PAIN EVALUATION FORM

Date: _____

Name: _____ _____ _____
Last First Initial

Date of Birth _____ SS # _____ - _____ - _____

Age: _____ Dominant Hand: Right _____ Left _____

Height: _____ Weight: _____

I *Referring Doctor*

Complete Name of Referring Doctor _____ _____
Last First

Complete Address _____

_____

Phone _____ Fax _____

II *Current Doctors*

List the names and COMPLETE addresses of all health care practitioners you are currently seeing:

NAME	SPECIALTY	PHONE	
ADDRESS	CITY	STATE	ZIP
NAME	SPECIALTY	PHONE	
ADDRESS	CITY	STATE	ZIP
NAME	SPECIALTY	PHONE	
ADDRESS	CITY	STATE	ZIP

III *Understanding Your Pain*

A. Describe in ***your own words*** the pain problem you would like help with:

B. How often does your pain occur?

- ☐ continuous
- ☐ several times a day
- ☐ once per day
- ☐ once per week
- ☐ less than once per week
- ☐ never

C. What is the duration of your pain? (Length it lasts)

- ☐ none
- ☐ seconds
- ☐ minutes
- ☐ hours
- ☐ days
- ☐ weeks
- ☐ continuous

D. Circle a number below to indicate your **highest** pain intensity over the past week

0	1	2	3	4	5	6	7	8	9	10

No pain — Mild pain — Moderate pain — Severe pain — Most intense pain imaginable

E. Circle a number below to indicate your **lowest** pain intensity over the past week

0	1	2	3	4	5	6	7	8	9	10

No pain — Mild pain — Moderate pain — Severe pain — Most intense pain imaginable

F. Circle a number below to indicate your **usual** pain intensity over the past week

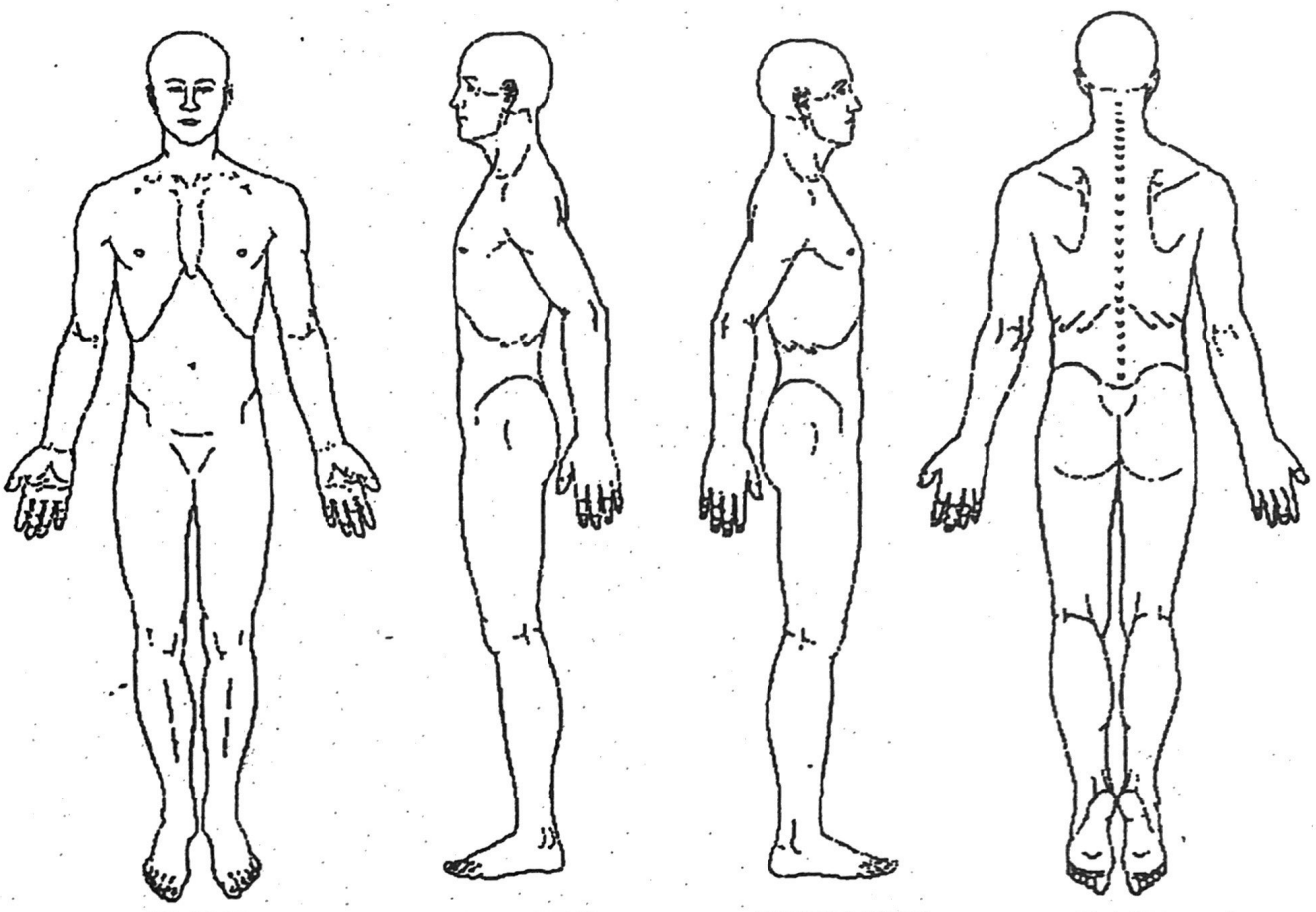
0	1	2	3	4	5	6	7	8	9	10

No pain — Mild pain — Moderate pain — Severe pain — Most intense pain imaginable

G. Below is a list of words that may describe your pain. Please rate each word on the 0 to 3 point scale to describe your pain.

	None	Mild	Moderate	Severe
Throbbing	0)_____	1)_____	2)_____	3)_____
Shooting	0)_____	1)_____	2)_____	3)_____
Stabbing	0)_____	1)_____	2)_____	3)_____
Sharp	0)_____	1)_____	2)_____	3)_____
Cramping	0)_____	1)_____	2)_____	3)_____
Gnawing	0)_____	1)_____	2)_____	3)_____
Hot-Burning	0)_____	1)_____	2)_____	3)_____
Aching	0)_____	1)_____	2)_____	3)_____
Heavy	0)_____	1)_____	2)_____	3)_____
Tender	0)_____	1)_____	2)_____	3)_____
Splitting	0)_____	1)_____	2)_____	3)_____
Tiring-Exhausting	0)_____	1)_____	2)_____	3)_____
Sickening	0)_____	1)_____	2)_____	3)_____
Fearful	0)_____	1)_____	2)_____	3)_____
Punishing-Cruel	0)_____	1)_____	2)_____	3)_____

