PAIN MANAGEMENT INITIAL EVALUATION

Patient name: ____

Date of Birth: ________________ Date: ________________

How long have you been having SEVERE problems with pain? ______________________

Was it the result of an injury or accident? _____ If so, what happened?

____

What is the MAIN problem for which you are seeking treatment? ____________________

Timing of Pain:

How often do you have your pain? (please check one)

[ ] Constantly (100% of the time)

[ ] Frequently (75% of the time)

[ ] Intermittently (50% of the time)

[ ] Occasionally (25% of the time)

Pain Quality:

How would you describe the pain? (choose as many adjectives as are applicable)

[ ] burning [ ] sharp [ ] cutting [ ] throbbing [ ] cramping [ ] numb

[ ] dull, aching [ ] pressure [ ] pins & needles [ ] shooting [ ] electric-like

[ ] other: ____

Rate your Pain Intensity:

"0" = No pain **"10" = worst pain imaginable**

Circle the number below that best describes the **WORST** your pain level gets:

0 1 2 3 4 5 6 7 8 9 10

Circle the one number that best describes the **BEST** your pain level gets:

0 1 2 3 4 5 6 7 8 9 10

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RELIEVING AND AGGRAVATING FACTORS

How do the following activities affect your pain (please check one for each item)?

	ACTIVITY	Improves	Worsens	No Change
1.	Lying down	[ ]	[ ]	[ ]
2.	Standing	[ ]	[ ]	[ ]
3.	Sitting	[ ]	[ ]	[ ]
4.	Walking	[ ]	[ ]	[ ]
5.	Moving	[ ]	[ ]	[ ]
6.	Ice	[ ]	[ ]	[ ]
7.	Heat	[ ]	[ ]	[ ]
8.	Rest	[ ]	[ ]	[ ]
9.	Thinking about something else	[ ]	[ ]	[ ]
10.	Changing positions	[ ]	[ ]	[ ]
11.	Pillows (support, positioning)	[ ]	[ ]	[ ]
12.	Driving	[ ]	[ ]	[ ]
13.	Stretching	[ ]	[ ]	[ ]

FUNCTIONAL LIMITATIONS

How does your pain interfere with the following activities: (check the appropriate box)

Activity	Does not Interfere	Interferes a little	Interferes a lot	Unable to do at all
Enjoying hobbies	[ ]	[ ]	[ ]	[ ]
Going to work	[ ]	[ ]	[ ]	[ ]
Performing household chores	[ ]	[ ]	[ ]	[ ]
Walking	[ ]	[ ]	[ ]	[ ]
Shopping	[ ]	[ ]	[ ]	[ ]
Socializing with friends	[ ]	[ ]	[ ]	[ ]
Exercising	[ ]	[ ]	[ ]	[ ]
Having sexual relations	[ ]	[ ]	[ ]	[ ]
Driving	[ ]	[ ]	[ ]	[ ]
Sleeping	[ ]	[ ]	[ ]	[ ]
Caring for self *(bathing, toilet, dressing, moving, eating)*	[ ]	[ ]	[ ]	[ ]

ENDURANCE

How many blocks can you walk before having to stop due to pain? _______ blocks
How long can you sit before having to get up and move about? _____ minutes _____ hours
How long can you stand before you have to sit down? _____ minutes _____hours
How many flights of stairs can you climb? ______
How often during the day do you lie down because of pain?
[ ] Never [ ] Rarely [ ] Occasionally [ ] Frequently [ ] Regularly [ ] Constantly
How many pounds are you able to lift OCCASIONALLY? _________

PREVIOUS DIAGNOSTIC STUDIES: *Please indicate approximate date **of most recent**, if known:*

MRI, CT scan, or X-rays:____

EMG/NCV Studies:____

Patient name: ________________________________ Date of Birth: __________________

PREVIOUS PAIN TREATMENTS:

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

	Treatment	Date of last treatment (approximate year)
[ ]	**Surgery (related to pain)**	
[ ]	**Hypnosis**	
[ ]	**Acupuncture**	
[ ]	**TENs unit**	
[ ]	**Physical therapy**	
[ ]	**Exercise**	
[ ]	**Biofeedback**	
[ ]	**Psychotherapy**	
[ ]	**Chiropractic**	
[ ]	**Injections: Nerve blocks, facet, epidural steroid, radio frequency ablation, joint, trigger point**	
[ ]	**Spinal Cord Simulator**	
[ ]	**Intrathecal Pump**	
[ ]	**Other:**	

MEDICATIONS:

Circle **ANY/ALL** medications you have tried in the past or are presently taking:

NSAIDS:
Tylenol Ibuprofen Naproxen meloxicam Celebrex diclofenac voltaren gel flector patches Toradol

MUSCLE RELAXANTS:
Flexeril tizanidine/Zanaflex baclofen Robaxin norflex Skelaxin soma

ADJUNCTIVE MEDICATIONS:
Gabapentin Lyrica Cymbalta/duloxetine Savella Gralise Horizant amitriptyline nortriptyline lidocaine CBD medical marijuana

SHORT ACTING OPIATES:
Tramadol hydrocodone/norco/Vicodin oxycodone/Percocet dilaudid morphine Nucynta oxymorphone/opana Codeine(Tylenol #3 or #4) Fioricet/fiorinal

LONG ACTING OPIATES:
Tramadol ER MS Contin Avinza Embeda Morphabond Oxycontin XTampza ER
Opana ER methadone Exalgo ER Nucynta ER Hysingla ER suboxone Butrans Belbuca buprenorphine Fentanyl Duragesic Subsys

If you had any negative or bad reactions to any of these medications, please describe. Use back of form if you need more space.

Have you been given/prescribed a form of Narcan to use in case of emergency? ____Yes _____No