The Lamb Pain Clinic Intake Package – Questionnaire

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This is the Lamb Pain Clinic new patient intake package. The intent of the package is to improve information for both the clinic and the patient, thereby improving overall patient care. The Lamb Pain Clinic specializes in the **rehabilitation** of injury and chronic pain, and is not a typical pain management style of clinic. The general purpose of the clinic is to facilitate the rehabilitation of a pain or injury often associated with an incomplete rehabilitation. The clinic is both non-interventional and interventional in its therapies and modalities and is patient-centered.

This package includes the following:

1. General patient questionnaire
2. General myofascio-neuropathic pain information and general explanation of services, procedures and products available through the Lamb Pain Clinic (LPC)
3. The Lamb Pain Clinic Treatment Protocols for Pain/Injury (Examples)
4. A Patient Disclosure Information document-REQUIRES PATIENT SIGNING

This information package, once completed by the patient, is considered confidential patient information and will not be mailed, faxed or copied without express written consent of the patient or their executor.

This form is considered a proprietary document of the Lamb Pain Clinic

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Patient Name____

Patient Address____

Patient Phone Numbers Home_____________________ **Cell**____________________

Patient Age_______________________

Main Pain Complaint

Medications____

Allergies____

Past Operations

Present and Past Medical History

Present and Past Psychological History

Family History

Which of the following do you have difficulties with?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is "minimal, and 10 is "extreme".

A.	B.
CHECK all that you have difficulties with	**If checked, RATE impairment from 1 to 10 (1= "minimal", 10 = "extreme")**
☐ Falling asleep	☐
☐ Awakening from sleep	☐
☐ Frequent awakenings	☐
☐ Fatigue	☐
☐ Daytime drowsiness	☐
☐ Pain during sleep	☐
☐ Insomnia	☐
☐ Poor concentration	☐
☐ **Depressed mood**	☐
☐ Delusions	☐
☐ Hallucinations	☐
☐ Overeating	☐
☐ Weight gain	☐
☐ Obesity	☐
☐ Weight loss	☐

☐ Anorexia	☐
☐ Reduced activities of daily living	☐
☐ Reduced ability to work	☐
☐ Strained family relations	☐
☐ Strained sexual relations	☐

Which of the following do you have difficulties with?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is “minimal, and 10 is “extreme”.

A.	B.
CHECK all that you have difficulties with	**If checked, RATE impairment from 1 to 10 (1= “minimal”, 10 = “extreme”)**
☐ Walking	☐
☐ Running	☐
☐ Sitting	☐
☐ Standing	☐
☐ Climbing stairs	☐
☐ Climbing ladders	☐
☐ Driving a vehicle	☐
☐ Addiction to alcohol	☐
☐ Addiction to illegal drugs	☐
☐ Addiction to gambling	☐
☐ Addition to food	☐
☐ Other type of addition	☐
☐ Family history of addiction	☐

HEAD CHECKLIST 1

Which of the following do you have difficulties with?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is "minimal, and 10 is "extreme".

A.	B.
CHECK all that you have difficulties with	**If checked, RATE impairment from 1 to 10 (1= "minimal", 10 = "extreme")**
☐ Left-sided headache	☐
☐ Right-sided headache	☐
☐ Migraine headache	☐
☐ Tension headache	☐
☐ Medicinal headache	☐
☐ Auras of migraines	☐
☐ Visual problems	☐
☐ Hearing problems	☐
☐ Jaw pain	☐
☐ Grinding teeth	☐
☐ Dizziness / vertigo	☐
☐ Ringing of ears / tinnitus	☐
☐ Left-sided facial pain	☐
☐ Right-sided facial pain	☐

☐ Left-sided facial numbness	☐
☐ Right-sided facial numbness	☐
☐ Sinus congestion/infections	☐
☐ Vasomotor rhinitis	☐
☐ Dental pain	☐

NECK and ARM CHECKLIST 1

Which of the following do you have difficulties with?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is "minimal, and 10 is "extreme".

