# HELMCKEN PAIN CLINIC – PATIENT DATABASE & PAIN INVENTORY (STD)

Please go to www.helmckenpainclinic.com for more information

Dear Patient,

Your doctor has referred you to the Helmcken Pain Clinic for assessment of a chronic pain condition. The waiting period for appointments varies from 2 months to 2 years based on information provided by the physician who referred you. If your pain condition changes please contact your family physician who can submit updated information.

We ask that you please fill out this form and bring it to the Pain Clinic or send via fax or mail. Please do not email completed forms. We do not recommend that confidential patient information ever be sent by email.

Your first appointment at the Pain Clinic will likely be a consultation where we will ask additional questions and perform a physical examination. There may be some additional forms to complete during the appointment. After that we will discuss management options. Depending upon available time and resources you may be offered an intervention (injection) at the first appointment. Other options include:

1. Ordering additional tests or imaging studies (x-rays).
2. Contacting your family doctor or another physician for additional information.
3. Booking a procedure for a future date.
4. Prescribing or changing medications (possibly with a follow-up appointment.)
5. Providing recommendations back to your family physician or referring physician.

If you have had paid for a private MRI or other private test or have reports from another province please attach a copy of the report or bring with you to your consultation appointment. If you have the images on a CD or DVD please bring a copy.

We will only assess and treat one pain condition at a time. We will manage the condition for which you were referred. If you have another chronic pain condition that you want us to treat you may be asked to get another referral from your family physician.

Many conditions cause nearly identical pain symptoms. Because of this every treatment that we provide is considered *diagnostic*. Some treatments are purposefully short-lived. Whether your pain is reduced or not, we will use the result of the procedure to narrow down the cause of your pain and provide better future treatment.

You must be an active participant in your therapy. We expect you to perform regular stretching and exercise. Your long-term result depends upon your willingness to work towards better overall body fitness and resilience.

Frequently asked questions about the Pain Clinic

Where are the procedures performed?
We have a procedure room complete with fluoroscopy (x-ray) and ultrasound right in the clinic itself.

Are the procedures covered by healthcare (MSP)?
Yes, all procedures that are listed as insured in the BC MSP billing schedule are covered provided you have an active healthcare number in BC or another Canadian Province with the exception of Quebec. If you have Quebec insurance please discuss this with us prior to booking an appointment. Medications are not covered by MSP. You will be given a prescription for medications to be used during the procedure. These medications are generic and usually covered by Pharmacare and third-party insurers. If cost is a major concern please discuss this with us at your consultation.

Do you see patients who are involved in active litigation (lawsuits), WorkSafe BC (WCB) or ICBC claims?
Yes, Please note that letters to WorkSafe BC, lawyers, ICBC, insurance companies or other third parties will only be sent out following written request and are billed at the current BCMA (Doctors of BC) uninsured services or third party rates. The invoice will be made out to the person or party making the request.

Cancellation policy: appointment cancellations require at least 24 hours notice but longer is appreciated so that we can book another patient into the open time. Short notice cancellations or missed initial consultation appointments will not be rebooked.

**Please use this pain scale when completing the questionnaire and for reporting all pain scores at the pain clinic.**

| | |
|---|---|
| 0 | **No pain** |
| 1<br>2<br>3<br>4 | **Functional**<br>The pain is present<br>It does not get in the way<br>No effect on my daily activities and my life |
| 5<br>6<br>7 | **Uncomfortable**<br>Hard to move, cannot concentrate<br>Impacting my abilities<br>Affects my daily activities and my life |
| 8<br>9 | **Severe**<br>Not able to leave my home<br>Unable to do anything; I am in bed<br>High effect on my daily activities and my life |
| 10 | **Unbearable**<br>Out of control, overwhelmed<br>Cannot tolerate the excruciating sensation<br>Seeking immediate attention<br>(Emergency Room) |

# HELMCKEN PAIN CLINIC – PATIENT DATABASE & PAIN INVENTORY (STD)

**Today's Date:** _____

**Patient**

Name | DOB | Age | ☐ M ☐ F

**Address**

Street# _____ City _____

Home Ph# | Cell Ph# | Postal Code

**Who is your family doctor?**

**Work status**

☐ Employed ☐ Stay-at-home ☐ Disability ☐ Student

☐ Retired ☐ Unemployed ☐ WorkSafe (WCB) ☐ Other _____

Who is/was your employer? _____

What type of work do/did you do?

