PAIN EVALUATION FORM

Date: _____

Name: _____ _____ _____
Last First Initial

Date of Birth: ____/____/____ Social Security # ____-____-____

Age: _____ Dominant Hand: Right _____ Left _____

Height: _____ Weight: _____

Complete Name of Referring Doctor:

_____ _____
Last First

Complete Address: _____

_____

Phone _____ Fax _____

Current Doctors

List the names and addresses of all health care practitioners you are currently seeing:

NAME	SPECIALTY	PHONE
ADDRESS	CITY	STATE ZIP
NAME	SPECIALTY	PHONE
ADDRESS	CITY	STATE ZIP
NAME	SPECIALTY	PHONE
ADDRESS	CITY	STATE ZIP

Describe in detail the pain problem you would like help with:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How often does your pain occur?

- ☐ Continuous
- ☐ Several times a day
- ☐ Once per day
- ☐ Once per week
- ☐ Less than once per week
- ☐ Never

What is the duration of your pain? (Length it lasts)

- ☐ None
- ☐ Seconds
- ☐ Minutes
- ☐ Hours
- ☐ Days
- ☐ Weeks
- ☐ Continuous

.Circle a number below to indicate your **highest** pain intensity over the past week:

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Most Intense

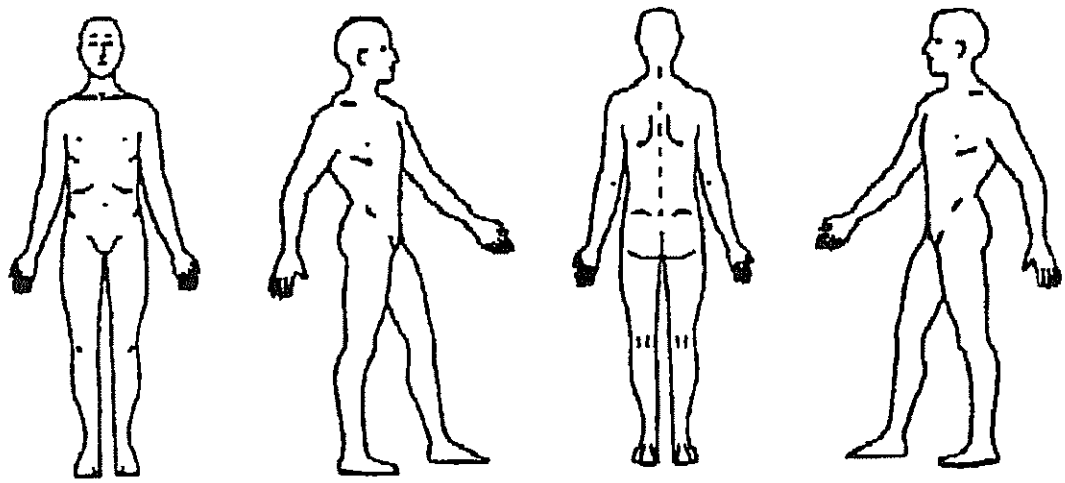
.Circle the number below to indicate your **lowest** pain intensity over the past week:

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Most Intense

.Circle a number below to indicate your **usual** pain intensity over the past week:

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Most Intense

Please indicate where you have pain: **(PAIN DIAGRAM)**



What makes the pain ***WORSE*****?** Be specific. _____

_____

What makes the pain ***BETTER*****?** Be specific. _____

_____

Effects of Pain

Circle the number to indicate how much your pain has interfered with your activities this **past week.**

0	1	2	3	4	5	6	7	8	9	10
No Interference		Mild			Moderate		Severe			Complete Interference

Circle the number to indicate how distressed or bothered you have been in the **past week** about the pain.

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate		Severe		Most Severe	

Current Medications

List **ALL** medicines you are currently taking for medical and pain problems (including prescribed, over counter, herbs, vitamins): (Write on the back of this sheet if necessary)

Name	Pill Strength	# of Times Taken Per Day	Prescribing Dr.

History of Your Pain

When did your pain start? _____

When did your pain become a problem? _____

How many times have you gone to the emergency room for pain in the past year?_____

What event or events led to your present pain:

- ☐ Accident
- ☐ Cancer
- ☐ Other injury
- ☐ Other disease
- ☐ No obvious cause
- ☐ Following an operation
- ☐ Other _____

What do YOU think is the cause of your pain?

Previous Doctors

Have you ever been evaluated at a pain center? Yes _____ No _____

If Yes list the Doctors Name _____

Facility Name and Address _____

List ALL doctors you have seen for your pain problem (continue on the back of this page if needed).

