Consultants in Pain Management

Initial Evaluation

Patient Name: _____

Account #: _____ Date of Appointment: _____ Age: _____ Sex: M __ F __

Referring Physician: _____ Primary Care Physician: _____

Worker's Comp: Y __ N __ Case Worker Name: _____

Location of your pain: _____

Date your pain started: _____

What caused your pain?

_____

Circle all the words below that describe your pain:

Constant Intermittent Gnawing Tingling Numb Sharp Dull Stabbing Shooting Burning

Aching Throbbing Horrible Miserable Uncomfortable Unbearable Excruciating

My pain is made worse by:

Lying Down Sitting Standing Walking Exercise Other _____

My pain is made better by:

Lying Down Sitting Standing Walking Exercise Other _____

My Sleep is: Good Fair Poor

Are you currently in physical therapy? Yes __ No __
Do you use a TENS unit or Stimulator? Yes __ No __
Functional Assessment:

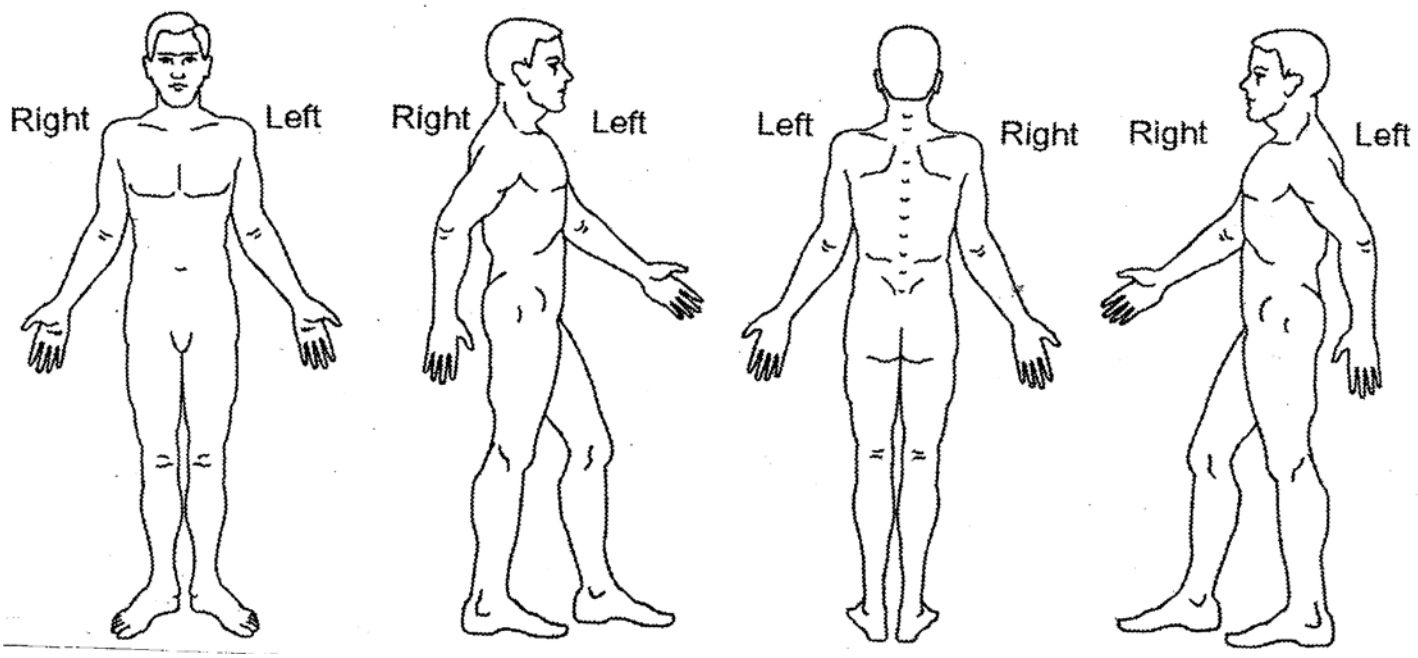
Today, are you able to:	No Difficulty	Some Difficulty	Much Difficulty	Unable
Stand Upright				
Walk Normally				
Sit Comfortably				
Bend Over				
Concentrate				
Bath/Groom Yourself				
Shop				
Housekeeping Chores				
Drive, Enter and Exit Vehicle				
Lift a Cup/Glass to Your Mouth				
Open a Jar				

