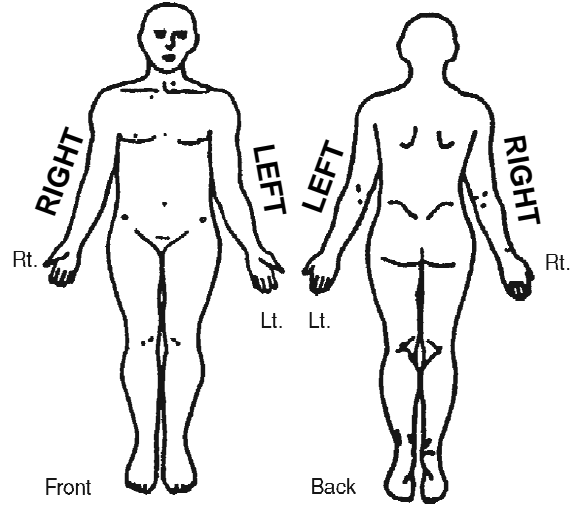


PAIN MANAGEMENT ASSESSMENT

- 1. **WHERE** is your worst pain located? _____
- 2. Does it spread and if so, where? _____
- 3. **WHEN** did your pain begin? _____
- 4. Did an injury cause your pain _____
- 5. Is this a Workman's Compensation claim? No Yes
If yes, who is your case manager? _____
Phone number _____
Have you had a Workman's Compensation claim previously?
 No Yes
- 6. Is your pain continuous or does it come and go? _____
- 7. Describe in your own words what your pain feels like: _____

16. SHADE AREA OF PAIN:



- 8. 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
- 9. At what pain number are you able to function? _____
- 10. What makes the pain **BETTER**? _____

17. What do you do to cope with your pain? _____

- 11. **BEST** position for comfort: (circle) lying standing sitting
- 12. What makes the pain **WORSE**? (eg. Physical activity, weather, stress?) _____

18. Current **PAIN** medications (please bring your entire medication list to the appointment): _____

- 13. **WORST** position for comfort: (circle) lying standing sitting

19. Are you on a blood thinner? (coumadin, plavix, other) _____

- 14. What treatment have you received for this pain in the past _____

20. Is there a chance you are pregnant? _____

- 15. How does your pain affect your:
Sleep _____
Work _____
Appetite _____
Physical Activity _____
Social Activity _____
Relationships _____

21. Working: No Yes Type: _____

Last day worked: _____

Longest term employed in any position? _____

22. Use of tobacco products: No Yes: _____ packs per day

Use of alcohol: No Yes: _____ drinks per day

Last drink: _____

Use of street drugs: No Yes Frequency: _____

Family Physician: _____

Referring Physician: _____

Insurance Company Name: _____

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

Form Completed by: _____

Reviewed by: _____

Date: _____



PAIN MANAGEMENT ASSESSMENT

Past Surgeries: _____

Implants: _____

Past Injuries: _____

Medical History

Have you EVER been treated for any of the following: (circle yes or no)

Anemia	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Back Problems	Yes	No
Blood Disorder	Yes	No
Bleeding with Surgeries/ Procedures	Yes	No
Cancer -Type: _____	Yes	No
<input type="checkbox"/> Chemotherapy (date) _____		
<input type="checkbox"/> Radiation (date) _____		
Cataracts	Yes	No
Circulation Problems	Yes	No
Diabetes	Yes	No
Drug/Alcohol Abuse	Yes	No
Glaucoma	Yes	No
Headaches	Yes	No
Heart Disease	Yes	No
Hepatitis / Liver Disease	Yes	No
High Blood Pressure	Yes	No
HIV	Yes	No
Kidney Disease	Yes	No
Lung Disease	Yes	No
Mental/Emotional Illness	Yes	No
Osteoporosis	Yes	No
Seizures	Yes	No
Sleep Apnea	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: _____

Review of Systems

Are you CURRENTLY experiencing any of the following symptoms?
 (Circle yes or no)

New and Return Patients	New Patients Only
<p>Constitutional symptoms:</p> <p>Fever Yes No Chills Yes No Headache Yes No Other _____</p> <p>Neurological:</p> <p>Weakness Yes No Dizziness Yes No Numbness/tingling Yes No Confusion Yes No Memory Loss Yes No Other _____</p> <p>Pulmonary:</p> <p>Wheezing Yes No New productive cough Yes No Shortness of breath Yes No Chest pleurisy Yes No Other _____</p> <p>Integumentary:</p> <p>Skin rash Yes No Boils Yes No Other _____</p> <p>Genitourinary:</p> <p>Painful urination Yes No Genital ulcers Yes No Blood in urine Yes No Sexual Dysfunction Yes No Other _____</p> <p>Musculoskeletal:</p> <p>Joint pain Yes No Swelling Yes No Neck pain Yes No Joint stiffness Yes No Back pain Yes No Other _____</p> <p>Psychological:</p> <p>Moderate/ Severe depression Yes No Suicidal thoughts Yes No Sleep disturbance Yes No Anxiety/Worry/Panic Yes No Anger/Agitation Yes No Other _____</p>	<p>Ears/Nose/Throat/Mouth:</p> <p>Ear Pain Yes No Decreased hearing Yes No Mouth Sores Yes No Other _____</p> <p>Eyes:</p> <p>Blurred vision Yes No Double vision Yes No Pain or redness Yes No Dryness Yes No Other _____</p> <p>Allergic:</p> <p>Hay fever Yes No Other _____</p> <p>Endocrine:</p> <p>Excessive thirst Yes No Tired/sluggish Yes No</p> <p>Hematological:</p> <p>Swollen glands Yes No Easy bruising Yes No Unusual bleeding Yes No Rectal bleeding Yes No Frequent infections Yes No Other _____</p> <p>Cardiovascular:</p> <p>Chest pains Yes No High blood pressure Yes No Heart failure Yes No Fluid retention Yes No Other _____</p> <p>Gastrointestinal:</p> <p>Abdominal pain Yes No Nausea/vomiting Yes No Indigestion/heartburn Yes No Other _____</p>

NEW PROBLEMS: Patient Denies

Form Completed by: _____

Reviewed by: _____

Date: _____