**My current symptoms are as a result of a:**

☐ Motor Vehicle Collision MVC Date: _____ ICBC Claim #: _____

☐ Work Place Injury Injury Date: WCB #:

**Height** _____ **Weight** _____ **Preferred or dominant hand** ☐ **R** ☐ **L**

*Please complete this as accurately as possible; height and weight are required on all CT, bone scan and MRI requisitions*

**Please list all of your current or past health problems including any operations and injuries you have had**

**Current Medications** (Please include all medications /supplements you currently take even those not taken for pain)

**Allergies / Sensitivities**

| | I currently use | I have used | The last time I used was | Average use /wk |
|---|---|---|---|---|
| **Smoking / Tobacco** | ☐ Yes ☐ No | ☐ Yes ☐ No | | |
| **Alcohol** | ☐ Yes ☐ No | ☐ Yes ☐ No | | |
| **Marijuana** | ☐ Yes ☐ No | ☐ Yes ☐ No | | |
| **Other illicit substances** | ☐ Yes ☐ No | ☐ Yes ☐ No | | |

# HELMCKEN PAIN CLINIC – PATIENT DATABASE & PAIN INVENTORY (STD)

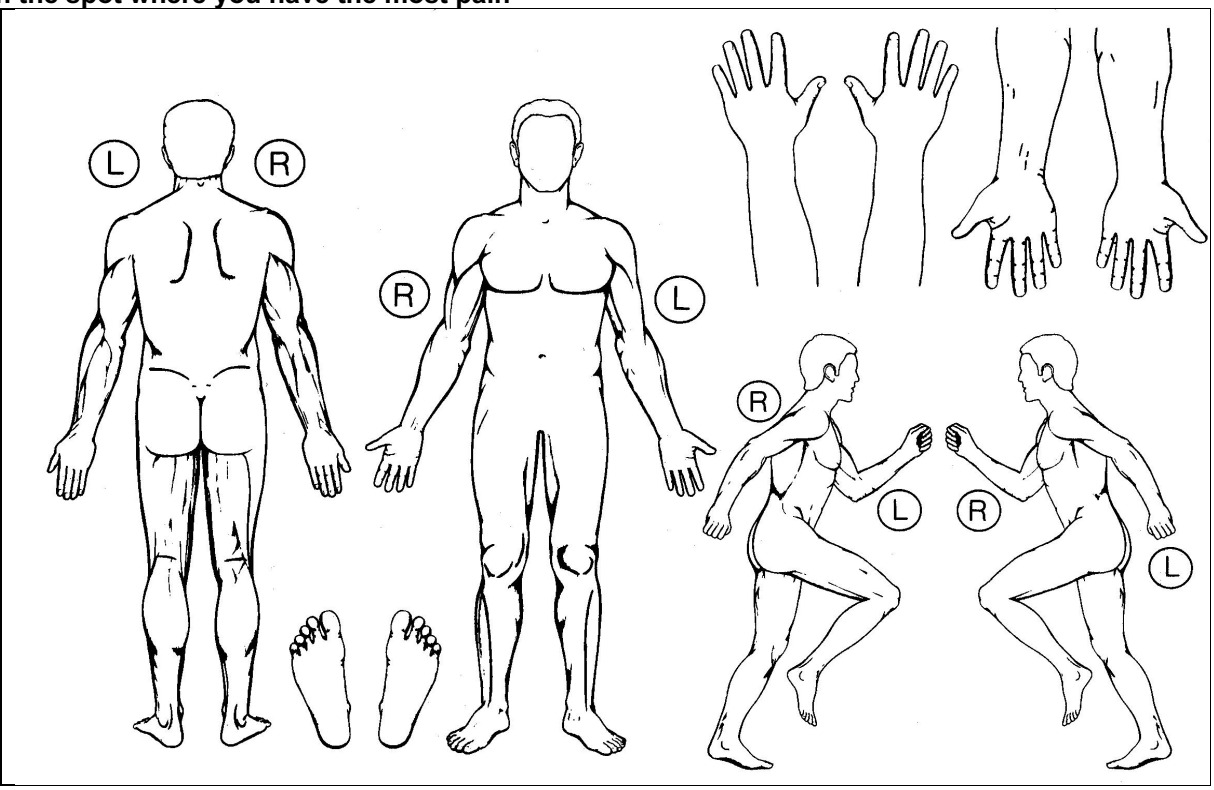
Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains and toothaches).

