Comprehensive Pain Care, P.C.

Patient Information

Name _____ Date _____ / _____ / _____

Date of Birth _____ / _____ / _____ Age _____ Sex _____

To be filled out by the nurse:

BP: _____ / _____ P: _____ R: _____ T: _____ Weight: _____ Height: _____

General Health Review:

(By answering the following questions, you will help your physician better understand and treat your pain.)

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, include nerve blocks, epidurals and other injections here)

_____ _____ _____

_____ _____ _____

Allergies (include medication and food allergies)

_____ _____ _____

_____ _____ _____

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

_____ _____ _____

_____ _____ _____

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

_____ _____ _____

_____ _____ _____

Current Physicians (include name and phone number and/or office address):

Primary Care Physician: _____

(We do not provide primary care services and highly recommend that you have a primary care physician.)

Psychiatrist: _____

Clinical Psychologist and/or counselor: _____

Specialty physician: _____

Specialty physician: _____

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:

Circle one: Single Married Widowed Divorced

Children: No Yes Ages: _____

With whom do you live? _____

Are there any substances abuse issues in the household? Yes _____ No _____

If yes, please explain _____

Are you able to take care of yourself? Yes _____ No _____

If not, please provide 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 used it occasionally ("O"), frequently ("F"), or continuously ("C").

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

Have you felt the need to cut down on your medication use? (Circle one.) Yes No

Have people annoyed you by criticizing your medication use? (Circle one.) Yes No

Do you presently smoke cigarettes or use tobacco in any form? (Circle one.) Yes No

If not, did you ever smoke cigarettes or use tobacco in any form? (Circle one.) Yes No

How many packs do (did) you smoke a day? _____ For how many years? _____

Pain Assessment:

When and how did you pain problem start? _____

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

What tests and studies have been done?

(for example: MRI, CT-Scan, X-Rays)	Month/Year Done	Results

What doctors have you seen for this problem in the past? (Do not list current physicians listed previously) 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

Circle the words that describe your pain.

Arching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Intermittent	Continuous	

Rate your pain on the scales below using a 0 to 10 scale where 0 = no pain and 10 = the worst pain that you can possibly imagine.

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

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

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

0	1	2	3	4	5	6	7	8	9	10

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

0	1	2	3	4	5	6	7	8	9	10

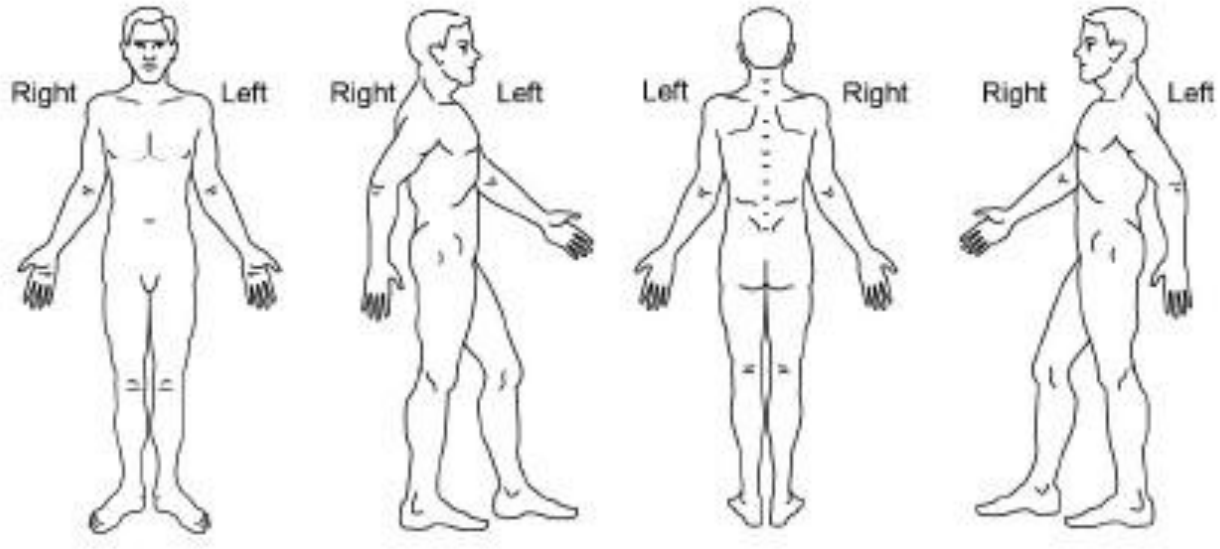
What sort of things make this pain feel **better** (for example: heat, rest, medicine)?

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

The following statement best reflects the effect of my **current pain medications** (circle one):

1. My pain medication does not help at all.
2. My pain medication provides some relief but not enough to be considered meaningful.
3. My pain medication helps and definitely improves my quality of life.

On the diagram below, shade the area(s) where you feel pain. "X" the areas that hurt the most.
Please be as exact as possible.



Circle the number below that best describes 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

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