How Intense Is Your Pain? Circle

1	2	3	4	5	6	7	8	9	10

No Pain **Excruciating Pain**

Using the diagrams below, shade all the areas of pain completely with a red pencil. Indicate more intense pain areas with darker markings. If applicable, use a yellow marker to indicate areas of spinal cord stimulation or TENS unit stimulation.



Which, if any, of the following has your pain affected? Describe the affect.

Sleep		**Weight**	
Mood (Nerves)		**Activities**	
Relationships		**Job (Work)**	

What Diagnostic Tests have you had for your pain? Indicate where and when.

X-Rays		**CT Scan**	
Ultrasound		**Bone Scan**	
Arteriogram		**MRI Scan**	
EMG/NCS		**Myelogram**	

Which, if any, of the following Pain Treatments have you had? Did it help? Yes/No

Bed Rest		**TENS Unit**		**Exercise Program**	
Traction		**Biofeedback**		**Physical Therapy**	
Heat Therapy		**Acupuncture**		**Work Hardening**	
Ultrasound		**Chiropractor**		**Psychotherapy**	

Which, if any, of the following Pain Procedures have you had? Did it help? Yes/No

Joint Injections		**Spinal Injections**		**Surgery**	
Trigger Point Injections		**Spinal Cord Stimulator**			
Nerve Block Injections		**Internal Narcotic Pump**			

Which, if any, of these medications have you taken for pain? Did it help? Yes/No

IBUPROFEN		**SKELAXIN**		**ZOLOFT**		**AMBIEN**	
EXALGO		**FLEXERIL**		**PROZAC**		**WELLBUTRIN**	
RELAFEN		**SOMA**		**EFFEXOR**		**NEURONTIN**	
ARTHROTEC		**ZANAFLEX**		**RESTORIL**		**DEPAKOTE**	
METHADONE		**KLONOPIN**		**MIDRIN**		**DILANTIN**	
VALIUM		**PERCOCET**		**FIORINAL**		**LOMICTIL**	
ULTRAM		**OXYCONTIN**		**AMERGE**		**TOPAMAX**	
TYLENOL 3		**MS CONTIN**		**IMITREX**		**TEGRETOL**	
DARVOCET		**KADIAN**		**MAXALT**		**STADOL**	
HYDROCODONE		**DURAGESIC**		**ZOMIG**		**LYRICA**	
DEMEROL		**DILAUDID**		**TRAZODONE**		**METHADONE**	
MEPERGAN		**PAXIL**		**ELAVIL**			
BACLOFEN		**CELEXA**		**REMERON**			

Past medical history: Which of the following do you currently have or had in the past?

Stroke		**Ulcers**		**Liver Disease**	
Seizures		**Diverticulitis**		**Heart Disease**	
Migraines		**Diabetes**		**High Blood Pressure**	
Asthma		**Arthritis**		**HIV, Syphilis, Gonorrhea**	
Emphysema		**Osteoporosis**		**Congestive Heart Failure**	
Gout		**Cancer**			
Reflux		**Hepatitis**			
Other					

Past Surgical History: Which of the following have you had and when? Circle L / R

Brain Surgery		**Gallbladder Surgery**		**Eye Surgery L / R**	
Facial Surgery		**Bowel Surgery**		**Kidney Surgery L / R**	
Oral Surgery		**Appendectomy**		**Shoulder Surgery L / R**	
Tonsillectomy		**Hernia Repair**		**Hand/Wrist Surgery L / R**	
Thyroid Surgery		**Bladder Surgery**		**Hip Surgery L / R**	
Lung Surgery		**Blood Vessel Surgery**		**Knee Surgery L / R**	
Heart Surgery		**Spine Surgery (Neck)**		**Foot Surgery L / R**	
Stomach Surgery		**Spine Surgery (Back)**			

