



ELM Medicine

Unit 4- 1521 Upper Ottawa Street
Hamilton, Ontario L8W 3J4

Phone: 905-318-3006
Fax: 833-268-3660
info.elmmedicine@gmail.com
www.elmmedicine.ca

**Specialist Clinic. Internal Medicine. Infectious Diseases. Hepatitis B & C. Chronic Pain.
Lifestyle Medicine Clinic. Stress Reduction Clinic**
Dr. Atreyi Mukherji, MD, MPH, FRCPC

PATIENT INTAKE PACKAGE: CHRONIC PAIN

Please complete the following documents in the package. All documents are required to be completed, before consultation.

1. Health Questionnaire
2. No Show Policy
3. Supplement disclaimer
4. Chronic Pain Diagram
5. Perceived Stress Scale
6. PROMIS29 Questionnaire

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HEALTH QUESTIONNAIRE: CHRONIC PAIN

PATIENT INFORMATION - PLEASE COMPLETE

Patient's Last Name: First: Mr. Mrs. Ms.

Home Address: City: Postal Code:

Email Address: Home Phone: Mobile Phone:

Date of Birth: OHIP Number:

1. What is your preferred method of contact by the office ?

2. What is your goal for the visit ?

3. List all medications that you are currently taking , either by prescription or over the counter. Please also bring a list or bottles of your medications, during the first office visit.

4. List all vitamins and supplements that you are currently taking , either by prescription or over the counter.

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5. List any allergies to medications or other items.

6. List all health problems that you have been diagnosed with, by a medical doctor.

7. List all prior surgeries.

8. <u>PREVENTATIVE HEALTH</u>	(YES OR NO)
Pap smear (women) in last 3 years:	
Mammogram in last 2 years:	
Colonoscopy or Stool check for Colon Cancer:	
Dental check up in last year :	
Influenza Vaccine:	
Pneumonia vaccine:	
Hepatitis A and or B Vaccine:	
Tetanus Vaccine:	
BCG Vaccine:	

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9. List any health problems in your immediate family (parents, grandparents, siblings, children)

10. SOCIAL HISTORY

Marital status: _____

Children: _____

Drug benefits: _____

11. LIFESTYLE

(YES OR NO AND EXPLAIN)

Current or past tobacco use: _____

Current or past cannabis use: _____

Current or past alcohol use: _____

Patient Signature: _____

Date: _____



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NO SHOW POLICY

PATIENT NAME: _____ DATE OF BIRTH: _____

In order to serve you better, we want you to be aware of our clinic policy for scheduled appointments.

PLEASE INITIAL BESIDE EACH STATEMENT:

_____ We understand that sometimes you cannot make your appointment. It is your responsibility to notify our clinic if you cannot make the appointment, for any reason.

_____ Please cancel or reschedule your appointment during our regular clinic hours (Tuesday-Thursday) and a minimum of 2 business days prior to your appointment.

_____ **NO SHOW:** If you do not attend an appointment and do not contact the clinic to cancel within 2 business days, you will be charged a no show fee of \$35 + HST.

_____ Changes made by us to your appointment: If we have changed your appointment and you fail to receive the message or you did not confirm the new appointment date, you will not be charged a fee.

_____ Arriving late for an appointment: We will do our best to accommodate you if you arrive late for your appointment. This may mean that you have to wait for the next available opening. If we cannot accommodate you, we will need to reschedule your appointment.

_____ You agree to provide up to date contact information to our receptionist.

_____ You agree to provide a valid email address, so we can email you health related education resources, or other communications.

Self reschedule of appointments on-line for follow up appointments, may be accessible in some cases. The same policy for rescheduling and no show apply.

Please sign below that you have read and understand these policies.

Patient Signature: _____

Date: _____

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SUPPLEMENT DISCLAIMER

Some patients in our clinic will be interested in taking supplements to manage their health . Dr. Mukherji in these instances may recommend evidence supported professional quality supplements, from professional supplement distributors.

