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

● Phone: 412-221-7640 ● Website: http://DavidProvenzanoMD.com ● Fax: 412-490-9850

301 Ohio River Boulevard
Edgeworth Medical Commons, Suite 203
Sewickley, PA 15143

INITIAL PAIN ASSESSMENT FORM

Patient Information

Name: _____

DOB: ____ / ____ / _____

Home Phone: _____

Cell Phone: _____

Advanced Care Planning

Living Will / DPOA? ☐ Yes ☐ No

If yes, Contact: _____

Phone: _____

Relationship: _____

Pharmacy: _____ **Location:** _____

Social History

- Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

History of Pain

- Primary Problem (main source of pain – 50% or more):

  ☐ Head/Neck ☐ Back ☐ Shoulder ☐ Arm ☐ Hip ☐ Leg ☐ Knee ☐ Other: _____

- Pain Level at Its Worst (0 = no pain, 10 = worst pain imaginable): 0 1 2 3 4 5 6 7 8 9 10

Nutritional Screening

- Height: ___ ft. ____in.
- Weight: _____lbs.

Substance	*Present Use* (Y/N)	Amount	*Past Use* (Y/N)	Amount
Alcohol	☐ Yes ☐ No	_____	☐ Yes ☐ No	_____
Cigarettes	☐ Yes ☐ No	_____	☐ Yes ☐ No	_____
Cigars	☐ Yes ☐ No	_____	☐ Yes ☐ No	_____
Chew/Snuff	☐ Yes ☐ No	_____	☐ Yes ☐ No	_____
Marijuana	☐ Yes ☐ No	_____	☐ Yes ☐ No	_____
Illegal Drugs	☐ Yes ☐ No	_____	☐ Yes ☐ No	_____

Family History (check if applicable)

Medical Condition	Father	Mother	Medical Condition	Father	Mother
Cancer	☐	☐	High Blood Pressure	☐	☐
Diabetes	☐	☐	Stroke	☐	☐
Heart Problems	☐	☐	Other: _____	☐	☐
Autoimmune Disease	☐	☐			

PERSONAL HEALTH HISTORY

Cardiovascular

☐ High blood pressure
☐ Heart attack
☐ Pacemaker / Defibrillator Implant
☐ Heart valve disease/surgery
☐ Irregular heartbeat
☐ Congestive Heart Failure
☐ Peripheral vascular disease
☐ Aneurysm
☐ Previous bypass/stent

Pulmonary

☐ Asthma
☐ COPD
☐ Lung Cancer
☐ Pulmonary hypertension
☐ Sleep apnea
☐ Tuberculosis

Hematology / Lymph

☐ Anemia
☐ Abnormal bleeding _____
☐ Prior blood transfusion
☐ Swelling in groin/armpit
☐ Clotting Disorder _____

Psychosocial

☐ Depression / Mania
☐ Anxiety
☐ Suicidal thoughts / attempts
☐ Seeing a psychiatrist
☐ Previous overdose

Genitourinary

☐ Kidney Disease / dialysis
☐ Loss of bladder control

Endocrine

☐ Hypothyroidism
☐ Hyperthyroidism
☐ Diabetes

Neurological

☐ Alzheimer's
☐ Stroke
☐ TIA / "Mini Stroke"
☐ Seizure
☐ Headaches
☐ Tremor
☐ Weakness
☐ Multiple sclerosis
☐ Parkinsons
☐ Spinal cord injury

Gastrointestinal

☐ Loss of bowel control
☐ Colitis
☐ Pancreatitis
☐ irritable bowel syndrome
☐ Inflammatory bowel syndrome
☐ Reflux (GERD) / indigestion
☐ Ulcer
☐ Liver disease
☐ Change in appetite
☐ Difficulty swallowing

Musculoskeletal

☐ Ankylosing Spondylitis
☐ Degenerative arthritis
☐ Rheumatoid arthritis
☐ Osteoporosis
☐ Joint surgery
☐ Fibromyalgia
☐ Use of cane / walker
☐ Females > 60:
Date of last bone scan: _____

Other

☐ HIV / AIDS
☐ Transplant surgery
☐ Recurrent infections
☐ Cancer: _____
☐ Other: _____

Falls

☐ Fallen 2 or more times in the past year
☐ Had 1 fall in the last year that resulted in injury
☐ Date of last fall: _____

Surgical History: (most recent, major, or related to why you are here)

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