COMPREHENSIVE CENTERS
FOR PAIN MANAGEMENT

PATIENT INFORMATION FORM
Please complete with blue or black ink only.

Please complete and bring with you to your appointment.

Name:____

Address:_______________________________City:_________________________State:_____Zip:_______________

Home Phone:___________________________ Work Phone:______________________ Cell:___________________

Age:________ Date of Birth:____________________ Sex: Male Female Height: _________Weight:____________

Physician Information:

Family: ____
Address:____
City: ____State: __________ Zip: ________________
Referring: ____
Address: ____State: __________Zip: ___________________

Present Problem:

Briefly list the main reason(s) for your visit today: ____

How did your pain problem first start (describe): ____

____
_

Please describe what your pain is like: ☐**Sharp** ☐**Shooting** ☐**Burning** ☐**Pressure** ☐**Throbbing** ☐**Cramping** ☐**Achy** ☐**Constant** ☐**Stabbing** ☐**Gnawing** ☐**Tender** ☐**Comes and goes**

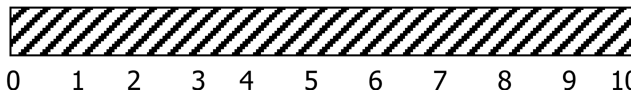
How long have you had this pain?____

At any given time, think of your pain intensity as falling somewhere on a scale from 0 to 10.
Please rate your pain on the following diagrams: **0=No pain** **10=Very severe pain**

Current Level of Pain

0 1 2 3 4 5 6 7 8 9 10

Average Level of Pain



0 1 2 3 4 5 6 7 8 9 10

When is your pain the worst? (check one): ☐**Morning** ☐**Afternoon** ☐**Evening** ☐**Night** ☐**Varies** ☐**All the time**

Are you awakened at night by your pain? ☐**No** ☐**Yes**

What improves your pain? : ____

What worsens your pain? : ____

Patient Name:____

Pain Evaluation Instructions: In each section, check **ONE** box that best describes your pain.
If section has no description that applies to your pain, please skip that section.

1.flickering		1.jumping		1.pricking	
2.quivering		2.flashing		2.boring	
3.pulsing		3.shooting		3.drilling	
4.throbbing				4.stabbing	
5.beating				5.lacinating	
6.pounding					

1.pinching		1.tugging		1.hot	
2.pressing		2.pulling		2.burning	
3.gnawing		3.wrenching		3.scalding	
4.cramping				4.searing	
5.crushing					

1.dull		1.tender		1.tiring	
2.sore		2.taut		2.exhausting	
3.hurting		3.rasping			
4.aching		4.splitting			
5.heavy					

1.fearful		1.punishing		1.wretched	
2.frightful		2.gruelling		2.blinding	
3.terrifying		3.cruel			
		4.vicious			
		5.killing			

1.spreading		1.tight		1.cool	
2.radiating		2.numb		2.cold	
3.penetration		3.drawing		3.freezing	
4.piercing		4.squeezing			
		5.tearing			

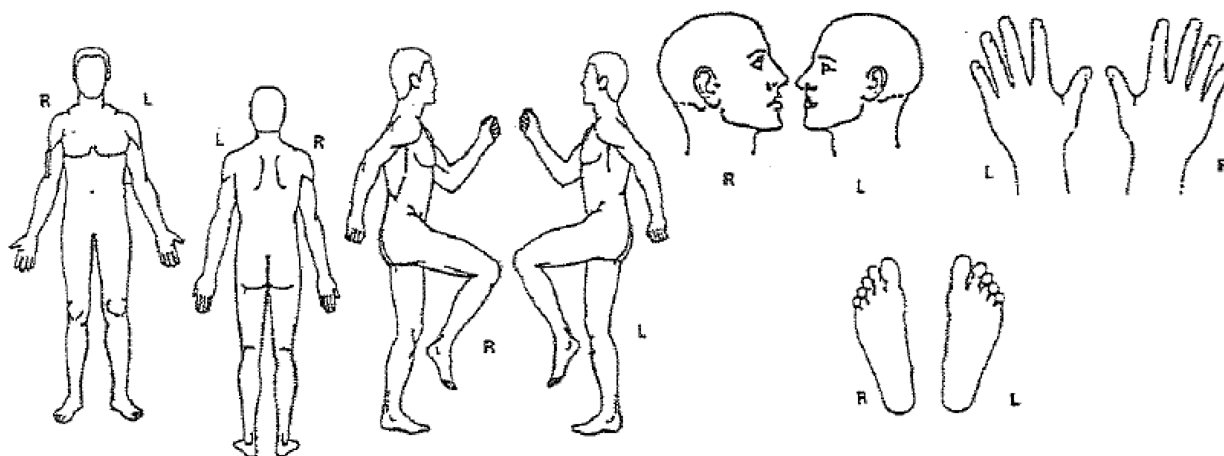
Patient Name:___________________________________

Previous Treatment for Pain:

Which of the treatments listed below have you participated in to relieve your pain.

	Helpful				
Treatment	**Y**	**N**	**Y**	**N**	**Date**
Nerve Blocks					
TENS Unit					
Occupational/Physical Therapy					
Bio-Feedback					
Hypnosis					
Counseling					
Chiropractor					
Acupuncture					
Other (please note treatment)					

Please shade in the areas where you feel pain and the degree of pain you are feeling on the drawings below. Please use the following examples: **minimal pain-light shading** **severe pain-dark shading**



Which of the tests below have you had to evaluate your pain problems?