A.	B.
CHECK all that you have difficulties with	**If checked, RATE impairment from 1 to 10 (1= "minimal", 10 = "extreme")**
⬇	⬇
☐ Left-sided neck pain	☐
☐ Right-sided neck pain	☐
☐ Left-sided neck arthritis	☐
☐ Right-sided neck arthritis	☐
☐ Left-sided neck numbness / tingling	☐
☐ Right-sided neck numbness/tingling	☐
☐ Left-sided arm numbness/tingling	☐
☐ Right-sided arm numbness/tingling	☐
☐ Left-sided carpal tunnel syndrome	☐
☐ Right-sided carpal tunnel syndrome	☐

☐ Left-sided ulnar neuritis	☐
☐ Right-sided ulnar neuritis	☐
☐ Left-sided thoracic outlet syndrome	☐
☐ Right-sided thoracic outlet syndrome	☐

NECK and ARM CHECKLIST 2

Which of the following do you have difficulties with?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is "minimal, and 10 is "extreme".

A.	B.
CHECK all that you have difficulties with	**If checked, RATE impairment from 1 to 10 (1= "minimal", 10 = "extreme")**
☐ Left-sided tennis elbow	☐
☐ Right-sided tennis elbow	☐
☐ Left-sided golfer's elbow	☐
☐ Right-sided golfer's elbow	☐
☐ Left arm pain	☐
☐ Right arm pain	☐
☐ Left shoulder arthritis	☐
☐ Right shoulder arthritis	☐
☐ Left elbow arthritis	☐
☐ Right elbow arthritis	☐
☐ Left wrist or hand arthritis	☐
☐ Right wrist or hand arthritis	☐
☐ Left-sided repetitive strain arm injury	☐
☐ Right-sided repetitive strain arm injury	☐

☐ Left-sided reflex sympathetic dystrophy	☐
☐ Right- sided reflex sympathetic dystrophy	☐
☐ Left-sided shoulder or elbow bursitis	☐
☐ Right-sided shoulder or elbow bursitis	☐

NECK and ARM CHECKLIST 3

Which of the following do you have difficulties with?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is "minimal, and 10 is "extreme".

A.	B.
CHECK all that you have difficulties with	**If checked, RATE impairment from 1 to 10 (1= "minimal", 10 = "extreme")**
⬇	⬇
☐ Left-sided shoulder blade pain	☐
☐ Right-sided shoulder blade pain	☐
☐ Left-sided tendonitis in arm	☐
☐ Right-sided tendonitis in arm	☐
☐ Throat pain	☐
☐ Difficulty swallowing	☐
☐ Itchy neck or arms	☐
☐ Bulging/degenerated disks in neck	☐
☐ Herniated disks in neck	☐
☐ Pinched nerves in neck	☐

UPPER BACK and CHEST CHECKLIST 1

Which of the following do you have difficulties with?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is "minimal, and 10 is "extreme".

A.	B.
CHECK all that you have difficulties with	**If checked, RATE impairment from 1 to 10 (1= "minimal", 10 = "extreme")**
☐ Upper back pain	☐
☐ Arthritis of the upper back	☐
☐ Bulging/degenerated disks of upper back	☐
☐ Herniated disks of upper back	☐
☐ Pinched nerves of upper back	☐
☐ Scoliosis	☐
☐ Kyphosis	☐
☐ Lordosis	☐
☐ Chest pain	☐
☐ Costal chondritis	☐
☐ GERD-gastro esophageal reflux disease	☐
☐ Heartburn	☐
☐ Irritable bowel syndrome (IBS)	☐

☐ Colitis	☐
☐ Constipation	☐
☐ Diarrhea	☐
☐ Abdominal pain	☐

UPPER BACK and CHEST CHECKLIST 2

Which of the following do you have difficulties with?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is “minimal, and 10 is “extreme”.

