Pain Diagnostics & Interventional Care
COMPASSIONATE CARE • RESEARCH DRIVEN • EVIDENCE-BASED

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INITIAL PAIN ASSESSMENT FORM

Patient Name: _____ Date of Birth: _____ Age: _____

Gender: □ Male □Female Social Security Number_____
Address: _____ Home Phone:_____
_____ Alternative Phone:_____

Email address:_____

Receive monthly newsletter: □ Yes □ No

Person to contact in case of an emergency:_____
Relationship: _____ Phone:_____

SOCIAL HISTORY:

Marital Status: □ Single □ Married □ Separated □ Divorce □ Widow(er)
Do you feel free from apparent physical or emotional abuse in your home? □ YES □ NO

Type	**Present Use	Amount		**Past Use	Amount
Alcohol					
Cigarettes					
Cigars					
Chew/Snuff					
Marijuana					
Illegal Drugs					

WORK:

Occupation: _____

Status:
□ Working FT □ Same Duties □ Reduced Duties
□ Working PT □ Same Duties □ Reduced Duties
□ Not working due to pain
□ Not working due to other non-pain related reasons
□ Unemployed □ Retired □ Homemaker □ Student

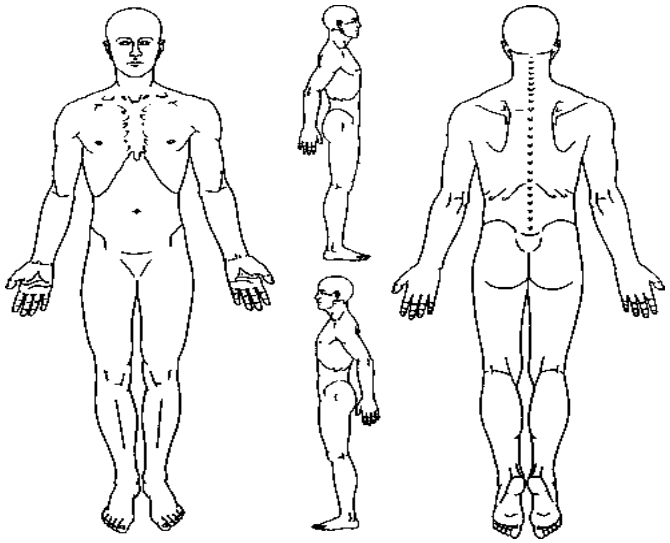
KNOWLEDGE ASSESSMENT:

Your Primary Language: _____ Secondary Language:_____

Current living arrangements (check all that apply):
□ House □ Apartment □ Assisted Living □ Personal Care Home/Nursing Home
□ Lives Alone □ Lives with relative/friend: _____ □ Stairs

PAIN DIAGRAM:

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



A =ACHES

P =PINS AND NEEDLES

B =BURNING

S =STABBING

N =NUMBNESS

O =OTHER

HISTORY OF PRESENT ILLNESS

What is the problem you are being seen for today? _____

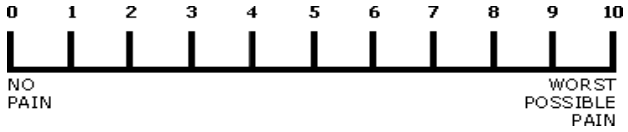
Location: _____

Where is your PRIMARY pain? (50% or more of your pain) _____

Please list the amount of time that you have been suffering from this condition: _____

RATING OF PAIN:

Rate your pain level TODAY on a 0-10 Scale? (O no pain, 10 worst imaginable)



NUTRITIONAL SCREENING TOOL:

Height: _____ Weight: _____ Current Diet: _____

How do you rate your appetite? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

FAMILY HISTORY: **Has anyone in your family ever had:**

Medical Condition	Father	Mother
Cancer		
Diabetes		
Heart Problems		
Circulatory Problems		
High Blood Pressure		
Stroke		
Other		

PERSONAL HEALTH HISTORY:

Check each of the health conditions you have now or have had in the past. Please enter the approximate date of onset next to each item marked. Items not checked are considered not to be applicable to you.