H. Please indicate where you have pain:



I. What makes the pain ***WORSE***? Be Specific. _____

_____

J. What makes the pain ***BETTER***? Be Specific. _____

_____

IV *Effects of Pain*

1. Circle the number to indicate how much your pain has interfered with your activities this past week.

0	1	2	3	4	5	6	7	8	9	10
No Interference		Mild			Moderate			Severe		Complete Interference

2. Circle the number to indicate how distressed or bothered you have been in the past week about the pain.

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		The most Severe Imaginable

V *Current Medications*

List ALL medicines you are currently taking for medical and pain problems (including prescribed, over-the-counter, herbs, vitamins): (Write on the back of this sheet if necessary)

Name	Pill strength	Number of times taken per day	Doctor who prescribed

VI *History of Your Pain*

A. When did your pain start?_____
B. When did your pain become a problem? _____
C. How many times have you gone to the emergency room for pain in the past year? _____
D. What event or events led to your present pain:

☐ accident ☐ other injury ☐ other disease ☐ other _____
☐ cancer ☐ no obvious cause ☐ following an operation

E. What do YOU think is the cause of your pain?

_____
_____
_____

VII *Previous Doctors*

Have you ever been evaluated at a pain center? Yes _____ ; No _____
If Yes List the Doctors Name _____
Facility Name and Address _____

List ALL doctors you have seen for your pain problem (continue on the back of this page if needed).

Date	Name	Specialty	Address/Phone/Fax

VIII *X-rays and Tests*

Please list, in chronological order, all tests and x-rays performed to evaluate your pain:

Date	Test	Results

XI *Previous Treatments*

Indicate which of the following treatments you have tried for your pain problem:

- ☐ antidepressants
- ☐ narcotics
- ☐ nerve blocks
- ☐ traction
- ☐ acupuncture
- ☐ chiropractor
- ☐ massage
- ☐ physical therapy
- ☐ psychotherapy
- ☐ biofeedback
- ☐ relaxation training
- ☐ hypnosis
- ☐ homeopathy
- ☐ TENS
- ☐ exercise program
- ☐ other (list) _____

X *Previous Medications*

List all previous pain medications you have taken for pain:

Name of medicine	Dose	Dates of use	Helpful?	Reason for stopping
			YES NO	
			YES NO	
			YES NO	
			YES NO	

XI *Surgeries*

List any operations, hospitalizations, or injuries you have ever had.

