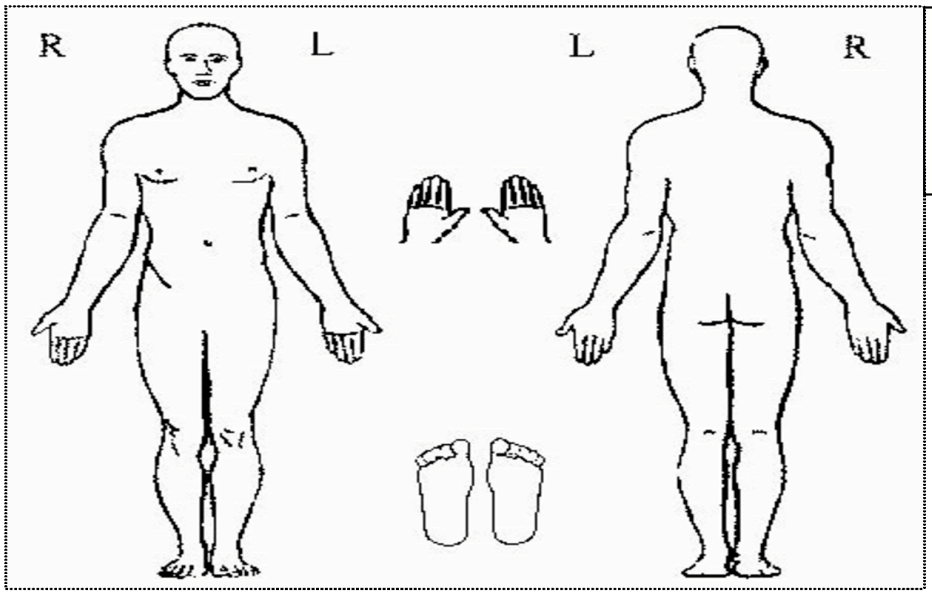
# *Pain Clinic Initial Evaluation Patient Form*

Name _____ Age _____ Appointment Date_____

Referring Physician _____ Primary Care Physician _____

*Please fill out the following papers to help us learn more about your condition so we can better assist your needs.*

**1) Where is your worst pain located?** _____




Shade the areas where you are having pain on this diagram

**2) When did your pain begin?** _____

**3) What was the injury or cause of the pain?** _____

**4) Circle any of these describe your pain**: Dull Sharp Burning Shooting Aching Pinpoint Other _____

**5) Is your pain associated with any of the following?**

| | | | |
|---|---|---|---|
| Weakness | ☐Yes ☐ No | Skin color or temperature changes | ☐Yes ☐ No |
| Numbness | ☐Yes ☐ No | Bladder or bowel problems | ☐Yes ☐ No |
| Tingling | ☐Yes ☐ No | Skin sensitive to light touch | ☐Yes ☐ No |
| | | Skin sensitive to heat or cold | ☐Yes ☐ No |

**6) Please place an X on the line below to answer each of the following:**

**What is the level of your pain?**

No pain — Worst pain

**How does the pain affect your level of activity?**

I can do anything I want — I can't do anything at all

**Does pain affect your sleep?**

No problem sleeping — I can't sleep at all

**6) When is your pain the best?** AM Afternoon Night
**When is your pain the worst?** AM Afternoon Night

**7) Circle which factors make your pain better**
Sitting Standing Walking Bending Lying down Driving Coughing/sneezing

**8) Circle which factors make your pain worse**
Sitting Standing Walking Bending Lying down Driving Coughing/sneezing

**9) List other Doctors who have treated you for this problem:**

**10) List tests that have been performed (i.e. MRI, CAT scan, myelogram, etc):**

**11) Circle any treatments you have tried before to treat your pain:**

Physical Therapy Chiropractor Massage Therapy Ice Heat TENS Unit Other

**12) Have you previously had any injections/epidurals for your pain?**

**13) Have you been treated by other pain specialists/clinics in the past?**

**14) List all pain medications you have tried in the past that did not relieve your pain or caused bad side effects:**

**15) Please answer the following questions if your problem is the result of an injury:**

Mark only one:

- ☐ I never had back/neck problems before this injury.
- ☐ I had back/neck problems before, and this injury made the problem worse.

