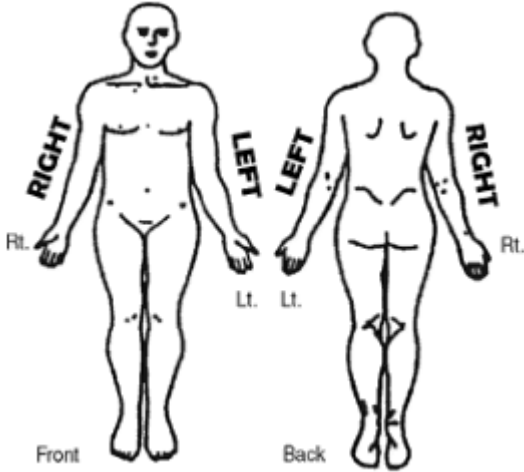


PAIN MANAGEMENT ASSESSMENT

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

SHADE AREAS OF PAIN



- When did your pain begin? _____
- When did it get worse? _____
- Is your pain related to an injury or accident? _____
- Is your pain continuous or does it come and go? _____
- Describe in your own words what your pain feels like: _____
- Rate your pain today: _____ (0-10)
- Indicate the range of your pain:
 0 1 2 3 4 5 6 7 8 9 10
 No Pain Worst Pain Imaginable
- Best position for comfort:
 (circle) lying standing sitting
- Most painful position:
 (circle) lying standing sitting
- What makes your pain better? _____
- What makes your pain worse? _____
- Current pain medications: _____

- What **treatment(s) / surgeries** have you received for this pain in the past? _____
- Previous x-ray scans related to present pain:
 MRI / CT / XRAY: _____
 Where: _____
- Does your pain effect your: (if yes, how ?)
 - Sleep: No / Yes, _____
 - Appetite: No / Yes, _____
 - Physical Activity: No / Yes, _____
 - Social Activity: No / Yes, _____
- 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: _____
- 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? _____
- Have you had a **new** MRI / CT / XRAY since your last visit? _____
- New** tests since last seen? _____
- List any changes in medications or medical history since **last** visit: _____
- As a result of your previous treatment, has there been improvement in your quality of life? _____
- If applicable, have you been able to return to work? _____



DOC TYPE: ASSESSMENT

Place patient label here or Print:

Patient Name: _____

DOB: _____ CSN# : _____

Mercy Medical Center

PAIN MANAGEMENT ASSESSMENT

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)

	No	Yes	New	History Of
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spine Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 symptoms:			Ears / Nose / Throat / Mouth:		
Fever	No	Yes	Ear Pain	No	Yes
Chills	No	Yes	Decreased	No	Yes
Headache	No	Yes	Hearing	No	Yes
Other _____			Other _____		
Eyes:			Cardiovascular:		
Blurred Vision	No	Yes	Chest Pain	No	Yes
Double Vision	No	Yes	Fluid Retention	No	Yes
Other _____			Other _____		
Pulmonary:			Gastrointestinal:		
Wheezing	No	Yes	Abdominal Pain	No	Yes
Frequent Cough	No	Yes	Nausea / Vomiting	No	Yes
Shortness of Breath	No	Yes	Indigestion / Heartburn	No	Yes
Other _____			Other _____		
Neurological:			Musculoskeletal:		
Weakness	No	Yes	Joint Pain	No	Yes
Dizziness	No	Yes	Swelling	No	Yes
Numbness / Tingling	No	Yes	Neck Pain	No	Yes
Other _____			Joint Stiffness	No	Yes
Psychological:			Other _____		
Severe Depression	No	Yes	Hematological:		
Suicidal Thoughts	No	Yes	Swollen Glands	No	Yes
Confusion	No	Yes	Bruising	No	Yes
Sleep Disturbance	No	Yes	Unusual Bleeding	No	Yes
Other _____			Rectal Bleeding	No	Yes
Genitourinary:			Frequent Infection	No	Yes
Painful Urination	No	Yes	Other _____		
Blood in Urine	No	Yes			
Other _____					

Patient Signature: _____

15888

05/21



ASSE PAI



DOC TYPE: ASSESSMENT

Place patient label here or Print:

Patient Name: _____

DOB: _____ CSN# : _____