PAIN TREATMENT CENTER

Name_____ Date_____ Age_____
Occupation_____ Referring Doctor_____

Have you ever been a patient of a Pain Clinic or Center? Yes_____ No_____
If yes where:_____
When did you first notice symptoms of your pain problem?
Date_____ Day of week_____ Time of day_____
What type of activity were you doing? _____
Where were you when the pain began? _____
Is your pain related to an injury? Yes_____ No_____
Type of injury:
____ Work related
____ Vehicle accident
____ Other
Are you planning to sue because of your pain/injury? Yes_____ No_____
Have you already sued because of your pain? Yes_____ No_____
Description of injury
_____
_____
Where was your pain located when it **BEGAN**? _____
Where is your pain located **NOW**? _____
Describe your pain.

___ Aching
___ Burning
___ Numb
___ Sharp
___ Shocking
___ Shooting
___ Squeezing
___ Stabbing
___ Throbbing
___ Tingling

Other: _____
Does your pain move to different areas? Yes___ No___
(If yes) Where does your pain move? _____
Pain is worsened by:

___ Lying
___ Sitting
___ Standing
___ Walking
___ Stairs
___ Bending
___ Changes in Position (Sitting to Standing)

Other: _____
Pain is better with:

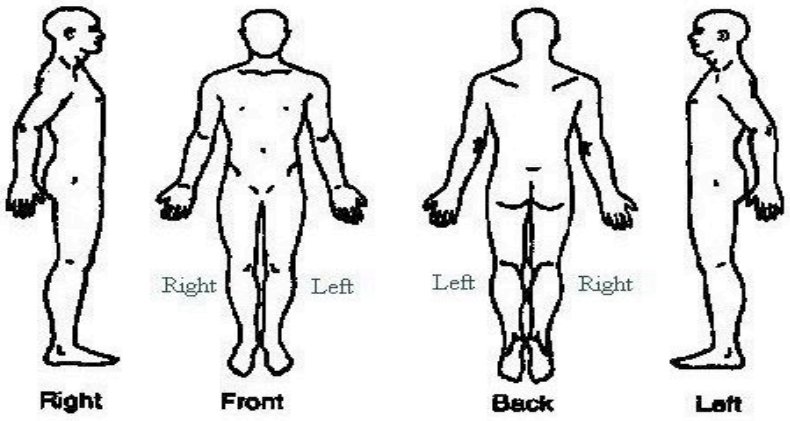
___ Rest
___ Lying
___ Sitting
___ Standing
___ Changes in Position
___ Medication
Other:
_____

Duration of Pain:
___0-3 months
___3-6 months
___6-12 months
___1-2 years
___More than 2 years
Timing of Pain:
___ Constant
___ Intermittent (comes and goes)
___ Worse in Morning
___ Worse in Evening

Check **all that apply:**

___ Abnormal or decreased feeling to touch or temperature
___ Unable to move your arm, leg or another part of your body
___ Loss of coordination
___Change in skin color
___Change in skin temperature
___Hotter
___Colder
If so to any of the above, where: _____

To your right are drawings that will help you describe where your pain is located. Please color or shade in the areas on the drawings that best describe where your pain is now



Below is a line to help you describe the level of your pain. 0 means "no pain" and 10 means "the worst pain you ever had". **CIRCLE** a number to describe your pain TODAY.

Severity of pain:

_____

0 1 2 3 4 5 6 7 8 9 10
None Mild Moderate Severe Very Severe Worst Possible

How often do you have pain:

___Always present/ Always the same level
___Always present but level changes
___Occasional pain – Periods free of pain
___Rarely present (only a few days OR weeks)

Does your pain limit your activities? Yes___ N0___

___I **can** look after myself without causing extra pain
___I can look after myself **but** it causes extra pain
___I **need help** to dress, bathe and do personal care

I can walk:

___ Without pain
___ A mile but with pain
___ ½ mile but with pain
___ ¼ mile but with pain
___Only with crutches, a cane or walker
___I am in bed most of the time

I can stand:

___As long as I want
___But only with pain
___But less than 1 hour without pain
___But less than 30 minutes without pain
___But less than 10 minutes without pain
___Cannot stand at all due to pain

Sleep problems:

___None
___Difficulty falling asleep
___Difficulty staying asleep
___ Restlessness
___ Sleep Apnea

***LIST ANY DRUG ALLERGIES**_____

_____

***Are you ALLERGIC to any LATEX (rubber gloves/plastics) products?**
_____YES _____NO

***Are you currently taking any Blood Thinners?**
_____ASPIRIN
_____COUMADIN
_____PLAVIX
_____AGGRENOX
_____EFFIENT
_____PRADAXA
_____PLETAL
_____OTHER _____ Who prescribes this drug for you?_____

Do you bruise easily? Yes_____ No_____

***DO YOU HAVE A "LIVING WILL" FOR HEALTH CARE? Yes_____ No_____**

Past and Present Medical History

Check the boxes if you **NOW** have or **EVER HAD:**

Cardiovascular
___Angina
___Arrhythmia (Irregular heart beat)
___Chest Pain
___Heart attack
___Heart Murmur
___Mitral Valve Prolapse
___Congestive Heart Failure
___High Blood Pressure
___Stroke

