Comprehensive Pain Centers

PATIENT NAME_____DATE_____DATE OF BIRTH_____

PAIN EVALUATION

CHIEF COMPLAINT: _____

HISTORY OF PRESENT ILLNESS:

Work injury MVA No known cause DATE:_____

How long have you had the pain? _____

What caused your pain to begin? _____

Please describe *"primary pain" you would* like to be treated for below.				
LOCATION:	head	chest abdomen	pelvic & groin upper back	lower back
	upper extremity (L R)		shoulder arm hand	
	lower extremity (L R)		hip leg foot	
QUALITY:	ache burning cramp shooting stabbing throbbing			
	dull sharp superficial deep continuous intermittent			
RADIATING TO:	head neck chest abdomen pelvis/groin upper back lower back			
	upper extremity (L R) shoulder arm hand			
	lower extremity (L R) hip leg foot			
PAIN SCALE:	present _____ best _____ worst _____ (scale 1-10, please describe your pain on scale where I is no pain 10 is the most pain you can ever have)			
INFLUENCING FACTORS: Pain relieved by:_____				
Exacerbated by:_____				
Please describe *"secondary pain" you would* like to be treated for below.				
LOCATION:	head	chest abdomen	pelvic & groin upper back	lower back
	upper extremity (L R)		shoulder arm hand	
	lower extremity (L R)		hip leg foot	
QUALITY:	ache burning cramp shooting stabbing throbbing			
	dull sharp superficial deep continuous intermittent			
RADIATING TO:	head neck chest abdomen pelvis/groin upper back lower back			
	upper extremity (L R) shoulder arm hand			
	lower extremity (L R) hip leg foot			
PAIN SCALE:	present _____ best _____ worst _____ (scale 1-10, please describe your pain on scale where I is no pain 10 is the most pain you can ever have)			
INFLUENCING FACTORS: Pain relieved by:_____				
Exacerbated by:_____				

ARE YOU CURRENTLY WORKING? (If yes, please indicate your position)

_____

ARE YOU CURRENTYLY IN LITIGATION OF HAVE A LAWYER?

_____

PATIENT NAME_____DATE_____DATE OF BIRTH_____

PAIN EVALUATION CONTINUED

RELATED PROBLEMS: Change in sleep pattern:_____
IF FEMALE: Pregnant ☐ Planning to Become ☐ Not Pregnant ☐
WEIGHT: Gain ☐ Loss ☐ Since_____ Weight Change _____ lbs.
SEXUAL ACTIVITY: No Change ☐ Decreased Libido ☐
MENTAL STATUS: Anxious ☐ Confused ☐ Depressed ☐ Since_____

PREVIOUS TREATMENTS: Medications ☐ Surgeries ☐ Nerve Block ☐ TENS ☐ Physical Therapy ☐
Others: _____
MEDICATIONS: Pain Meds_____
Other Meds (not listed on front sheet) _____
Herbals/Vitamins_____
Allergies _____
PAST MEDICAL HISTORY: Heart Disease ☐ Lung Disease ☐ Diabetes ☐ Stroke ☐ Kidney ☐ Liver ☐
Stomach Ulcers ☐ Explain:_____
_____
FAMILY HISTORY: Mother_____
Father_____
Brothers/Sisters_____
SURGICAL HISTORY: List Procedure & Dates _____
_____
SOCIAL HISTORY: Smoke ☐ How much_____ Quit/How long ago_____ Never ☐
Alcohol Intake:_____ Drug Abuse:_____
Radiology Studies: (MRI, BONE SCAN, X-RAYS, CT SCANS) Results: _____