Mercy Medical Center

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: __________

____

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**? ______________________

____

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

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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 ______________________

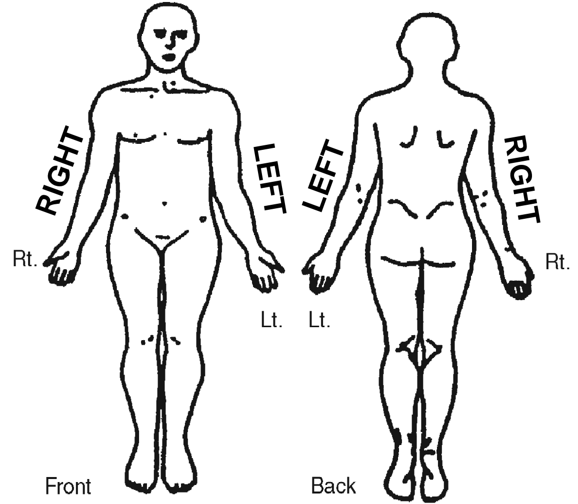
    Relationships ______________________

Form Completed by: ______________________

Reviewed by: ______________________

Date: ______________________

16. SHADE AREA OF PAIN:



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

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

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____

19. Are you on a blood thinner? (coumadin, plavix, other) ________
20. Is there a chance you are pregnant? ______________________
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

408–50017 07/11

ASSE PAI

D1–10 ASSESSMENT – PAIN MANAGEMENT

PAIN MANAGEMENT ASSESSMENT

Past Surgeries: ______________________________

____

Implants: ______________________________

Past Injuries: ______________________________

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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
☐ Chemotherapy (date)________________		
☐ 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: ______________________________		

Form Completed by: ______________________________

Reviewed by: ______________________________

Date: ____________________

Review of Systems

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

New and Return Patients

Constitutional symptoms:		
Fever	Yes	No
Chills	Yes	No
Headache	Yes	No
Other ____________________		
Neurological:		
Weakness	Yes	No
Dizziness	Yes	No
Numbness/tingling	Yes	No
Confusion	Yes	No
Memory Loss	Yes	No
Other ____________________		
Pulmonary:		
Wheezing	Yes	No
New productive cough	Yes	No
Shortness of breath	Yes	No
Chest pleurisy	Yes	No
Other ____________________		
Integumentary:		
Skin rash	Yes	No
Boils	Yes	No
Other ____________________		
Genitourinary:		
Painful urination	Yes	No
Genital ulcers	Yes	No
Blood in urine	Yes	No
Sexual Dysfunction	Yes	No
Other ____________________		
Musculoskeletal:		
Joint pain	Yes	No
Swelling	Yes	No
Neck pain	Yes	No
Joint stiffness	Yes	No
Back pain	Yes	No
Other ____________________		
Psychological:		
Moderate/ Severe depression	Yes	No
Suicidal thoughts	Yes	No
Sleep disturbance	Yes	No
Anxiety/Worry/Panic	Yes	No
Anger/Agitation	Yes	No
Other ____________________		

New Patients Only

Ears/Nose/Throat/Mouth:		
Ear Pain	Yes	No
Decreased hearing	Yes	No
Mouth Sores	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 ____________________		
Endocrine:		
Excessive thirst	Yes	No
Tired/sluggish	Yes	No
Hematological:		
Swollen glands	Yes	No
Easy bruising	Yes	No
Unusual bleeding	Yes	No
Rectal bleeding	Yes	No
Frequent infections	Yes	No
Other ____________________		
Cardiovascular:		
Chest pains	Yes	No
High blood pressure	Yes	No
Heart failure	Yes	No
Fluid retention	Yes	No
Other ____________________		
Gastrointestinal:		
Abdominal pain	Yes	No
Nausea/vomiting	Yes	No
Indigestion/heartburn	Yes	No
Other ____________________		

NEW PROBLEMS: ☐ Patient Denies

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