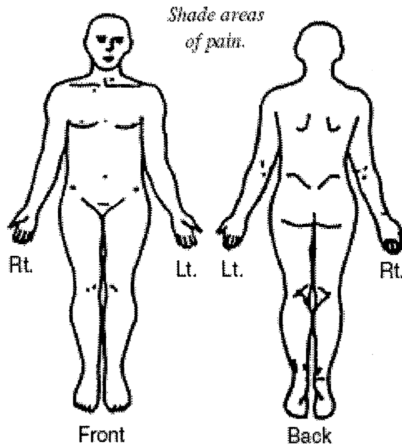
Pain Management Services Pain Assessment- Page 1

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

15. What treatment(s) have you received for this pain in the past? ____________________
____
16. Previous x-ray scans, related to present pain:
MRI:__________ Where:______________
CT Scan:__________ Where:______________
17. Does your pain effect your: (if yes, how?)
 - Sleep: No / Yes, ____________________
 - Work: 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. Allergies to medication:
Name: ______________________________Reaction:
Name: ______________________________Reaction:
Name: ______________Reaction:______________
20. Current PAIN medication: ____________________
____
21. Medications you take regularly: **See Medication List**
22. . Are you taking an antibiotic?
 - Name: ____________________
 - Started: ____________________
 - Reason for taking:____________________
23. Do you take a blood thinner? (circle) NO YES
 - List blood thinner: <u>NAME</u> <u>LAST TAKEN</u>

1. ________ __________
2. ________ __________

24. Is there a chance you are pregnant? (circle) NO YES
25. Use of tobacco products:(circle)NO YES, __ packs/day
26. Use alcohol: (circle) NO YES, ______ drinks/day
27. Have you had a drug /alcohol problem? __________
28. Use illegal drugs: (circle) NO YES, __________

IF NOT LABELED, PLEASE PRINT ACCOUNT NUMBER AND NAME

Pain Management Services Pain Assessment- Page 2

29. Medical History:
    - Implants: ______________________________
    - Past Surgeries: ______________________________
      ____
      ____
      ____
      ____
    - Past Injuries: ______________________________
    - Bleeding problems with surgery? ____________

30. Does your insurance require a referral or pre-authorization to be seen? (circle) NO YES

    If yes, have you obtained this from your primary care Physician? (circle) NO YES

31. PHYSICIAN:
    - Family Physician: ______________________
    - Referring Physician: ______________________

Medical History

Do you have or are you currently being treated for:

(Circle No or Yes: Check if applicable)

Condition			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		
Hepatitis			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
Famly History:				
Spine Disease	No	Yes	Who: ___________	
Drug/Alcohol Abuse	No	Yes	Who: ___________	

Signature: ________________________________

Review of Systems

Presently experiencing any of the following symptoms?

(Circle No or Yes)

Symptom		
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 Infections	No	Yes
Other: ______________		

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