ADVANCED PAIN MANAGEMENT

Patient Name_____ Date_____

Date of Birth_____Sex_____Marital Status_____

Phone Numbers: Home ( ) _____Work ( ) _____Cell ( ) _____

Street_____

City_____State_____Zip_____

General Health Review

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as Psychiatric illnesses, etc.)

_____ _____ _____

_____ _____ _____

Surgical History (**unrelated** to pain; such as appendectomy)

_____ _____ _____

_____ _____ _____

Surgical History (**related** to pain; such as laminectomy)

_____ _____ _____

_____ _____ _____

Allergies (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

_____ _____ _____

_____ _____ _____

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

_____ _____ _____

_____ _____ _____

Current Medications (include vitamins and birth control pills, if applicable)

_____ _____ _____

_____ _____ _____

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

Headaches	Stomach Pain	Chest Pain
Vision Problems	Nausea	Shortness of Breath
Hearing Problems	Vomiting	Urinary Problems
Dizziness	Constipation	Rashes
Difficulty Swallowing	Diarrhea	Swollen Joints
		Chronic Fatigue

Domestic Situation

With whom do you live? _____
Are there any substance abuse issues in the household? Yes _____ No _____
If yes, please explain _____
Any physical abuse issues? Explain: _____
Are you able to take care of yourself? Yes _____ No _____
If not, please enter name of caregiver _____

Work History

Job Years worked Why did you leave?

_____

_____

Legal Matters

Are you presently involved in a lawsuit? Yes _____ No _____ If yes, please explain.

_____

_____

Substance Use

Which of the following drugs or substances, if any, have you used in the **past**? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin _____	Amphetamines _____	Marijuana _____
Other _____ (specify)	Other _____ (specify)	Other _____ (specify)

Are you presently using any of the drugs or substances below? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin _____	Amphetamines _____	Marijuana _____
Other _____ (specify)	Other _____ (specify)	Other _____ (specify)

Do you presently smoke cigarettes or use tobacco in any form? Yes _____ No _____

If not, did you ever smoke cigarettes or use tobacco in any form? Yes _____ No _____
How much packs do (did) you smoke a day? _____ For how many years? _____

Reason for visit: _____

History of present illness: _____

•Location _____ •Quality _____
(How severe is the pain/problem?) (Example normal vs abnormal color, activity, etc.)

•Severity _____ •Duration _____
(How severe is pain on scale of 1 -10?) (How long have you had this pain/problem? When did it start?)

•Timing _____ •Context _____
(Does this pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

•Associated signs/symptoms _____ •Modifying factors _____

•_____ •_____
(What other associated problems are you having?) (What makes the pain/problem worse or better?)

Medical History:

*Patient Medical History:

Diabetes	Yes	No	_____
Hypertension	Yes	No	_____
Cancer	Yes	No	_____
Stroke	Yes	No	_____
Heart Trouble	Yes	No	_____
Arthritis/Gout	Yes	No	_____
Convulsions	Yes	No	_____
Bleeding tendency	Yes	No	_____
Acute Infections	Yes	No	_____
Venereal Diseases	Yes	No	_____
Heredity Defects	Yes	No	_____

*Patient Social History:

Marital Status: Single:____ Married:_____Seperated:_____Divorced:_____Widowed:_____

Use of Alcohol: Never:____ Rarely:_____Moderate:_____Daily:_____

Use of Tobacco: Never:____Previosly quit:_____Current packs per day:_____

Use of Drugs: Never:____Type/Frequency:_____

Excessive Exposure at home/work: Fumes:____Dust:_____Solvents:_____Air-borne particles:____Noise:____

Occupation/Work History:_____

*Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Review of Systems: Please indicate any personal history:

•CONSTITUTIONAL SYMPTOMS

Good general health lately……	Yes	No
Recent weight change……	Yes	No
Decreased appetite……	Yes	No
Fever/Night sweats……	Yes	No
Fatigue/Weakness…….	Yes	No
Headaches…….	Yes	No