Date	Name	Specialty	Address/Phone/Fax

X-rays and Tests

Please list, in chronological order, all tests and x-rays performed to evaluate your pain:

Date	Test	Results

Previous Treatments

Indicate which of the following treatments you have tried for you pain problem:

- ☐ Antidepressants
- ☐ Narcotics
- ☐ Nerve blocks
- ☐ Traction
- ☐ Acupuncture
- ☐ Chiropractor
- ☐ Massage
- ☐ Physical therapy
- ☐ Psychotherapy

- ❑ Biofeedback
- ❑ Relaxation training
- ❑ Hypnosis
- ❑ Homeopathy
- ❑ TENS
- ❑ Exercise program
- ❑ Other (List) _____

Previous Medications

List all previous pain medications you have taken for pain:

Name of Medicine	Dose	Dates of Use	Helpful?	Reason for stopping
			YES NO	
			YES NO	
			YES NO	
			YES NO	

Allergies

List all allergies to medications and the reaction you had to any medicine:

Medicine	Reaction	Medicine	Reaction

PAST MEDICAL HISTORY

List any past medical problems such as: (check)

- ☐High blood pressure
- ☐Diabetes
- ☐Chest pain
- ☐Heart attack
- ☐Blood clots
- ☐Asthma/emphysema
- ☐Stroke
- ☐Other _____

Surgeries

List any operations, hospitalizations, or injuries you have ever had.

Year	Type of Surgery	Hospital	Doctor

REVIEW OF SYSTEMS

Please check if you have or had any of the following:

A. General
- ☐ Weight loss
- ☐ Poor appetite
- ☐ Severe fatigue/low energy

B. Skin
- ☐ Rash
- ☐ Nail changes
- ☐ Bumps/nodules
- ☐ Herpes

C. Head and Neck
- ☐ Headaches
- ☐ Visual changes
- ☐ Mouth problems
- ☐ Thyroid problems
- ☐ Neck pain
- ☐ Difficulty swallowing

D. Hematological
- ☐ Anemia
- ☐ Easy bruising
- ☐ Bleeding disorder
- ☐ Taking blood thinners

E. Cardiopulmonary
- ☐ Shortness of breath
- ☐ Cough
- ☐ Exercise limitations
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Heart murmurs
- ☐ High or low blood pressure
- ☐ Circulation problems
- ☐ Ankle swelling

F. Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Constipation or diarrhea
- ☐ History of ulcers or heartburn

G. Genitourinary
- ☐ Pregnant
- ☐ Frequent or hesitant urination
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Sexual dysfunction

REVIEW OF SYSTEMS (CONT'D)

H. Musculoskeletal
- ☐ Arthritis Type: _____
- ☐ Osteoporosis
- ☐ Muscle pain
- ☐ Muscle wasting
- ☐ Fractures

I. Neurologic
- ☐ Numbness
- ☐ Weakness
- ☐ Falling or loss of balance
- ☐ Stroke
- ☐ Seizures
- ☐ Memory loss

J. Infections
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ Hepatitis
- ☐ HIV/AIDS

SOCIAL HISTORY

A. Relationship Status
- ☐ Single
- ☐ Significant other _____Male _____Female
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

B. Highest level of education you have completed:
- ☐ Less than high school
- ☐ High school
- ☐ Vocational
- ☐ College
- ☐ Graduate
- ☐ Other_____

C. With whom do you live? Name:_____Relationship:_____

D. What is your current employment status?
- ☐ Employed full time
- ☐ Employed part time
- ☐ Self employed
- ☐ Homemaker
- ☐ Retired
- ☐ Unemployed due to pain

- ☐ Unemployed due to other reasons:_____

How long have you been unemployed or retired?_____
Are you on disability? Yes_____ No_____
Date disability started: _____
Reason for disability: _____

E. Number of hours worked per week? _____Are you happy with your job?_____
Your current or most recent occupation_____

Habits

Smoking: Yes___No___# of Packs/Day_____# of Years Smoked_____
. Alcohol Use None__Occasional____Daily__How much per week?_____
Recreational Drugs: Current Use? Yes___ No___
Is anyone concerned about your use of alcohol, drugs, or medications? Yes/No

Financial Information

A. What are your present sources of financial support?
- ☐ Personal earnings
- ☐ Disability
- ☐ Workman's compensation
- ☐ Spouse's earnings
- ☐ Pension/retirement
- ☐ Insurance
- ☐ Other
- ☐ None

B. Are you hoping to receive other income or compensation? If so, please indicate:
- ☐ Disability payment
- ☐ Legal settlement
- ☐ Workman's compensation
- ☐ Other (Describe)_____
- ☐ C. Do you have any legal action pending related to this pain or any other health problem?

C. Do you have any legal action pending related to this pain or any other health problem? Yes___ No___

Family History

Member	Deceased or Living	Age	Medical Problems
1. Father			
2. Mother			
3. Siblings			
4. Spouse			