Women of childbearing years:

Are you pregnant? Y___ N___ Are you nursing? Y___ N___
Do you plan to become pregnant? Y___ N___
Have you had a hysterectomy? Y___ N___ Date: _____
Have you had a tubal ligation? Y___ N___ Date: _____
If no; Date of last menstrual cycle: _____
Birth control method used: Oral contraceptives Y___ N___ IUD Y___ N___
Other _____

List all current medications including Herbs, Vitamins, Supplements:

List all medication allergies:

Medication	Reaction	Other Allergies
		Are you allergic to latex? Y__ N__
		Are you allergic to metals? Y__ N__
		Are you allergic to tape? Y__ N__

Family history (Parents, Grandparents, Brothers, Sisters) Which, if any, of the following do they have?

Stroke		Reflux/Ulcers		Osteoporosis	
Seizures		Diverticulitis		Cancer	
Migraines		Diabetes		Asthma	
Emphysema		Heart Disease		Kidney Disease	
Liver Disease		High Blood Pressure		Arthritis	
Gout		Congestive Heart Failure			

	Living	Deceased		Living	Deceased
Mother			Brother(s)		
Father			Sister(s)		

Marital Status:

Married		Single		Widowed		Divorced-Remarried	
Divorced		Separated		Significant Other		Widowed-Remarried	

Living Situation:	With Spouse		Alone		With Family		With a Friend	

Tobacco Use:	Nonsmoker		Quit		Smokes, # of packs per day	

Drug Use:	Marijuana		Cocaine		Methamphetamine	
	Heroin		Other			

Alcohol Use:	Drink Socially		Drink Rarely		# Drinks/Day		Abstains at this time	

Occupation:

What type of work do you do?				Hours per week?	
Unemployed		Employed Full-Time		Short Term Disability	
Disabled		Employed Part-Time		Long Term Disability	
Retired		Self-Employed		Workers Comp	
Homemaker					

Are there any legal issues associated with your pain problem? Y___ N___

Have you retained an Attorney? Y___ N___ If yes, Name _____

Review of Systems: Circle all that apply.

General:	Fatigue	Fever	Weight (Gain,Loss)
Gastrointestinal:	Blood in Stools	Constipation	Change in Bowel Movement
	Heartburn	Loss of Appetite	Nausea and/or Vomiting
Endocrine:	Excessive Thirst	Excessive Urination	Gland or Hormone Problems
	Heat Intolerance	Cold Intolerance	
Skin:	Itching	Rash	Skin Color Changes
Hematologic:	Anemia	Bleeding Tendencies	Bruising Tendencies
	Slow Healing	Bleeding Gums	Past Blood Transfusions
HEENT:	Headache	Blurred Vision	Double Vision
(head, eyes ,ears,	Eye Pain	Earache/Drainage	Mouth Sores
nose, throat)	Hearing Loss	Ringing in Ears	Swollen Neck Glands
	Sinus Problems		
Genitourinary:	Birth Control	Frequent Urination	Irregular Menstrual Cycle
	Prostate Problems	Painful Urination	Sexual Dysfunction
Psychiatric:	Depression	Nervousness	Poor Sleep
Cardiovascular:	Chest Pain	Swelling of Feet	Swelling of Hands
	Irregular Heartbeat		
Respiratory:	Shortness of Breath	Spitting up Blood	Chronic Cough
Musculoskeletal:	Back Pain	Difficulty Walking	Joint Pain
	Joint Stiffness	Joint Swelling	Muscle Cramps
	Muscle Pain	Neck Pain	
Neurological:	Dizziness	Frequent Headaches	Lightheaded
	Numbness	Tremors	Tingling