•EYES

Eye disease or injury…….	Yes	No
Wear glasses/contact lenses…….	Yes	No
Blurred or double vision……..	Yes	No
Glaucoma/cataracts……..	Yes	No

• EARS/NOSE/THROAT

Hearing loss or ringing……	Yes	No
Earaches or drainage……..	Yes	No
Chronic sinus problems or rhinitis.…	Yes	No
Nosebleeds……	Yes	No
Mouth sores……	Yes	No
Sore throat or voice change…….	Yes	No
Swollen glands in neck……..…	Yes	No

•CARDIOVASCULAR

Heart trouble……	Yes	No
Chest pain or angina pectoris…….	Yes	No
Palpitation……..	Yes	No
Shortness of breath w/walking or lying flat	Yes	No
Swelling of feet, ankles, or hands…….	Yes	No

•RESPIRATORY

Chronic or frequent coughs……..	Yes	No
Spitting up blood…….	Yes	No
Shortness of breath…….	Yes	No
Asthma or Wheezing……..	Yes	No

•GASTROINTESTINAL

Loss of appetite……	Yes	No
Change in bowel movement ……..	Yes	No
Nausea or vomiting…….	Yes	No
Frequent diarrhea……	Yes	No
Painful bowel movements or constipation...	Yes	No
Rectal bleeding or blood in stool……..…	Yes	No
Abdominal pain……	Yes	No
Peptic ulcer (stomach or duodenal)…….	Yes	No

•GENITOURINARY

Frequent urination……	Yes	No
Burning or painful urination……	Yes	No
Awaken at night to urinate……	Yes	No
Blood in urine……	Yes	No
Change in force or strain when urinating	Yes	No
Incontinence or dribbling……	Yes	No
Sores or discharge……	Yes	No
Kidney stones……	Yes	No
Sexual difficulty……..	Yes	No
Male – testicle pain/lumps……..	Yes	No
Female – pain with periods	Yes	No
Female – irregular periods…….	Yes	No
Female – vaginal discharge…….	Yes	No
Female - # of pregnancies ……	_____	
Female - # of miscarriages……..	_____	
Female – date of last pap smear…..	_____	

•ENDOCRINE

Glandular or hormone problem ..	Yes	No
Thyroid disease……...	Yes	No
Diabetes(insulin or noninsulin)…..	Yes	No
Excessive thirst or urination..	Yes	No
Heat or cold intolerance……	Yes	No

•MUSCULOSKELETAL

Joint Pain……	Yes	No
Joint stiffness or swelling…...	Yes	No
Weakness of muscle or joints..	Yes	No
Muscle pain or cramps……...	Yes	No
Back pain……..……..	Yes	No
Difficulty walking……..	Yes	No

•INTEGUMENTARY (skin, breast)

Rash or itching……	Yes	No
Change in skin color……	Yes	No
Change in hair or nails……...	Yes	No
Varicose veins……	Yes	No
Breast pain……	Yes	No
Breast lump……..	Yes	No
Breast discharge……...	Yes	No

•NEUROLOGICAL

Frequent or recurring headaches	Yes	No
Lightheaded or dizzy…….	Yes	No
Convulsions or seizures…….	Yes	No
Numbness or tingling sensations	Yes	No
Tremors…….	Yes	No
Paralysis……	Yes	No
Stroke……	Yes	No
Head injury……	Yes	No

•PSYCHIATRIC

Memory loss or confusion…	Yes	No
Nervousness……	Yes	No
Depression……	Yes	No
Insomnia……..	Yes	No

•HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts…….	Yes	No
Bleeding or bruising tendency	Yes	No
Anemia……	Yes	No
Phlebitis……	Yes	No
Past transfusion…….	Yes	No
Enlarged glands……	Yes	No

•ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reactions:

