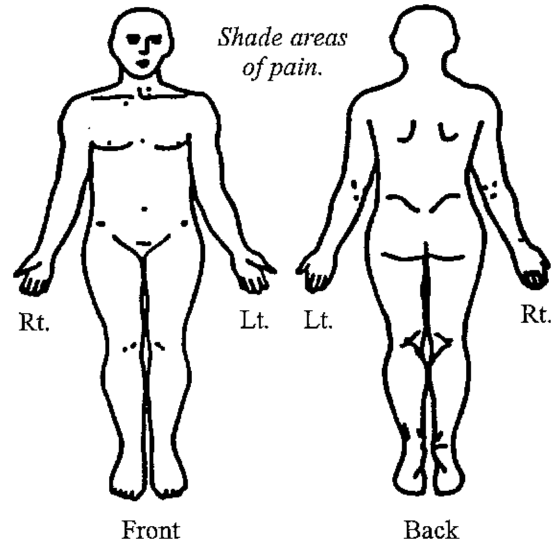
Pain Management Services, Pain Assessment – Page 1

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 ____________________

Medical History

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

Condition		
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 ____________