Either an electronic prescription through FULLSCRIPT or OPTIFAST CANADA (weight management patients only), will be provided.

If you decide to purchase supplements from these professional distributors , please be aware that Dr. Mukherji does not make any income or commissions from your purchases. As Dr. Mukherji does not make any commission, the vendor sells the supplements at wholesale price (25% below MRP-Minimum Retail Price), to current ELM Medicine patients. You are under no obligation to purchase supplements from these specific distributors .

Additionally, if you use these vendors, you must be seen in follow up every 3 months for monitoring and safety.

I have read and understood the above.

PATIENT INFORMATION - PLEASE COMPLETE

Patient's Last Name:			First:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
Home Address:		City:		Postal Code:		
Email Address:		Home Phone:		Mobile Phone:		
Date of Birth:		OHIP Number:				

Patient Signature: _____

Date: _____

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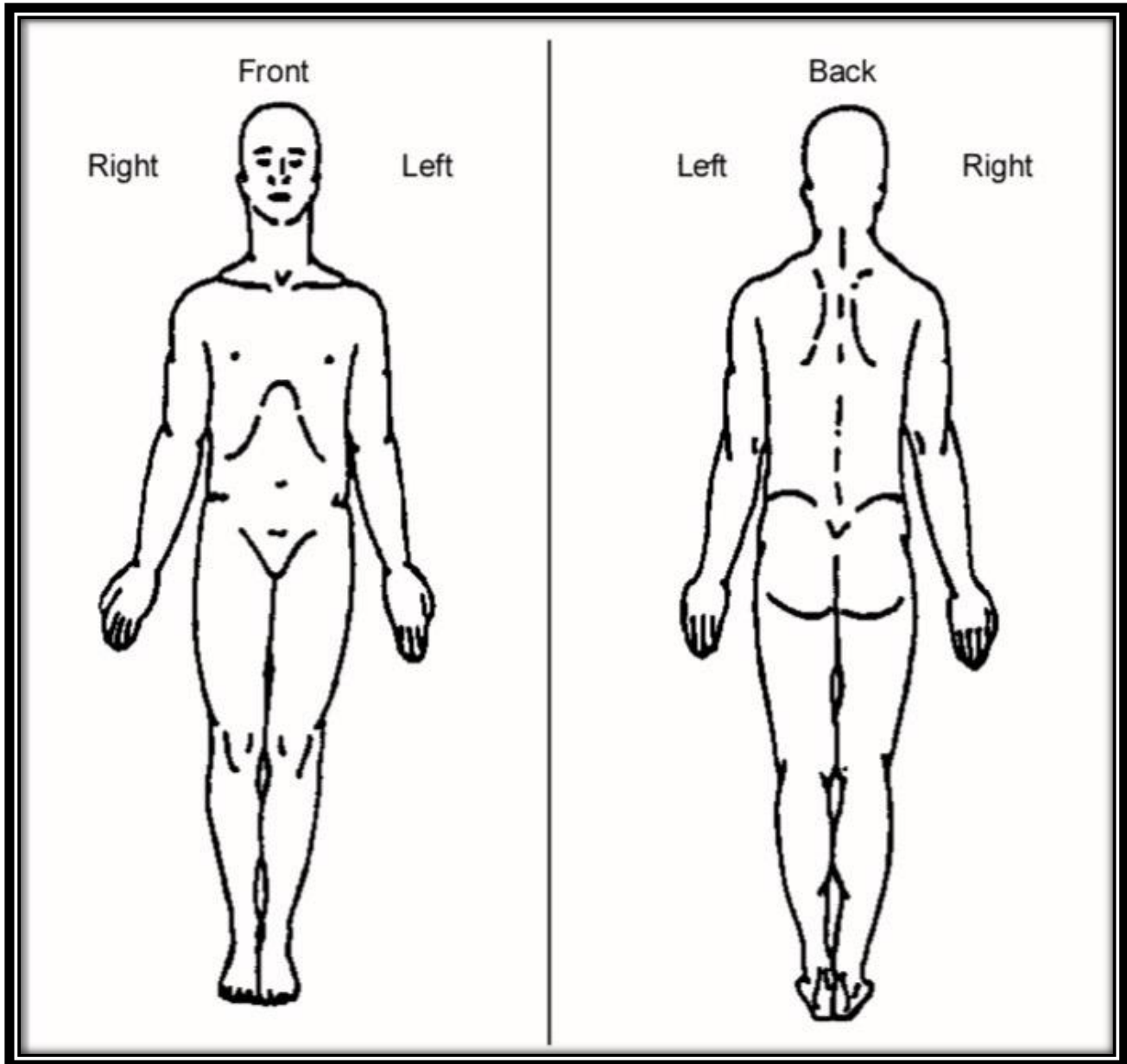
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CHRONIC PAIN DIAGRAM