A.	**B.**
CHECK all that you have difficulties with	**If checked, RATE impairment from 1 to 10 (1= “minimal”, 10 = “extreme”)**
☐ Left-sided rib / side pain	☐
☐ Right-sided rib / side pain	☐
☐ Left-sided shingles chest/back/abdomen	☐
☐ Right-sided shingles chest/back/abdomen	☐
☐ Left-sided burning/tingling chest/back/abdomen	☐
☐ Right-sided burning/tingling chest/back/abdomen	☐
☐ Other back / chest pain	☐

LOW BACK and LEG CHECKLIST 1

Which of the following do you have difficulties with?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is "minimal, and 10 is "extreme".

A.	B.
CHECK all that you have difficulties with	**If checked, RATE impairment from 1 to 10 (1= "minimal", 10 = "extreme")**
☐ Left-sided low back pain	☐
☐ Right-sided low back pain	☐
☐ Left-sided low back arthritis	☐
☐ Right-sided low back arthritis	☐
☐ Left-sided low back numbness or tingling	☐
☐ Right-sided low back numbness or tingling	☐
☐ Left leg numbness/tingling	☐
☐ Right leg numbness/tingling	☐
☐ Left foot numbness/tingling	☐
☐ Right foot numbness/tingling	☐
☐ Left leg or foot clumsiness	☐
☐ Right leg or foot clumsiness	☐
☐ Left-sided sciatica	☐

☐ Right-sided sciatica	☐
☐ Left hip pain	☐
☐ Right hip pain	☐
☐ Left knee pain	☐
☐ Right knee pain	☐

LOW BACK and LEG CHECKLIST 2

Which of the following do you have difficulties with?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is “minimal, and 10 is “extreme”.

A.	B.
CHECK all that you have difficulties with	**If checked, RATE impairment from 1 to 10 (1= “minimal”, 10 = “extreme”)**
⬇	⬇
☐ Left foot pain	☐
☐ Right foot pain	☐
☐ Left plantar fasciitis/metatarsalgia	☐
☐ Right plantar fasciitis/metatarsalgia	☐
☐ Left hip arthritis	☐
☐ Right hip arthritis	☐
☐ Left knee arthritis	☐
☐ Right knee arthritis	☐
☐ Left ankle/foot arthritis	☐
☐ Right ankle/foot arthritis	☐

☐ Left leg repetitive strain injury	☐
☐ Right leg repetitive strain injury	☐
☐ Left leg reflex sympathetic dystrophy	☐
☐ Right leg reflex sympathetic dystrophy	☐
☐ Left hip or knee bursitis	☐
☐ Right hip or knee bursitis	☐

LOW BACK and LEG CHECKLIST 3

Which of the following do you have difficulties with?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is “minimal, and 10 is “extreme”.

A.	**B.**
CHECK all that you have difficulties with	**If checked, RATE impairment from 1 to 10 (1= “minimal”, 10 = “extreme”)**
⬇	⬇
☐ Left leg pain	☐
☐ Right leg pain	☐
☐ Left leg tendonitis	☐
☐ Right leg tendonitis	☐
☐ Groin pain	☐
☐ Difficulty urinating	☐
☐ Itchy low back or legs	☐

☐ Bulging/degenerated low back disks	☐
☐ Herniated low back disks	☐
☐ Pinched nerves of low back	☐
☐ Other leg pain	☐

ACCIDENT / ILLNESS HISTORY

Which of the following have you experienced?

A. For each factor that applies to you, check the box in column A below.
B. Then rate the level of impairment in column B using a number from 1 to 10, where 1 is "minimal, and 10 is "extreme".

A.	B.
CHECK all that you have experienced	**If checked, RATE impairment from 1 to 10 (1= "minimal", 10 = "extreme")**
☐ Rheumatoid arthritis	☐
☐ Polymyalgia rheumatic (PMR)	☐
☐ Trauma	☐
☐ Work accident	☐
☐ Motor vehicular accident	☐
☐ Repetitive strain injuries	☐
☐ Psoriasis	☐
☐ Lupus-systemic lupus	☐
☐ Burns (chemical/thermal/electrical)	☐
☐ Falls	☐
☐ Lifting injuries	☐
☐ Whiplash associated disorder	☐
☐ Fibromyalgia syndrome (FMS)	☐
☐ Age-related pain condition	☐

☐ Diabetic neuropathy	☐
☐ Colitis	☐
☐ Lyme disease	☐
☐ Other rheumatoid condition	☐

INVESTIGATION HISTORY (1)

Below is a list of tests and consultations that you may or may have not received. For each one that applies to you, please outline the results to the best of your ability. If you have not received this type of investigation, please leave it blank.

