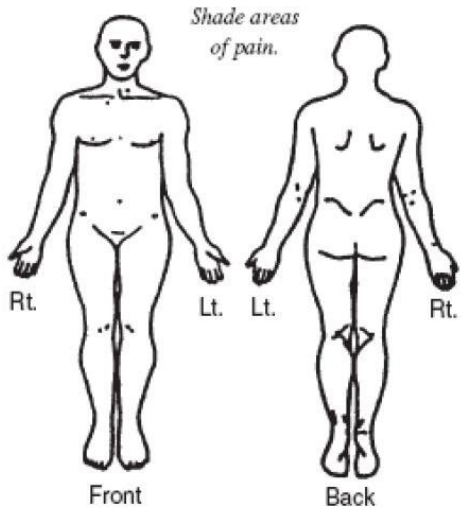
Pain Management Services Pain Assessment

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

_____

SHADE AREAS OF PAIN



3. **When** did your pain begin? _____
4. When did it get worse? _____
5. Is your pain related to an injury or accident?

_____

6. Is your pain continuous, or does it come and go?_____
7. Describe in your own words what your pain feels like:

_____

8. Rate your pain today:_____(0-10)
9. Indicate the **range** of your pain:
   0 1 2 3 4 5 6 7 8 9 10
   No pain Worst Pain Imaginable
10. Best position for comfort:
    (circle) lying standing sitting
11. Most painful position:
    (circle) lying standing sitting
12. What makes your pain better? _____

_____

13. What makes your pain worse? _____

_____

14. Current pain medications: _____

_____

15. What **treatment(s)/surgeries** have you received for this pain in the past? _____

_____

16. Previous x-ray scans, related to present pain:
    MRI/CT/XRAY: _____
    Where: _____
17. Does your pain effect your: (if yes, how?)
    - Sleep: No / Yes, _____
    - Appetite: No / Yes, _____
    - Physical Activity: No / Yes, _____
    - Social Activity: No / Yes, _____
18. Working: (circle) NO YES
    - Occupation: _____
    - Restrictions: _____
    - Have you missed work: _____
    - Last day worked: _____
    - Is this a Workmen's Compensation claim?
      NO YES
    - If yes, who is your case manager? _____
    - Case Manager's phone number: _____
19. Following your last visit to the Pain Clinic:
    - Was there an improvement in your pain?

      _____
    - Indicate best pain score or percent improvement

      _____
    - If so, how long did the improvement last?

      _____
    - Has your activity level changed?

      _____
    - Has your pain changed since your last visit?

      _____
20. Have you had a **new** MRI/CT/XRAY since your last visit? _____
21. **New** tests since last seen? _____

_____

22. List any changes in medications or medical history since **last** visit: _____

_____

23. As a result of your previous treatment, has there been improvement in your quality of life?

_____

24. If applicable, have you been able to return to work?

_____

PATIENT LABEL

25. Change in control of bowel or bladder? _____
_____
26. Unexplained weight loss or gain? _____
_____
27. Do you have any bleeding problems? _____
_____
28. Do you have any of the following: (circle)
Fever Productive Cough Sore Throat
Sinus Infection Burning with Urination
29. Are you on an antibiotic? _____
30. Do you take a blood thinner or aspirin? (circle) NO YES
- List blood thinner: NAME LAST TAKEN
1. _____
2. _____
31. Is there a chance you are pregnant? (circle) NO YES
32. Use of tobacco products:
(circle) NO YES,_____packs/day
33. Use alcohol: (circle) NO YES,_____drinks/day
34. Have you had a drug/alcohol problem? _____
35. Use illegal drugs: (circle) NO YES, _____

Fill this section out if ** first visit for current issue

Medical History

Do you have or are you currently being treated for:
(Circle No or Yes: Check if applicable)

			New	History Of
Anemia	No	Yes	___	____
Arthritis	No	Yes	___	____
Asthma	No	Yes	___	____
Back Problems	No	Yes	___	____
Blood Disorder	No	Yes	___	____
Bruising	No	Yes	___	____
Cancer	No	Yes	___	____
Cataracts	No	Yes	___	____
Circulation Problems	No	Yes	___	____
Diabetes	No	Yes	___	____
Glaucoma	No	Yes	___	____
Headaches	No	Yes	___	____
Heart Disease	No	Yes	___	____
Heart Failure	No	Yes	___	____
High Blood Pressure	No	Yes	___	____
HIV	No	Yes	___	____
Kidney Disease	No	Yes	___	____
Lung Disease	No	Yes	___	____
Osteoporosis	No	Yes	___	____
Seizures	No	Yes	___	____
Stroke	No	Yes	___	____
Stomach Ulcers	No	Yes	___	____
TB	No	Yes	___	____
Thyroid Disorder	No	Yes	___	____
Spine Disease	No	Yes	___	____

Family History:

Spine Disease	No	Yes	Who: _____
Drug/Alcohol Abuse	No	Yes	Who: _____

Surgical History: _____
_____
_____

See Medication List

Review of Systems

Presently experiencing any of the following symptoms?
(Circle No or Yes)

Constitutional Symptom:

Fever	No	Yes
Chills	No	Yes
Headaches	No	Yes

Other: _____

Eyes:

Blurred Vision	No	Yes
Double Vision	No	Yes

Other: _____

Pulmonary:

Wheezing	No	Yes
Frequent Cough	No	Yes
Shortness of Breath	No	Yes

Other: _____

Neurological:

Weakness	No	Yes
Dizziness	No	Yes
Numbness/ Tingling	No	Yes

Other: _____

Psychological:

Severe Depression	No	Yes
Suicidal Thoughts	No	Yes
Confusion	No	Yes
Sleep Disturbance	No	Yes

Other: _____

Genitourinary:

Painful Urination	No	Yes
Blood in Urine	No	Yes

Other: _____

Ear/Nose/ Throat/Mouth:

Ear Pain	No	Yes
Decreased Hearing	No	Yes

Other: _____

Cardiovascular:

Chest Pain	No	Yes
Fluid Retention	No	Yes

Other: _____

Gastrointestinal:

Abdominal Pain	No	Yes
Nausea/Vomiting	No	Yes
Indigestion/ Heartburn	No	Yes

Other: _____

Musculoskeletal:

Joint Pain	No	Yes
Swelling	No	Yes
Neck Pain	No	Yes
Joint Stiffness	No	Yes

Other: _____

Hematological:

Swollen Glands	No	Yes
Bruising	No	Yes
Unusual Bleeding	No	Yes
Rectal Bleeding	No	Yes
Frequent Infection	No	Yes

Other: _____

Patient Signature: _____

PATIENT LABEL