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Chronic Pain Clinic Survey Date:28.1.2022.

Please complete the survey below to help us collect the required information before your chronic pain clinc appointment

**Thank you!**

Patient name: Sai Boddu Hospital Id: undefined

| | **Patient Details:** |
|---|---|
| FirstName:Sai | |
| LastName: Boddu | |
| Contact: | undefined |
| Are you filling this form : | For self |
| Address: | 65 CLAREMONT ROAD |
| Postcode: | TW18 3AS |
| Email: | bsaireshma.7@gmail.com |
| Date of Birth: | undefined |
| Year Pain Began: | undefined |
| How did Pain Start: | |
| was the onset of pain: | undefined |
| Sex: | Male |
| Please indicate what words describe your pain now | |
| Any comments you wish to make: | |
| How often do you have pain?: | |
| Are there times during which you experience no pain?: | |
| Time of day pain is best: | |
| Time of day pain is worst: | |
| What causes an increase in your pain?: | |
| What can you do to help relieve the pain?: | |
| What can you do to help relieve the pain?: | |
| Does pain affect your sleep? | |
| Trouble falling asleep | |
| Medication needed to fall asleep | |
| Awakened by pain | |
| Any comments you wish to make: | |
| Please tick if you have seen any of the following people regarding your pain?: | |
| Please give details of any tests or investigations you have had for the pain listing the health professinals | |

and hospitals if possible

scans

Blood Tests

Nerve Tests

Regular Medication

Medication 1 - Name

Medication 1 - Dose

Medication 1 - Frequency

Medication 2 - Name

Medication 2 - Dose

Medication2 - Frequency

Medication 3 - Name

Medication 3 - Dose

Medication 3 - Frequency

Medication name & reason for taking