Year	Type of Surgery	Hospital	Doctor

XII *Allergies*

List all allergies to medications and the reaction you had to any medicine:

Medicine	Reaction	Medicine	Reaction

XIII *Review of Systems*

Please check if you have or had any of the following:

A. General
- ☐ weight loss
- ☐ poor appetite
- ☐ severe fatigue/low energy

B. Skin
- ☐ rash
- ☐ nail changes
- ☐ bumps/nodules
- ☐ herpes

C. Head and Neck
- ☐ headaches
- ☐ visual changes
- ☐ mouth problems
- ☐ thyroid problems
- ☐ neck pain
- ☐ difficulty swallowing

D. Hematological
- ☐ anemia
- ☐ easy bruising
- ☐ bleeding disorder
- ☐ taking blood thinners

E. Cardiopulmonary
- ☐ shortness of breath
- ☐ cough
- ☐ exercise limitations
- ☐ chest pain
- ☐ irregular heartbeat
- ☐ heart murmurs
- ☐ high or low blood pressure
- ☐ circulation problems
- ☐ ankle swelling

F. Gastrointestinal
- ☐ abdominal pain
- ☐ nausea or vomiting
- ☐ constipation or diarrhea
- ☐ history of ulcers or heartburn

G. Genitourinary
- ☐ pregnant
- ☐ frequent or hesitant urination
- ☐ pain with urination
- ☐ blood in urine
- ☐ incontinence
- ☐ sexual dysfunction

H. Musculoskeletal
- ☐ arthritis Type:_____
- ☐ osteoporosis
- ☐ muscle pain
- ☐ muscle wasting
- ☐ fractures

I. Neurologic
- ☐ numbness
- ☐ weakness
- ☐ falling or loss of balance
- ☐ stroke
- ☐ seizures
- ☐ memory loss

J. Infections
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ Hepatitis
- ☐ HIV / AIDS

XIV *Past Medical Problems: Please indicate any other medical problems you have had.*

_____

_____

_____

XV *Habits*

A. Smoking: Yes___ No___ Quit ___ Number of Packs/Day_____
Number of years smoked _____
B. Alcohol Use: None ___ Occasional___ Daily ___ How much per week?_____
C. Recreational Drugs: Current use ? Yes _____; No _____
◊ cocaine ◊ amphetamines ◊ marijuana ◊ heroin ◊ other_____
D. Coffee/Tea/Caffeine: Number of Cups/Day_____
E. Clenching teeth: Yes___ No___ Grinding Teeth: Yes___ No___
F. Do you wear an intra oral splint? Yes _____; No _____
G. Is anyone concerned about your use of alcohol, drugs, or medications? Yes____ No____

XVI *Family History*

Member	Deceased or Living	Age	Medical Problems
1. Father			
2. Mother			
3. Siblings			
4. Spouse			

Are you adopted? Yes _____; No _____

XVII *Social History*

A. Relationship Status
- ☐ Single
- ☐ Significant Other ___ Male ___ Female
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

B. Highest level of education you have completed:
- ☐ Less than high school
- ☐ High school
- ☐ Vocational
- ☐ College
- ☐ Graduate
- ☐ Other_____

C. With whom do you live? Name: _____ Relationship: _____
D. What is your current employment status?
- ☐ Employed full time
- ☐ Employed part time
- ☐ Self Employed
- ☐ Homemaker
- ☐ Retired
- ☐ Unemployed due to pain
- ☐ Unemployed due to other reasons: _____

How long have you been unemployed or retired?
_____

Are you on disability? Yes___ No___
Date disability started:_____
Reason for disability:
_____
_____

E. Number of hours worked per week: _____ Are you happy with your job? _____
Your current or most recent occupation _____

XVIII *Financial Information*

A. What are your present sources of financial support?
- ☐ Personal earnings
- ☐ Disability
- ☐ Workman's comp
- ☐ Spouse's earnings
- ☐ Pension/retirement
- ☐ Insurance
- ☐ Other_____
- ☐ None

B. Are you hoping to receive other income or compensation? If so, please indicate:

- ☐ Disability payment
- ☐ Workmen's compensation
- ☐ Legal settlement
- ☐ Other (describe)_____

C. Do you have any legal action pending related to this pain or any other health problem? Yes___ No___
If yes please list: Attorneys name _____
Address _____
Phone # _____

XIX *Psychological History*

1. Describe your mood.

_____

_____

2. Do you have problems with any of the following:

- ☐ concentration
- ☐ anxiety
- ☐ homicidal thoughts
- ☐ motivation
- ☐ depression
- ☐ appetite
- ☐ sleep
- ☐ self-worth
- ☐ suicidal thoughts

3. Are you currently in therapy Yes___ No___
4. If Yes, Name _____: Degree M.D.____; Ph.D. ____; MFCC ____
Phone # (_____) _____