Abnormal blood test

____

____

____

____

Abnormal X-rays/CT scans/MRI/bone scan

____

____

____

____

Abnormal EMG/nerve conduction

____

____

____

____

Physician Consultations

____

____

____

____

Other tests not asked

____

HISTORY OF THERAPY (1)

Which of the following treatments have you tried to manage your pain or rehabilitation?

A. For each one that applies to you, check the box in column A below.
B. Then rate the effectiveness of the treatment in column B using a number from 1 to 10 where 1 is "not at all effective, & 10 is "extremely effective".

A.	B.
CHECK all that you have tried	**If checked, RATE effectiveness from 1 to 10 (1= "not at all effective", 10 = "extremely effective")**
☐ Physiotherapy with standard resistance training	☐
☐ Physiotherapy with stretching training specific to your condition	☐
☐ Physiotherapy with manual traction	☐
☐ Physiotherapy with a traction machine	☐
☐ Chiropractic with standard manipulation	☐
☐ Chiropractic with activator manipulation	☐
☐ Chiropractic with table manipulation	☐
☐ Chiropractic with spinal analysis	☐
☐ Chiropractic with VAX-D (spinal vertebral axial decompression)	☐
☐ Chiropractic with ART (active release technique)	☐
☐ EMS / TENs	☐

HISTORY OF THERAPY (2)

Which of the following treatments have you tried to manage your pain or rehabilitation?

A. For each one that applies to you, check the box in column A below.
B. Then rate the effectiveness of the treatment in column B using a number from 1 to 10 where 1 is "not at all effective, & 10 is "extremely effective".

A.	B.
CHECK all that you have tried	**If checked, RATE effectiveness from 1 to 10 (1= "not at all effective", 10 = "extremely effective")**
☐ Nerve blockade treatment	☐
☐ Trigger point injections	☐
☐ Cortisone injections into spine	☐
☐ Cortisone injections in limbs or joints	☐
☐ Spinal epidural injections	☐
☐ Spinal facet blocks	☐
☐ Head / facial Botox therapy	☐
☐ Spinal Botox therapy	☐
☐ Limb Botox therapy (trigger point)	☐
☐ Intramuscular Stimulation (IMS) / dry needling of spine	☐
☐ Intramuscular Stimulation (IMS) / dry needling of limbs	☐
☐ Acupuncture	☐
☐ Percutaneous EMS	☐

HISTORY OF THERAPY (3)

Which of the following treatments have you tried to manage your pain or rehabilitation?

A. For each one that applies to you, check the box in column A below.
B. Then rate the effectiveness of the treatment in column B using a number from 1 to 10 where 1 is “not at all effective, & 10 is “extremely effective”.

A.	B.
CHECK all that you have tried	**If checked, RATE effectiveness from 1 to 10 (1= “not at all effective”, 10 = “extremely effective”)**
☐ Massage therapy	☐
☐ Relaxation therapy	☐
☐ Biofeedback therapy	☐
☐ Ultrasound therapy	☐
☐ Radial ultrasound/shock wave therapy	☐
☐ Laser/photodynamic therapy	☐
☐ Whole body Vibration therapy (WBV)	☐
☐ Osteopathy therapy	☐
☐ Magnetic therapy	☐
☐ Psychotherapeutic pain management	☐
☐ Inversion therapy	☐
☐ Spinal surgery	☐
☐ Limb surgery	☐
Other therapies not mentioned:	

(please write in space below)	
☐	☐
☐	☐
☐	☐

TREATMENT HISTORY using MEDICATIONS (1)

Which of the following medications have you tried to manage your pain or rehabilitation?