Respiratory
___Sleep Apnea
___COPD
___Chronic cough
___Emphysema/Bronchitis
___Shortness of breath
___Coughing up blood

Musculoskeletal
___Arthritis
___Back pain/stiffness
___Joint pain/stiffness
___Fibromyalgia

Gastrointestinal
___Hepatitus
___Reflux disease
___Stomach ulcers
___Abdominal pain
___Diverticulitis
___Heartburn
___Nausea/vomiting

___Diarrhea

Hematology
__Bleeding problems
__Blood clots
__Anemia
__HIV/AIDS

Endocrinology
__Diabetes
__Thyroid Problems

Neurological
__Dizziness
__Weakness
__Numbness
__**Seizures** (date of last seizure)_____
__Syncope/Fainting
__Loss of coordination
__Loss of balance
__Blackouts

Head/Ears/Eyes/Nose/Throat
___Sinus congestion
___Glaucoma
___Contacts
___Hearing loss
___Ringing in the ears

___Blurred vision
___Glasses
___Sore throat
___Difficulty swallowing
___Hearing aid

Psychological
___Anxiety

___Constipation
___Black Stools
___Bloody stools
___Weight loss
___Appetite change

Genitourinary

___Difficulty urinating
___Urinary Tract Infections
___Inability to control Urination (incontinence)

Cancer

Yes_____ No_____

___Depression
___Suicidal attempt or thoughts
___Frequent feelings of sadness
___Crying spells
___Treatment with antidepressant medications

(If so) Is current medication helpful? Yes____ No____

Have you ever had psychological or Psychiatric treatment? Yes___ No___

Where?_____

Other medical problems_____

Do you have any implants in your body? Pacemaker_____ Heart stents_____
Lens implants (eye)_____ Breast Implants_____ Cervical (neck) Hardware_____
Lumbar (back) Hardware_____ Plates/Pins/Wires/Clips_____
Artificial Joints_____ Other_____

Surgical History

Enter Date, if known, and **check** if you have had:

_____Back surgery
_____Neck surgery
_____Hip surgery
_____Tonsillectomy
_____Appendectomy
_____Hernia Repair
_____Sinus Surgery
_____Stomach surgery
_____Cystoscopy
_____Other _____

_____Gallbladder surgery
_____**Heart** surgery
___Bypass
___Valve replacement
___Heart Stents
_____Brain surgery
_____Hysterectomy
_____C-section
_____Tubal ligation

Have you ever had problems with anesthesia or sedation? Yes_____No_____
Describe: _____

Has anyone in your family ever had problems with anesthesia or sedation? Yes_____ No_____
Describe _____

Previous treatments/tests

Have you had any of the following treatments for your pain?

	Helped a lot	Helped a little	Did Not help	Made worse	
_____Hypnosis	□	□	□	□	
_____Biofeedback	□	□	□	□	
_____TENS unit	□	□	□	□	
_____Acupuncture	□	□	□	□	
_____Chiropractor	□	□	□	□	
_____Physical Therapy	□	□	□	□	
_____Traction therapy	□	□	□	□	
_____Massage therapy	□	□	□	□	
_____Lumbar Spine surgery	□	□	□	□	
_____Cervical Spine Surgery	□	□	□	□	
_____Medication	□	□	□	□	

Related to your **current** pain condition, have you had:

___X-rays
___CT scans
___MRI
___Bone scan
___Blood test
___Nerve test
___Other
Where: _____
When: _____

Occupational/Family/Social History

Are any of your family members receiving disability: Yes___No___
Has anyone in your family ever had a problem like yours? Yes___No__

Marital status:

___Single ___ Married ___ Widowed ___ Separated ___Divorced

Total number of children? _____

Number 2 yrs old or under___

Number 3 to 6___

Number of teenagers___

Number of adult children___

Has your pain stopped you from working? Yes_____ No_____

(If yes) ___ Unable to do any work

___Can work limited amounts (short periods/light duty)

Describe the type of work that you do:

____None

____Heavy lifting

____Constant strain

____Standing most of the time

____Sitting most of the time

____Frequent bending/turning

Do you smoke? Yes___No___

____1/2 pack a day ___1pack a day ___2 packs a day ___more than 2 packs a day

Do you drink alcohol? Yes___ No___

____Seldom (___ 1 or 2 per week) (___3 or more times per week)

____Every day (___1 per day) (___ 2-3 per day) (___More than 3 per day)

Have you ever used *un*prescribed drugs? Yes_____No_____

____ Marijuana

____Cocaine

____Amphetamines

____Opioids (narcotics)

Have you been treated for Drug or Alcohol abuse or addiction? Yes_____ No_____

If yes: When:_____ Where:_____

Medication History

Pharmacy_____ **location**_____

Current medications:

Drug	**Amount/Dosage**	**Times each day**	**Prescribed by Dr:**

Patient's signature_____ Date_____

RN signature_____ Date_____

Physician signature_____ Date_____