**Have you had pain other than these everyday kinds of pain during the last week?**

☐ Yes ☐ No

On the diagrams, please shade the area(s) where you feel pain. (Use different colors if desired)
**Put an 'X' on the spot where you have the most pain**

| |
|---|
| ***S*** *Sharp / Stabbing* |
| ***B*** *Burning* |
| ***N*** *Numbness* |
| ***P*** *Pins & needles* |
| ***A*** *Aching* |
| ↗ *Shooting pain* |




**Select the word(s) that best describe(s) your pain**

| | | | | |
|---|---|---|---|---|
| ☐ Tingling | ☐ Numb | ☐ Cramping | ☐ Lancinating | ☐ Gnawing |
| ☐ Radiating | ☐ Tearing | ☐ Deep | ☐ Excruciating | ☐ Other (list) |
| ☐ Shooting | ☐ Throbbing | ☐ Aching | ☐ Exhausting | |
| ☐ Tender | ☐ Stabbing | ☐ Cutting | ☐ Unbearable | |
| ☐ Sharp | ☐ Penetrating | ☐ Piercing | ☐ Burning | |
| ☐ Splitting | ☐ Boring | ☐ Continuous | ☐ Heavy | |

**Please rate your pain** (Using the 1-10 scale provided)

At its **worst** in the past week. _____

At its **least** in the past week. _____

On **average** _____

**Right now** _____

Please use the 1-10 scale provided

# HELMCKEN PAIN CLINIC – PATIENT DATABASE & PAIN INVENTORY (STD)

**What pain medication(s) have you taken in the past?** (For this pain)

| | | | | |
|---|---|---|---|---|
| ☐ Tylenol | ☐ Ibuprofen (Advil) | ☐ Naproxen (Aleve) | ☐ Diclofenac (Voltaren) | ☐ Arthrotec |
| ☐ Celebrex | ☐ Tylenol #3 | ☐ Tramacet | ☐ Tramadol | ☐ Methadone |
| ☐ Morphine | ☐ Dilaudid | ☐ Fentanyl patch | ☐ BuTrans patch | ☐ Capsaicin |
| ☐ Gabapentin | ☐ Lyrica | ☐ Cymbalta | ☐ Amitriptyline | ☐ Nortriptyline |
| ☐ Topiramate | ☐ Other (List) | | | |

**I take my pain medication(s)** (In a 24 hour period)

| | | | |
|---|---|---|---|
| ☐ I don't take medications | ☐ 1-2 times a day | ☐ 5-6 times a day | ☐ Other: |
| ☐ Not every day | ☐ 3-4 times a day | ☐ More than 6 times a day | |

**I think I need a stronger pain medication** ☐ Yes ☐ No

**I think that I need to take more of the pain medicine than I have been prescribed** ☐ Yes ☐ No

**I feel that I use too much pain medicine** ☐ Yes ☐ No

**If yes why?**

**Other forms of treatment I have tried include:**

| | | | | |
|---|---|---|---|---|
| ☐ Physiotherapy | ☐ Acupuncture | ☐ Massage | ☐ IMS | ☐ Heat |
| ☐ Chiropractic | ☐ Pain Education Class | ☐ Stretching | ☐ TENS | ☐ Cold |
| ☐ Other (List) | | | | |

**Have you been to a pain clinic in the past?** ☐ Yes ☐ No

If yes which one(s)?

**Have you had spinal, epidural, facet or other injections for pain control in the past?** ☐ Yes ☐ No

If yes what type(s)?

***Thinking only about activities that you do specifically for exercise (ie. not work related)***

| **How often do you perform:** | **Daily** | **4-5 / wk** | **2-3 / wk** | **Don't/can't** | **Duration or distance** |
|---|---|---|---|---|---|
| Stretching? | ☐ | ☐ | ☐ | ☐ | |
| Exercise? (gym, yoga etc) | ☐ | ☐ | ☐ | ☐ | |
| Aerobic exercise? (walking, cycling etc) | ☐ | ☐ | ☐ | ☐ | |

**What physical activities/chores do you do on an average day?**

# HELMCKEN PAIN CLINIC – PATIENT DATABASE & PAIN INVENTORY (STD)

**How much, during the past week, has pain interfered with your:**

| | |
|---|---|
| **General activity** | _____ |
| **Mood** | _____ |
| **Walking ability** | _____ |
| **Normal work** | _____ |
| **Relations with other people** | _____ |
| **Sleep** | _____ |

Use a scale of 0-10 where:
0 = no interference and
10 = completely unable to function

| **Sleep patterns** | | **Reason** |
|---|---|---|
| I have trouble falling asleep | ☐ Yes ☐ No | |
| I wake up during the night | ☐ Yes ☐ No | |
| I have trouble falling back asleep if I wake | ☐ Yes ☐ No | |

**What activities does your pain prevent you from doing?**

**What is your goal of attending the Helmcken Pain Clinic?** If your goal is reduced pain how much of a reduction would you be happy with?

**What questions would you like answered during your consultation?**

**Are there specific topics or treatments that you would like to discuss during your appointment?**

**If possible would you want to have a procedure performed at your first appointment?** ☐ Yes ☐ No

Please attach any additional information that you think is important for us to know ahead of time.