Comprehensive Pain Management Group
Patient Pain Assessment Form

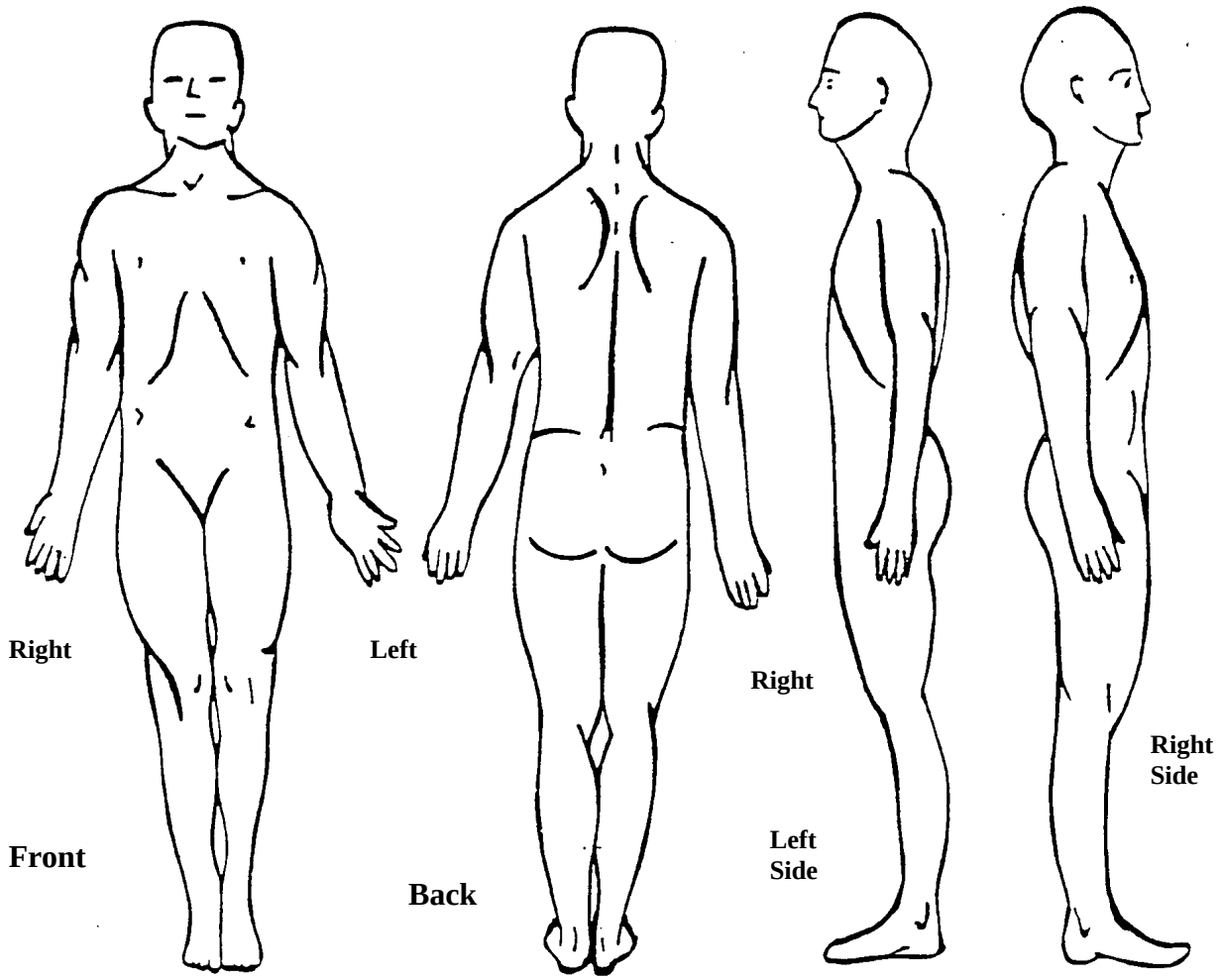
Name: _____

Visit Date: _____

Reviewed with patient by: _____ **Date:** _____

I. LOCATION:

A. Shade in the areas of your body that have pain in **red**, *and numbness in* **blue**.
B. Place "X1" next to area of greatest pain.
C. Place "X2" next to area of second greatest pain. For office use: BP: HR: O2 sat:



II. Intensity: VAS Pain Rating Scale

1. a. Rate your **current** feelings of pain on the scale.
(0 is **no pain** and 10 is the **worst** pain you can imagine.)

0 1 2 3 4 5 6 7 8 9 10

No pain ⟷ Worst possible pain

b. Rate your pain when you are at rest and when you move. (0 - 10)

Rest pain score: _____ Movement pain score: _____

2. On your area of **1st** greatest pain:

a. Rate how your pain is now: _____

b. Rate the worst your pain gets: _____

c. Rate the best your pain gets: _____

d. Rate what pain score is acceptable to you: _____

3. On your area of **2nd** greatest pain:

a. Rate how your pain is now: _____

b. Rate the worst your pain gets: _____

c. Rate the best your pain gets: _____

d. Rate what pain score is acceptable to you: _____

III a. Duration, Variations, Rhythm
(1st greatest pain):

a. How often does your pain occur? *(circle)*

Constant *Frequent* *Occasional*

b. Is the pain better or worse at certain times or certain hours during the day or night? *Yes* *No*

c. If yes, what part of the day is the pain worse?

_____

d. What part of the day is the pain better?

