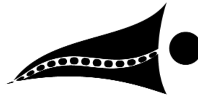


IDEAL PAIN MANAGEMENT

Tel: 443-519-5353, Fax: 443-519-5317

PAIN MANAGEMENT INITIAL ASSESSMENT

Patient Name: ____ **Date**_____________

Date of Birth: ____________________ **Sex: M / F** **Cell Phone#**___________________________

Home Phone# _________________________________ **Work Phone#** _________________________________

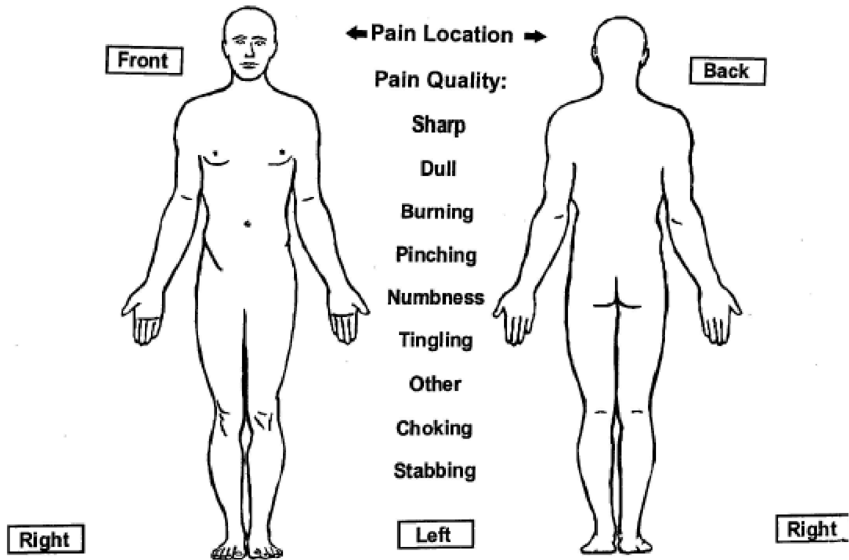
Home Address: ____

City _______________________________________ **State** _____________________ **Zip Code**___________________

Referring Dr.: ______________________________ **How did you hear about us?** ___________________________________

Do we currently treat any friends or relatives? ___________**If so, who and relation:** _________________________________

Below is a picture of your head and/or body below and shade the area(s) where you feel pain. "X" the areas that hurt the most.



Where is your pain? ____

When and how did your pain start? ____

____

____

What is the cause of your complaints (i.e. the diagnosis)? ____

What doctors have you seen? When did you see them? What did they do?
(For example: Doctor did physical exam, eye exam, ordered tests, prescribed medications).

Doctors Name:	Month/Year Seen	What was done?
____________	____________	____________
____________	____________	____________
____________	____________	____________

What tests and studies have been done? (for example: MRI, CAT, Scan, X-rays)	Month/Year Done	Results
____________	____________	____________
____________	____________	____________
____________	____________	____________

Circle he words that best describe the pain

Aching	**Sharp**	**Penetrating**	**Throbbing**	**Tender**	**Nagging**	**Shooting**
Burning	**Numb**	**Stabbing**	**Exhausting**	**Miserable**	**Gnawing**	**Tiring**
Unbearable	**Intermittent**	**Continuous**				

Circle the number that best describes your pain at its worst during the last month.

0 1 2 3 4 5 6 7 8 9 10 (Worst imaginable)

Circle number that best describes your pain on average during the last month.

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your pain as it is right now.

0 1 2 3 4 5 6 7 8 9 10

What makes this pain feel better (for example: heat, rest, medicine)?

____

What makes this pain feel worse (for example: walking, standing, lifting)?

____

Other complaints (i.e. numbness, tingling, memory loss, tremor, fatigue, dizziness, loss of vision, visual spots, neck pain, etc.)

____

Circle the number (s) below that best describes how pain or other complaints have interfered with your daily functioning past 3 months on average.

0 = Does not interfere **10 = Completely interferes**

General Activity	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Walking Ability	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Normal Work Routine	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Sleep	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Enjoyment of Life	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

What treatments or medications are you receiving now or have received in the past? (For example, pain or other medications, physical therapy, acupuncture, TENS, etc.) Circle the number to signify the amount of pain relief.

Treatment or Medication	No Relief — Complete Relief	Check if Receiving Now
	0 1 2 3 4 5 6 7 8 9 10	( )
	0 1 2 3 4 5 6 7 8 9 10	( )
	0 1 2 3 4 5 6 7 8 9 10	( )
	0 1 2 3 4 5 6 7 8 9 10	( )

Social History: Married | Divorced | Single | other _______________ No. of Children: ____

Which of the following drugs or substances, if any, are you using currently or used in the past? (Circle all that apply).

Alcohol__________ Cocaine _____________ Heroine ___________

Amphetamines __________ Marijuana ___________ Other _______________

Are you in a rehab program? Yes | No

Do you presently smoke cigarettes or use tobacco in any form? Yes/No Age you started smoking: _____

How many packs do (did) you smoke a day? ____________________ **For how many years?** ________

Past Medical History: (e.g. heart disease, cancer, diabetes, hypertension, gynecologic history, psychiatric illnesses, etc.)

____

____

Surgical History (unrelated to pain, such as appendectomy) ____

____

Family History ____

Allergies (Include medication and food allergies) ____

____

Current medications : ____

Work History

Job | **Years Worked** | **Why did you leave?**

____

____

Legal Matters

Are you presently involved in a lawsuit? Yes _______ No ________

Is this Work or Auto accident related? _______________________________

Review of System

Do you have any of the following? (Circle all that apply)

Headaches	**Stomach Pain**	**Chest Pain**	**Depression**	**Visual Problems**
Nausea	**Shortness of Breath**	**Anxiety**	**Hearing Problems**	**Vomiting**
Urinary Problems	**Insomnia**	**Dizziness**	**Constipation**	**Rashes**
Weight loss/gain	**Difficulty Swallowing**	**Diarrhea**	**Swollen Joints**	**Sexual Problems**
Other (specify)				