Mark all that apply:

- ☐ This injury occurred at work.
- ☐ My injury did not occur at work.
- ☐ I have filed a claim through worker's compensation
- ☐ I have pursued or will pursue legal action as result of this injury.

## Current Medications

List all your medications, dosages and how often you take them every day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

## Drug Allergies

A _____

B _____

C _____

D _____

E _____

Are you taking any blood thinners? ☐ Yes ☐ No

## Past Medical History

Do you have any of the following conditions?

| | | | | | |
|---|---|---|---|---|---|
| Any contagious disease | ☐Yes | ☐ No | Thyroid disease | ☐Yes | ☐ No |
| High blood pressure | ☐Yes | ☐ No | Bleeding problems | ☐Yes | ☐ No |
| Diabetes | ☐Yes | ☐ No | Suppressed immune system | ☐Yes | ☐ No |
| Heart disease or chest pain | ☐Yes | ☐ No | Cancer | ☐Yes | ☐ No |
| Lung disease (asthma/COPD) | ☐Yes | ☐ No | Stomach ulcers | ☐Yes | ☐ No |
| Kidney disease | ☐Yes | ☐ No | Seizure Disorder | ☐Yes | ☐ No |
| Liver disease | ☐Yes | ☐ No | Rheumatiod Arthritis | ☐Yes | ☐ No |

**If any of the above yes, or if you have any other medical problems, please explain:**

_____

_____

## Previous Surgeries

1. _____
2. _____
3. _____
4. _____
5. _____

## Family History

(Your blood relatives)

1. Cancer
2. Chronic Pain
3. Other

## Social History

- Marital Status: Single Married Divorced Legally Separated Widowed
- Children living at home? ☐Yes ☐ No Do you live alone? ☐Yes ☐ No
- Occupation: ____ Currently: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled

I have missed significant time from work because of my pain ☐Yes ☐ No
Because of my pain, I am working part-time ☐ or limited duty ☐.
The last date I worked was ___/___/___ I have been on disability since ___/___/___

- Tobacco Do you smoke? ☐Yes ☐ No
  If yes, for how many years? _____ How many packs per day? _____
- Alcohol Do you drink alcohol? ☐Yes ☐ No If so, how often? _____
  Do you have any history of alcohol or drug addiction? ☐Yes ☐ No

## Review of Systems

In the past few months have you experienced any of the following symptoms or complaints?

| | | | | | |
|---|---|---|---|---|---|
| Fever/Chills | ☐Yes | ☐ No | Difficulty controlling bowels | ☐Yes | ☐ No |
| Night sweats | ☐Yes | ☐ No | Difficulty controlling urine | ☐Yes | ☐ No |
| Chest pain | ☐Yes | ☐ No | Any new rashes or blisters | ☐Yes | ☐ No |
| Difficulty breathing | ☐Yes | ☐ No | Red swollen joints | ☐Yes | ☐ No |
| Persistent cough | ☐Yes | ☐ No | Numbness | ☐Yes | ☐ No |
| Constipation | ☐Yes | ☐ No | Weakness | ☐Yes | ☐ No |
| Diarrhea | ☐Yes | ☐ No | Depression | ☐Yes | ☐ No |
| Nausea | ☐Yes | ☐ No | Anxiety | ☐Yes | ☐ No |
| Sudden weight gain | ☐Yes | ☐ No | Recurrent infections | ☐Yes | ☐ No |
| Sudden weight loss | ☐Yes | ☐ No | Bleeding Problems | ☐Yes | ☐ No |

**Scribed by:** _____ **All above reviewed by:** _____**M.D.**