_____

e. Duration of episodes:

Minutes *Hours* *Days* *Longer*

III b. Duration, Variations, Rhythm
(2nd greatest pain):

a. How often does your pain occur? *(circle)*

Constant *Frequent* *Occasional*

b. Is the pain better or worse at certain times or certain hours during the day or night? *Yes* *No*

c. If yes, what part of the day is the pain worse?

_____

d. What part of the day is the pain better?

_____

e. Duration of episodes:

Minutes *Hours* *Days* *Longer*

IV a. Quality of your pain (1st greatest pain area)
(circle all that apply)

burning stabbing / sharp dull / diffuse

throbbing cramps / spasm-like tingling

numbness aching heavy shooting

other _____

IV b. Quality of your pain (2nd greatest pain area)
(circle all that apply)

burning stabbing / sharp dull / diffuse

throbbing cramps / spasm-like tingling

numbness aching heavy shooting

other _____

V. When did the pain start? Greatest Pain _____ 2nd Greatest Pain _____

a. How did the pain start? Where was the pain when it started? _____

_____

b. If your pain developed after lifting or trauma please describe: (example): Tell us what you were lifting and how. If this occurred while driving you may want to draw a picture of the accident.

_____

_____

c. If your pain radiates down your arm or leg, how soon did this start after you first developed your pain?

---

d. Do any parts of your arms or legs swell up with edema or turn hot or cold? Yes No

If "Yes," answer the following questions (if "No," go to e):
I have edema (swelling) that intermittently develops in the following areas. (please circle)
This occurs _____ times per day day / week / month

Hands	R	L	Elbows	R	L	Shoulders	R	L
Knees	R	L	Ankles	R	L	Feet	R	L

e. Do you have areas on your body which are super-sensitive to light touch or trauma, way out of proportion to what you would expect to feel? Yes / No

If yes, what areas? _____

f. When did this start? _____

g. Do you have any weakness in your muscles? Yes / No If yes, please circle:

Hands	R	L	Elbows	R	L	Shoulders	R	L
Knees	R	L	Ankles	R	L	Feet	R	L

h. Have you lost conrol of your bladder or bowels since your pain started? Yes / No

i. Does any of your pain increase with coughing or sneezing? Yes / No

j. If yes, where? _____

k. Have you ever had pain similar to what you described before in your whole life? Yes / No

When / Describe / What happened? _____

l. How much control do you have over your pain through your own efforts (besides medications)?

1 Can you get relief?

None 0 1 2 3 4 5 Great deal

2 Can you make it worse?

None 0 1 2 3 4 5 Great deal

VI. Effects of pain: Accompanying symptoms (please circle all that apply)

Nausea	Headache	Dizziness	Hallucinations
Drowsiness	Constipation	Sweating	Anxiety
Depression	Irritability	Sleep problems	Suicidal thoughts

VII. Sleeping pattern

a. How many hours do you sleep per night? _____

b. Do you have trouble falling asleep? (check below)

Always ____ Sometimes ____ Never ____

c. Do you have a hitory of difficulty falling asleep? (check below)

Always ____ Sometimes ____ Never ____

d. How many times during the night does pain awaken you? _____

e. Do you take medications to help you fall asleep? (check below)

Always ____ Sometimes ____ Never ____

f. If yes, what type of sleeping medication do you take to help you fall asleep?

_____

g. What position do you sleep in? _____

VIII. Past Medical History (circle all that apply)

1. Family history of substance abuse

Alcohol	Yes	No
Illegal drugs	Yes	No
Prescription drugs	Yes	No

2. Personal history of substance abuse

Alcohol	Yes	No
Illegal drugs	Yes	No
Prescription drugs	Yes	No

3. Age _____

4. History of preadolescent sexual abuse Yes No

5. Psychologic disease (ADD, OCD, bipolar disorder, schizophrenia, depression) Yes No

IX. Please list all <u>current medications</u> you take for <u>pain</u> and who is prescribing:

Name of medication	Dose	Total daily dose	Prescriber

X. What medications for pain have you taken in the <u>past?</u>

Name of medication	Dose	Total daily dose	Prescriber

XI. Please list any <u>other</u> medications that you take:

Name of medication	Dose	Total daily dose	Prescriber

XII. Have you had any side effects from pain medications in the past? If yes, please list side effects:

_____

Do you have any allergies to medications? If yes, please decribe below:

_____

XIII. Do you take any Herbal Supplements and/or any Vitamins? Please list:

_____

XIV. Are you on **<u>Coumadin / Plavix / Blood Thinners</u>**? Yes No

XV. Do you have an **<u>Allergy to Latex / Iodine / Shrimp</u>**? Yes No

XVI. Have you had any cortisone steroid injections in the last 6 months? Yes No

If yes, where on your body? _____

XVII. Circle if you have had any of the following: epidural (s) trigger point injection (s) facet block (s)

If yes, how many and at what facility? _____

XVIII. a. Which hand-dominant are you? Right Left Both

b. Is there any litigation or legal action related to your current condition? Yes No

c. Do you have an attorney? **Yes** **No**

If yes: Name: _____

Address: _____

Phone #: _____

Fax #: _____

d. *(For female patients only)* Is there a chance you are pregnant?

Do you plan to become pregnant within 2 months? _____

When was your last period? _____

Do you use birth control? Yes No

If yes, what type? _____

Patient Completed _____ *Staff Assisted Completion* _____ *Initials* ___ _____

Revised 2012