Pain Management Services, Pain Assessment – Page 1

1. Where is your worst pain located?_____
2. Does it spread and if so, where?_____

   _____
3. When did your pain begin?_____
4. Was there any injury or accident before?_____
5. Is this a Workman's Compensation claim? ❑ Yes ❑ No

   If yes, who is your case manager?_____

   Phone number_____
6. Does anything bring on your pain? _____
7. Is your pain continuous or does it come and go?_____
8. Describe in your own words what your pain feels like:

   _____
9. Rate your pain on the pain scale by circling number(s)

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable
10. What makes the pain better?_____
11. Best position for comfort: (circle) lying standing sitting
12. What makes the pain worse?_____
13. Worst position for comfort: (circle) lying standing sitting
14. What treatment have you received for this pain in the past?

    _____

    _____
15. How does your pain affect your:

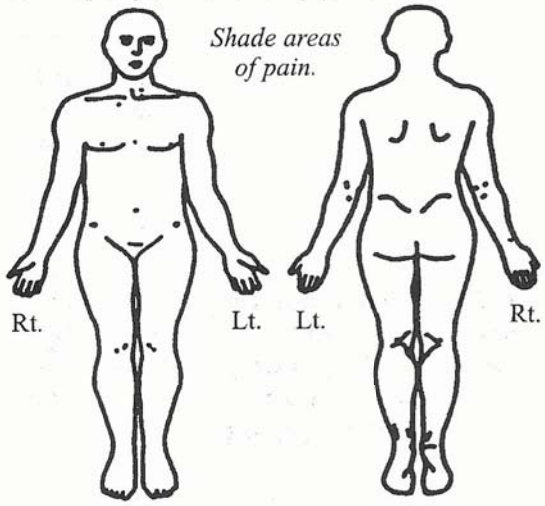
    Sleep:_____

    Work:_____

    Appetite: _____

    Physical activity:_____

    Social activity: _____
16. Current pain medication: _____



Allergies to medication (include reaction): _____

_____

Medications you take regularly:_____

_____

_____

Are you on a blood thinner? (Coumadin, Plavix, other)_____

Is there a chance you are pregnant? ❑ Yes ❑ No

Working: ❑ Yes ❑ No Type: _____

Last day worked _____

Use of tobacco products ❑ Yes ❑ No cig. _____ packs/day

Use of alcohol ❑ Yes ❑ No drinks/day _____

Last drink _____

Family Physician:_____

Referring Physician: _____

Insurance Company Name: _____

Does your insurance require a referral or preauthorization to be seen at the pain clinic? ❑ Yes ❑ No

If yes, have you obtained this from your primary care physician? ❑ Yes ❑ No

Form Completed by:_____

Reviewed by _____

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Medical History

Do you have or are you currently being treated for: (circle yes or no)

Anemia	yes	no
Arthritis	yes	no
Asthma	yes	no
Back Problems	yes	no
Blood Disorder (bruising)	yes	no
Cancer	yes	no
Cataracts	yes	no
Circulation Problems	yes	no
Diabetes	yes	no
Drug Abuse	yes	no
Glaucoma	yes	no
Headaches	yes	no
Heart Disease	yes	no
Hepatitis	yes	no
High Blood Pressure	yes	no
HIV	yes	no
Kidney Disease	yes	no
Lung Disease	yes	no
Osteoporosis	yes	no
Seizures	yes	no
Stroke	yes	no
Stomach Ulcers	yes	no
TB	yes	no
Thyroid Disorders	yes	no
Family History: Spine Disease	yes	no

Who_____

Drug/Alcohol Abuse yes no

Who_____

Implants:_____

Past Injuries:_____

_____

Past Surgery:_____

_____

Review of Systems

Are you presently experiencing any of the following symptoms? (circle yes or no)

Constitutional symptoms:

Fever	yes	no
Chills	yes	no
Headache	yes	no

Other_____

Eyes:

Blurred vision	yes	no
Double vision	yes	no
Pain or redness	yes	no
Dryness	yes	no

Other_____

Allergic:

Hay fever	yes	no

Other_____

Neurological:

Weakness	yes	no
Dizziness	yes	no
Numbness/tingling	yes	no

Other_____

Endocrine:

Excessive thirst	yes	no
Too hot/cold	yes	no
Tired/sluggish	yes	no

Other_____

Integumentary:

Skin rash	yes	no
Boils	yes	no
Itching	yes	no

Other_____

Muscaloskeletal:

Joint pain	yes	no
Swelling	yes	no
Neck pain	yes	no
Joint stiffness	yes	no
Back pain	yes	no

Other_____

Genitourinary:

Painful urination	yes	no
Genital ulcers	yes	no
Blood in urine	yes	no

Other_____

Ears/Nose/Throat/Mouth:

Ear pain	yes	no
Decreased hearing	yes	no
Mouth sores	yes	no
Dryness	yes	no

Other_____

Pulmonary:

Wheezing	yes	no
Frequent cough	yes	no
Shortness of breath	yes	no
Chest pleurisy	yes	no

Other_____

Gastrointestinal:

Abdominal pain	yes	no
Nausea/vomiting	yes	no
Indigestion/heartburn	yes	no

Other_____

Cardiovascular:

Chest pains	yes	no
High blood pressure	yes	no
Heart failure	yes	no
Fluid retention	yes	no

Other_____

Hematological:

Swollen glands	yes	no
Easy bruising	yes	no
Unusual bleeding	yes	no
Rectal bleeding	yes	no
Frequent infections	yes	no

Other_____

Psychological:

Severe depression	yes	no
Suicidal thoughts	yes	no
Confusion	yes	no
Sleep disturbance	yes	no

Other_____

Form Completed by:_____

Reviewed by _____