Cardiovascular
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Pacemaker/ Defibrillator Implant
- ☐ Heart valve disease/surgery
- ☐ Irregular heart beat
- ☐ Heart Failure
- ☐ Peripheral vascular disease
- ☐ Aneurysm
- ☐ Previous bypass/stent
- ☐ Other:_____

Pulmonary
- ☐ Asthma
- ☐ COPD
- ☐ Lung Cancer
- ☐ Pulmonary hypertension
- ☐ Sleep apnea
- ☐ Tuberculosis
- ☐ Other:____

Neurological
- ☐ Stroke
- ☐ TIA/ "Mini Stroke"
- ☐ Seizure
- ☐ Headaches
- ☐ Tremor
- ☐ Weakness
- ☐ Multiple sclerosis
- ☐ Spinal cord injury
- ☐ Other:_____

Skin
- ☐ Change in mole
- ☐ Rash
- ☐ Open sore
- ☐ Other:_____

Genintourinal
- ☐ Prostate cancer
- ☐ Sexually transmitted disease
- ☐ Kidney disease/dialysis
- ☐ Frequent urination
- ☐ Loss of bladder control
- ☐ Other:_____

Endocrine
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Diabetes, diet controlled
- ☐ Diabetes, on medication
- ☐ Diabetes, on insulin
- ☐ Other: _____

Psychosocial
- ☐ Depression/Mania
- ☐ Anxiety
- ☐ Suicidal thoughts/attempts
- ☐ Seeing a psychiatrist
- ☐ Previous overdose
- ☐ Other:_____

Hematology/Lymph
- ☐ Anemia
- ☐ Abnormal bleeding
- ☐ Prior blood transfusion
- ☐ Swelling in groin/armpit
- ☐ Other:_____

Head/Neck
- ☐ Eye problems
- ☐ Congestion
- ☐ Nosebleeds
- ☐ Sore throat/Hoarseness
- ☐ Other:_____

Gastrointestinal
- ☐ Colitis
- ☐ Pancreatitis
- ☐ Irritable bowel syndrome
- ☐ Inflammatory bowel syndrome
- ☐ Reflux (GERD)/indigestion
- ☐ Ulcer
- ☐ Liver disease
- ☐ Change in appetite
- ☐ Difficulty swallowing
- ☐ Black/bloody stools
- ☐ Loss of bowel control
- ☐ Other:_____

Musculoskeletal
- ☐ Degenerative arthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Frequent Falls
- ☐ Date of last fall:
- ☐ Joint surgery
- ☐ Fibromyalgia
- ☐ Use of cane/walker
- ☐ Work injury
- ☐ Other: _____
- ☐ Females > age 60: Date of last bone density scan: _____

Other
- ☐ HIV/AIDS
- ☐ Transplant surgery
- ☐ Recurrent infections
- ☐ Cancer_____
- ☐ Other:____

Surgical History:

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

Do you have a Living Will or designated Durable Power of Attorney to help with medical decision-making if you are unable to do so? Yes_ No____
Name of Responsible Person/Relationship to you: _____
Their phone Number: _____Location of Document: _____

Patient Authorization Form

Name of Physician who referred you to Pain Diagnostics and Interventional Care:

Name: _____Phone: _____

Name of Your Primary Care Physician:

Name: _____Phone: _____

Name of any Other Physicians whom you see regarding your current health or pain treatment (PLEASE INCLUDE NAMES OF ANY PHYSICAL THERAPY OR CHIROPRACTORS USED):

Name: _____Phone: _____

Name: _____Phone: _____

Name of Your Pharmacy:

Name/Location: _____Phone: _____

Consent for Phone Contact

In an effort to give you the best possible patient care, it is often necessary to leave a message at your home regarding test results or more often, an upcoming appointment. Please read the following and check all that apply.

- ☐ I prefer all discussions and/or confirmation of appointments be given only to me. If I am unavailable you may leave a message for me to call you back.
- ☐ You may leave test results or confirm appointments with *any* member of my family.
- ☐ You may leave test results, confirm appointments and discuss my care with a specific person(s):

  _____
- ☐ You may leave test results, confirm appointments, and leave messages on my voice mail.

_____ _____ _____
Signature of Patient Date Time