Penicillin or other antibiotics	Yes	No
Morphine, Demerol or other narcotics	Yes	No
Novocain or other anesthetics…….	Yes	No
Aspirin or other pain remedies……	Yes	No
Tetanus antitoxin or other serums…	Yes	No
Iodine, merthiolates or other antiseptics..	Yes	No

Other drugs/medications:_____

Known food allergies:_____

Environment allergies:_____

Reviewed By:_____

Date:_____

Primary Care Physician_____
Address_____
City_____State_____Zip_____Phone_____

If Workman's Compensation, list case worker_____
Address_____
City_____State_____Zip_____Phone_____

Would you like letters sent to other physicians? Yes No If yes, please list name and address
Name_____
Address_____
City_____State_____Zip_____Phone_____

Emergency Contact_____Relationship_____
Address_____
City_____State_____Zip_____
Telephone numbers: (Home)_____(Work)_____

Initial Pain Assessment

By answering the following questions, you will help your physician better understand and treat your pain.
When and how did your pain problem start? _____
_____
_____

As far as you know, what is the cause of your pain (ie, the diagnosis)? _____
_____
_____

What doctors have you seen? When did you see them? What did they do? (for example: Doctor did physical exam, Ordered tests, prescribed medication)

Doctor's Name	Month/Year Seen	What Was Done
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What tests and studies have been done?
(for example: MRI, CT-Scan, X-Rays)

	Month/Year Done	
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the body sites where you experience pain and circle the words that best describe the pain at that site. Also, indicate The intensity of the pain and those things that make your pain better or worse. Use a separate sheet for each body site.

Body Site _____

Circle the words that describe you 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
No Pain										Worst pain imaginable

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

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

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

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

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

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

What sorts of things make this pain feel **better** (for example: heat, rest, medicine)?

_____

_____

_____

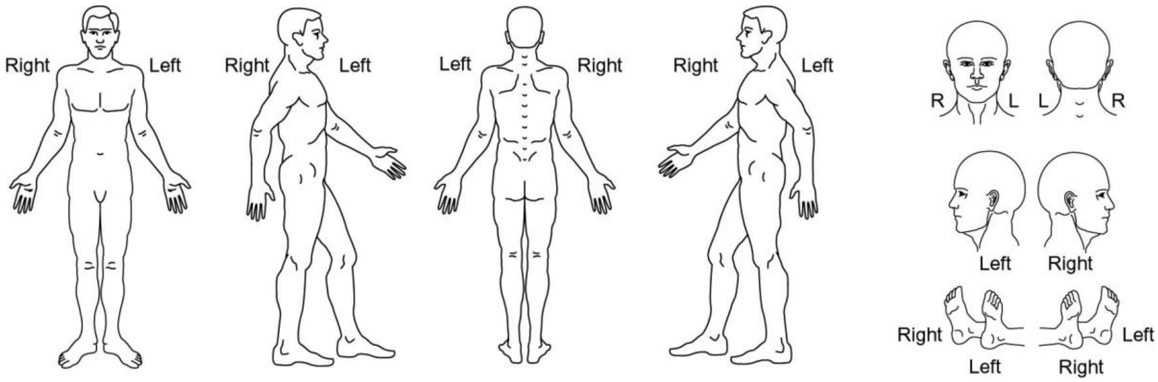
What sorts of things make this pain feel **worse** (for example: walking, standing, lifting)?

_____

_____

_____

On the diagram below, shade the areas where you feel pain. “X” the areas the hurt the most.



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

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	☐
	0	1	2	3	4	5	6	7	8	9	10	☐
	0	1	2	3	4	5	6	7	8	9	10	☐

Circle the numbers below that best describe how pain has interfered with your daily functioning.

General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Normal Work Routine

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Relations With Other People

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Enjoyment of Life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Ability to Concentrate

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Appetite

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Cz0020**What level of pain do you think you could function with on a daily basis?**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

The attached information was reviewed with the patient by:

_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)
_____ (Physician)	on	_____ (Date)