Please record the location of your pain in the diagrams below.

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PERCEIVED STRESS SCALE

**The questions in this scale ask you about your feelings and thoughts during the last month.
In each case, you will be asked to indicate by circling how often you felt or thought a
certain way.**

Name _____ Date _____

Age _____ Gender (Circle): **M** **F** Other _____

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly? 0 1 2 3 4
2. In the last month, how often have you felt that you were unable to control the important things in your life? 0 1 2 3 4
3. In the last month, how often have you felt nervous and "stressed"? 0 1 2 3 4
4. In the last month, how often have you felt confident about your ability to handle your personal problems? 0 1 2 3 4
5. In the last month, how often have you felt that things were going your way? 0 1 2 3 4
6. In the last month, how often have you found that you could not cope with all the things that you had to do? 0 1 2 3 4
7. In the last month, how often have you been able to control irritations in your life? 0 1 2 3 4
8. In the last month, how often have you felt that you were on top of things? 0 1 2 3 4
9. In the last month, how often have you been angered because of things that were outside of your control? 0 1 2 3 4
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? 0 1 2 3 4

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PROMIS-29 Profile v1.0

Please respond to each question or statement by marking one box per row.

		Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Physical Function						
1	Are you able to do chores such as vacuuming or yard work?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Are you able to go up and down stairs at a normal pace?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Are you able to go for a walk of at least 15 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Are you able to run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Anxiety					
	In the past 7 days...	Never	Rarely	Sometimes	Often	Always
5	I felt fearful.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	I found it hard to focus on anything other than my anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	My worries overwhelmed me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	I felt uneasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Depression					
	In the past 7 days...	Never	Rarely	Sometimes	Often	Always
9	I felt worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	I felt helpless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	I felt depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	I felt hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fatigue					
	During the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
13	I feel fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	I have trouble starting things because I am tired.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	In the past 7 days...					
15	How run-down did you feel on average? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
16	How fatigued were you on average?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Sleep Disturbance

In the past 7 days...

		Very poor	Poor	Fair	Good	Very good
17	My sleep quality was.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
18	My sleep was refreshing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	I had a problem with my sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	I had difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Satisfaction with Social Role

In the past 7 days...

		Not at all	A little bit	Somewhat	Quite a bit	Very much
21	I am satisfied with how much work I can do (include work at home)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	I am satisfied with my ability to work (include work at home).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	I am satisfied with my ability to do regular personal and household responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	I am satisfied with my ability to perform my daily routines.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pain Interference

In the past 7 days...

		Not at all	A little bit	Somewhat	Quite a bit	Very much
25	How much did pain interfere with your day to day activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	How much did pain interfere with work around the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	How much did pain interfere with your ability to participate in social activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	How much did pain interfere with your household chores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pain Intensity

In the past 7 days...

29	How would you rate your pain on average?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		0	1	2	3	4	5	6	7	8	9	10
		No pain										Worst imaginable pain

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