Test	Y	N	Date	Where were tests done?
X-Rays				
CT Scan				
MRI				
EMG				
Myelogram				
Other (please indicate type of test)				

Patient Name:___________________________________

Medical History:

Check All that Apply

Head/Eyes/Ears/Nose/Throat	
None	
Cataract	
Glaucoma	
Sinus Infection	
Heart	
None	
Rheumatic Fever	
Heart Failure	
Abnormal Heart Rhythm	
High Blood Pressure	
Lung	
None	
Asthma	
Sleep Apnea	
Tuberculosis	
Emphysema/COPD	
Pneumonia	
Gastrointestinal	
None	
Stomach/Duodenal Ulcer	
Cirrhosis	
Hepatitis (Type)__________	
Gallstones	
Pancreatic Disease	
Esophagus Disease	
Crohn's or Colitis	
Diverticulitis	
Acid Reflux/GERD	
Genitourinary	
None	
Kidney Infection	
Kidney Stones	
Kidney Failure	
Dialysis	
Prostate Problems	
Muscle Skeletal	
None	
Rheumatoid Arthritis	
Gout	
Lupus	
Serious Joint Injury	
Broken Bone/Fracture	
Degenerative Arthritis	
Osteoporosis	
Fibromyalgia	

Neurological/Psychological	
None	
Headache	
TIA(Mini Stroke)	
Multiple Sclerosis	
Stroke/Paralysis	
Seizure/Epilepsy	
Depression	
Anxiety	
Eating Disorder	
Endocrine	
None	
Thyroid Disease	
Diabetes	
Hemtological/Oncological	
None	
Cancer (Type)_______________	
Chemotherapy	
Radiation	
Anemia	
Blood Clot (Leg__Lung__other_____)	
Bleeding Tendency	
Peripheral Vascular	
Aneurysm	
Varicose Veins	
Peripheral Vascular Disease (PVD)	
Skin	
Skin Ulcer-Lower Leg	
Psoriasis	
Rash	
Other	
Alcoholism	
Drug Abuse	
Immune Deficiency	
Chronic Fatigue Syndrome	
Other________________________	

Patient Name:___________________________________

Past Surgeries:

Please list all surgeries

SURGERY	DATE	SURGERY	DATE

Allergies:

Are you allergic to any medications? ☐ Yes ☐ No If Yes, which medications? ____________________________________

____
_

Have you ever had difficulties with spinal, epidural or anesthetics? ☐ Yes ☐ No

Current Medications:

What, if any, medications are you currently taking. Please list all medications, prescriptions and over the counter, including herbs and vitamins.

Medication/Dosage	Frequency	Medication/Dosage	Frequency

List any medications that you have previously taken for your pain.

Medication/Dosage	Frequency	Why did you discontinue??

Patient Name:___________________________________

Family History:

Check All That Apply

	Mother	Father	Sisters	Brothers	Grandmother	Grandfather
Cancer						
Heart Disease						
Lung Disease						
Diabetes						
Kidney Disease						

Social History:

Alcohol Use: Frequency____ Amount: _______________________________

Tobacco Use: None:____________ or per day:____

Marital Status: Married_______ Single: _______ Widowed: ________ Divorced: _________

Employment Status: Full-Time:____ Part-Time: ____ Unemployed: ____ Student:_____ Retired: ____ Disabled:______

Occupation: ____

What does your work involve? ____

Who lives at home with you? ____

Drug Use: ☐ None ☐ Prescribed ☐ Marijuana-frequency_________________ ☐ Cocaine-frequency_________________

☐ Other:

____

Patient Name:___________________________________

Review of Systems:

In the **PAST 4 WEEKS** have you noticed any of the following symptoms? Please check all that apply.

General	
None	
Weight Change	
Appetite Change	
Fever, Chills, Sweats	
Dizziness/Fainting	
Head/Eyes/Ears/Nose/Throat	
None	
Vision Change	
Hearing Change	
Dry Mouth	
Trouble swallowing	
Mouth Sores	
Cardiopulmonary	
None	
Shortness of Breath	
Chest Pain	
Swollen Ankles	
Coughing up Blood	
Rapid heart rate	
Gastrointestinal	
None	
Heartburn	
Nausea	
Abdominal Pain	
Constipation	
Diarrhea	
Bleeding from Rectum	
Black Bowel Movements	

Genitourinary	
None	
Problems with passing urine	
Urine Leakage	
Menstrual problems	
I may be pregnant	
Pain with passing urine	
Muscoskeletal/Neurological	
None	
Headache	
Joint Pain	
Joint Swelling	
Stiff Muscles	
Painful Muscles	
Weakness	
Numbness/Tingling	
Where?_______________________	
Back Pain	
Neck Pain	
Skin	
None	
Rashes	
Skin Ulcers	
Peripheral Vascular	
None	
Cool Hands/Feet	
Color Change	
Leg Pain when Walking	

Patient Name:___________________________________

Patient Plan of Care/Goals:

(To be completed with the Nurse at the time of the first appointment)
It is important that you take an active role in a plan to control your pain. Please communicate with our Pain Management Staff, your Pain Management goals. (Including any educational needs)

1. Restore or improve functioning by reducing pain whenever possible:_____________________________________
2. Develop self-help and maintenance skills for managing pain and it's related problems:_______________________
3. Increase knowledge of Chronic Pain Management:____
4. What do you expect from the Pain Management Clinic? ____
5. ____
6. ____
7. ____

Completed By:____Date:______________________________

Reviewed By:____Date:______________________________