Pain Center Initial Patient Evaluation

Thank you for taking the time to fill out this form. Completing this form prior to your first visit with us, facilitates your evaluation and keeps us running on time!

Name: _____ Today's Date:_____ DOB_____

Referral Doctor_____ Primary Doctor:_____

Other Doctors Helping You With This Problem_____

Present History:

1. Briefly describe the main reason you are seeing us today

_____

_____

2. When did this problem first start (month/year if possible)_____

3. How did this pain start?

○ Suddenly	○ Fall	○ Injured at work	○ Sports
○ Gradually	○ Bending	○ Injured at home	○ No apparent cause
○ Lifting	○ Pulling	○ Auto accident	

○ Other_____

4. What activities make the pain worse?

○ Walking	○ Exercise	○ At night	○ Climbing Stairs
○ Standing	○ Coughing	○ Sneezing	○ Looking up
○ Sitting	○ Bending Forward	○ Twisting	
○ Bending Back	○ Light touch		

○ Other_____

5. What reduces the pain?

○ Lying down	○ Standing	○ TENS unit	○ Brace/Corset
○ Sitting	○ Walking	○ Exercise	○ Physical therapy
○ Chiropractic Manipulation	○ Pain Injections	○ Pain Medication	○ Bending Forward

○ Other_____

6. My pain is: (Check all that apply)

○ Present Intermitently	○ Getting Worse	○ Always there but changes	○ Improving

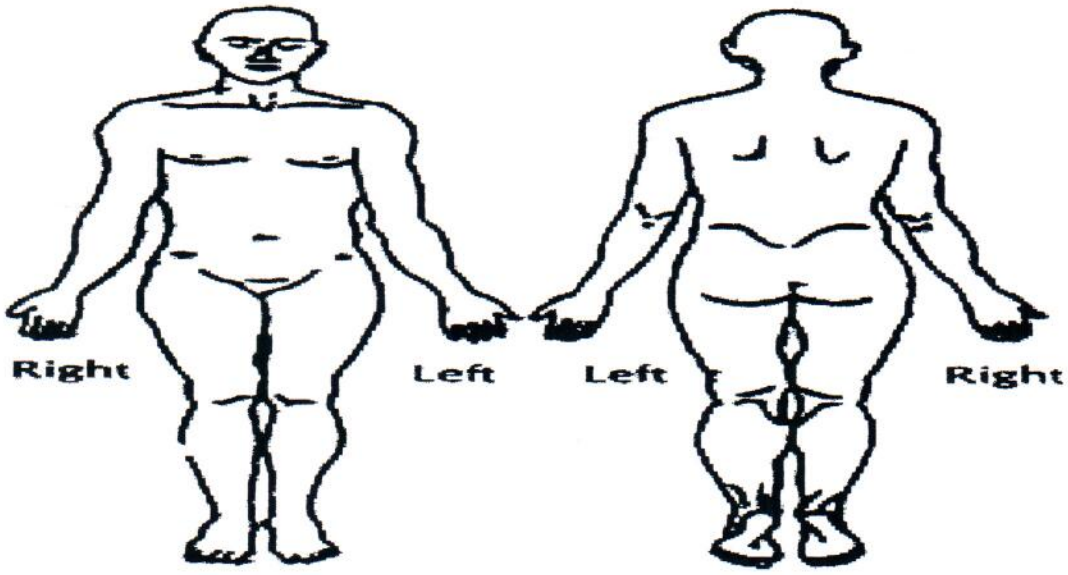
7. My pain affects my life by:

○ I'm not able to work	○ I'm not able to take care of myself	○ I can't socialize and enjoy activities	○ Doesn't really stop me from doing things

8. Where is your pain now? Mark your areas of pain using the appropriate symbol.

Mark the areas on your body where you feel pain using the following symbols:

Aching	Numbness	Tingling	Pins and Needles	Burning	Stabbing
------	= = =	000	+ + +	XXX	///



Pain Rating Scale

Please circle the number that corresponds to the area of your body you feel pain and it's severity on an average day.

No Pain Worst Pain I Can Imagine

Back Pain _____

0 1 2 3 4 5 6 7 8 9 10

Leg Pain _____

0 1 2 3 4 5 6 7 8 9 10

Neck Pain _____

0 1 2 3 4 5 6 7 8 9 10

Arm Pain _____

0 1 2 3 4 5 6 7 8 9 10

9. Do you have loss of bowel or bladder control that is new? ___Yes ___No

10. Have you gained or lost significant weight recently? ___Yes ___No

11. Have you experienced weakness?

○ None	○ In my legs	○ In my arms	○ Generally weak

12. Do you have trouble sleeping?

○ None	○ Every day	○ Occasionally

13. Activities I can comfortably do
Stand for ___ minutes Sit for ___ minutes Walk ___ blocks

14. Have you had this problem before? __Yes ___ No
If yes, when? _____

15. What other treatments have you had for **this** problem?

Treatment	Approx. Dates	Doctor or Clinic	Was it helpful?
Physical Therapy			
Chiropractic			
Brace			
TENS unit			
Epidural cortisone injection			
Medications			
Radiofrequency Ablation			
Spinal Cord Stimulation			
Triggerpoint injections			

16. Testing you have had for **this** problem?

Type of Test	Date	Where	Result if known
xrays			
CAT scan			
MRI			
Bone Scan			
EMG			
Discogram			
Myelogram			

17. Surgeries that you have had for **this** problem

Type of Surgery	Approx. date	Surgeon	Date

18. Are you currently employed? ___Yes ___No

Present Employer_____

Current Occupation_____

Are you on any job restrictions or reduced hours?_____

Past Medical History

○ HIV/AIDS	○ bronchitis	○ Emphysema	○ Kidney prob
○ Acid reflux	○ cancer	○ Glaucoma	○ Liver disease
○ Anemia	○ CHF	○ Thyroid issues	○ Migraines
○ Arthritis	○ Light touch	○ Gout	○ Pacemaker
○ Asthma	○ Alcoholism	○ Heart disease	○ Osteoporosis
○ Arrhythmia	○ Addiction	○ Hypertension	○ Seizures
○ Bleeding prob	○ Diabetes	○ High cholesterol	○ Sleep Apnea
○ Depression	○ Anxiety		○ Stroke

Other Surgeries Not Related to Your Pain Problem

19. Have you had any problems with anesthesia?_____

20. Allergies

21. Tobacco _____

22. Alcohol_____

23. Family History

○ Diabetes	○ Heart Disease	○ Bleeding disorders	○ Alcholism
○ Cancer	○ High blood pressure	○ Blood clots	○ Addiction
○ Osteoarthritis	○ Lung disease	○ Anesthesia problems	○ Depression or Anxiety

24. Medications(please list or provide us a list of all medications or supplements)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Dominant Hand ___Right ___Left

Pain Center Staff to fill Vitals Below

Height_____ inches Weight_____ lbs Vitals : Pulse___ BP_____ Resp_____