A. For each medication you've tried, check the box in column A below.
B. Then rate the effectiveness it had in managing your pain in column B using a number from 1 to 10 where 1 is "not at all effective, & 10 is "extremely effective".

A.	**B.**
CHECK all that you have tried	**If checked, RATE effectiveness from 1 to 10 (1= "not at all effective", 10 = "extremely effective")**
⬇	⬇
☐ Tylenol / acetaminophen	☐
☐ Celebrex	☐
☐ Mobicox	☐
☐ Naprosyn	☐
☐ Indocid	☐
☐ Advil / ibuprophen	☐
☐ Other anti-inflammatory medications	☐
☐ Aspirin / acetysalicylic acid	☐
☐ Robaxacet	☐
☐ Flexeril / cylobenzaprine	☐

☐ Baclofen	☐
☐ Other muscle relaxant(s)	☐

TREATMENT HISTORY using MEDICATIONS (2)

Which of the following medications have you tried to manage your pain or rehabilitation?

A. For each medication you've tried, check the box in column A below.
B. Then rate the effectiveness it had in managing your pain in column B using a number from 1 to 10 where 1 is "not at all effective, & 10 is "extremely effective".

A.	B.
CHECK all that you have tried	**If checked, RATE effectiveness from 1 to 10 (1= "not at all effective", 10 = "extremely effective")**
☐ Neurontin / gabapentin	☐
☐ Lyrica / pregabalin	☐
☐ Topamax	☐
☐ Other epilepsy / seizure medications	☐
☐ Tramacet / Tramadol	☐
☐ Tridural	☐
☐ Codeine	☐
☐ Codeine contin	☐
☐ Percocet	☐
☐ Oxycontin	☐
☐ Duragesic / Fentanyl	☐
☐ Dilaudid	☐
☐ Hydromorph contin	☐

☐ Other opiate(s)	☐
☐ Oral steroids / prednisone	☐
☐ Rheumatoid arthritis medications	☐

TREATMENT HISTORY using MEDICATIONS (3)

Which of the following medications have you tried to manage your pain or rehabilitation?

A. For each medication you've tried, check the box in column A below.
B. Then rate the effectiveness it had in managing your pain in column B using a number from 1 to 10 where 1 is "not at all effective, & 10 is "extremely effective".

A.	B.
CHECK all that you have tried	**If checked, RATE effectiveness from 1 to 10 (1= "not at all effective", 10 = "extremely effective")**
☐ Amitriptylline / Elavil	☐
☐ Nortriptylline	☐
☐ Trazadone	☐
☐ Paxil	☐
☐ Effexxor	☐
☐ Prozac	☐
☐ Celexa	☐
☐ Cipralex	☐
☐ Remeron / mirtazapine	☐
☐ Other antidepressant(s)	☐
Other medications not mentioned: (please write in space below)	
☐	☐
☐	☐

☐	☐

ADDITIONAL INFORMATION OR COMMENTS REGARDING PAIN CONDITION(S)

Opioid Screening Questionnaire

Your Name____

Check the box for each factor that applies to you. Then, using the number beside each box you've checked, add up your total score.

1. Family History of Substance Abuse	**Female**	**Male**
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Prescription drugs	☐ 4	☐ 4

2. Personal History of Substance Abuse	**Female**	**Male**
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Prescription drugs	☐ 5	☐ 5

3. History of Psychological Illness	**Female**	**Male**
ADD / OCD / Bipolar / Schizophrenia	☐ 1	☐ 1
Depression	☐ 1	☐ 1

4. Other Factors	**Female**	**Male**
Age (check if between 16 and 45)	☐ 1	☐ 1
History of preadolescent sexual abuse	☐ 3	☐ 0

Total Score	☐	☐

LOW RISK (0-3) MEDIUM RISK (4-7) HIGH RISK (8 or above)

Based upon research from Lynn R Webster MD 2005/predicting aberrant behaviour in opioid patients