidney disease ☐ Bleeding problem
☐ Asthma

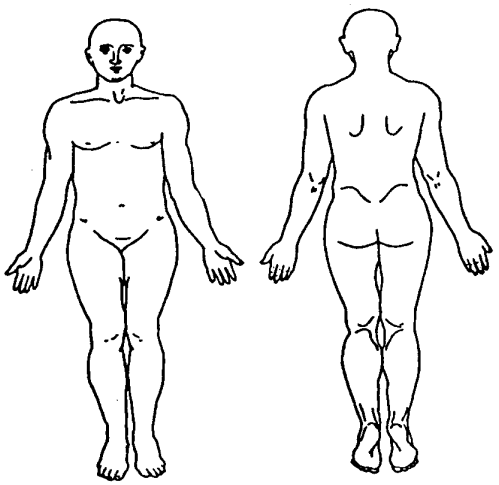
Past medical history:

☐ Cardiac problem:_____
☐ Respiratory problem:_____
☐ Seizure ☐ Diabetes ☐ Depression ☐ Anxiety disorder
☐ Other: _____

Where is your pain?
(please mark, on the drawings below, the areas where you feel the described sensations. Use the appropriate symbol. Include all affected areas.) Burning: xxxxxxx Stabbing: //////////



Do you have numbness or feel 'pins and needles' in your body?
(please mark, on the drawings below, the areas where you feel the described sensations. Use the appropriate symbol. Include all affected areas: Numbness:====== Pins and needles:°°°°°°



Did you have any type of back or neck surgery for back or neck pain in the past? _____

What type of surgery and when? _____

Did you have MRI/CT of lumbar spine/cervical spine before and after surgery? _____

What did it show? _____
Please bring the written report of MRI/CT of your spine as well as the film itself

Physicians that you have seen for your pain:
☐: Orthopedic surgeon: _____
☐: Neurosurgeon: _____
☐: Physical medicine and rehab medicine specialist: _____
☐: Neurologist: _____
☐: Pain specialist: _____
☐: Other: _____
Which of the following best describes your pain? (Check more than one, if necessary):
☐ Hot ☐ Burning ☐ Lancinating
☐ Sharp ☐ Shooting ☐ Tingling
☐ Dull ache ☐ Throbbing ☐ Pulsating ☐ Gnawing ☐ Pulling
☐ Other:_____

Which word would you use to describe the pattern of you pain?
☐ Constant ☐ Intermittent ☐ Transient

How severe is you pain on 0 to 10 verbal rating scale (0: no pain, 10: worst pain)? _____/10

☐ Mild ☐ Moderate ☐ Severe

What kind of things increase your pain?

What kind of things relieve your pain?

Treatments that you have received:
☐: physiotherapy
how long ago: ____, how often: _____, duration of treatment: _____
☐: pool therapy
how long ago: ____, how often: _____, duration of treatment: _____
☐: chiropractic manipulation
how long ago: ____, how often: _____, duration of treatment: _____
☐: TENS
how long ago: ____, how often: _____, duration of treatment: _____
☐: acupuncture
how long ago: ____, how often: _____, duration of treatment: _____
☐: Canadian Back Institute rehab program
how long ago: ____, how often: _____, duration of treatment: _____
☐: Cherokee rehab program
how long ago: ____, how often: _____, duration of treatment: _____

☐: Botox injection for pain
how long ago: _____, how often: _____, duration of treatment: _____
☐: epidural steroid injection
how long ago: ____, how often: _____, duration of treatment: _____
☐: facet block
how long ago: ____, how often: _____, duration of treatment: _____
☐: nerve block
how long ago: ____, how often: _____, duration of treatment: _____
☐: back surgery
how long ago: _____
☐: other type: specify: _____
how long ago: ____, how often: _____, duration of treatment: _____

What kind of exercises do you do at home?

What do you do to relieve your pain at home?

Check only those statements that describe you in relation to your pain
☐: I am totally incapacitated.
☐: I had to stop working.
☐: I am not able to do any type of house activities.
☐: I wear back brace.
☐: I had to give up some sports such as: _____.
☐: I had to give up some activities such as: _____.
☐: I try to do as much house activities as possible.
☐: I can do most of house activities but slowly and carefully.
☐: Despite of pain I manage to function at work.
☐: I have difficulty going into sleep.
☐: My pain wakes me up at night frequently.
☐: I wake in the morning tired.
☐: I never feel rested.
☐: My back pain is worse in the morning.
☐: I try not to bend or kneel down.

Type of activities that you have not been able to do because of pain:
_____
_____

Activities that you have difficulty:
☐ Self-care ☐ Making beds ☐ Cleaning ☐ Vacuuming ☐ Cooking
☐ Shopping ☐ Walk outside ☐ Exercise ☐ Work

Sleep:
☐ Little or no sleep ☐ fragmented ☐ uninterrupted

Mood:
☐ Depressed ☐ normal

Work:
☐ Unable to work ☐ more sick days than usual ☐ not affected

Household chores:
☐ Not possible ☐ light chores ☐ usual chores

Leisure activities:
☐ Not possible ☐ occasionally ☐ normal

How does the pain affect you?
Concentration: _____
Emotions: _____
Social relationships: _____

In the past have you ever:

a) Felt that you wanted or needed to cut down on your drinking or drug use?
Yes: ☐ No: ☐
b) Been annoyed or angered by others complaining about your drinking or drug use?
Yes: ☐ No: ☐
c) Felt guilty about the consequences of your drinking or drug use?
Yes: ☐ No: ☐
d) Had a drink or taken a drink in the morning to decrease hangover or withdrawal symptoms?
Yes: ☐ No: ☐
e) Had a history of addiction to drugs?
Yes: ☐ No: ☐
f) Is there a family history of addiction?
Yes: ☐ No: ☐
g) Is there a family history of psychiatric disease?
Yes: ☐ No: ☐

OSWESTRY DISABILITY QUESTIONNAIRE

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement ***which most clearly describes your problem.***

Section 1: Pain Intensity
- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing,Dressing,etc.)
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed e.g. on a table
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 2 kilometres
- ☐ Pain prevents me from walking more than 1 kilometre
- ☐ Pain prevents me from walking more than 500 metres
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing
- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping
- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)
- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life
- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Travelling
- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

NECK DISABILITY QUESTIONNAIRE

This questionnaire has been designed to provide information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the ONE sentence which applies to you. We

realize you may consider that two of the statements in any one section relate to you, but please just mark the sentence which most closely describes your problem.

Section 1 – Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6 – Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation
- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I can't do any recreational activities at all.

Beck Depression Index

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describe the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you don't choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

OPIOID RISK TOOL

	Mark each box That applies	item score If female	Item score if male
Family history of substance abuse			
Alcohol	( )	1	3
Illegal drugs	( )	2	3
Prescription drugs	( )	4	4
Personal history of substance abuse			
Alcohol	( )	3	3
Illegal drugs	( )	4	4
Prescription drugs	( )	5	5
Age between 16-45	( )	1	1
History of preadolescent sexual abuse	( )	3	0
Psychological disease	( )		
Attention deficit disorder		2	2
Obsessive-compulsive disorder			
Bipolar, schizophrenia			
Depression		1	1