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Patient Name_____ Date_____

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 (i.e., the diagnosis)?_____

_____

_____

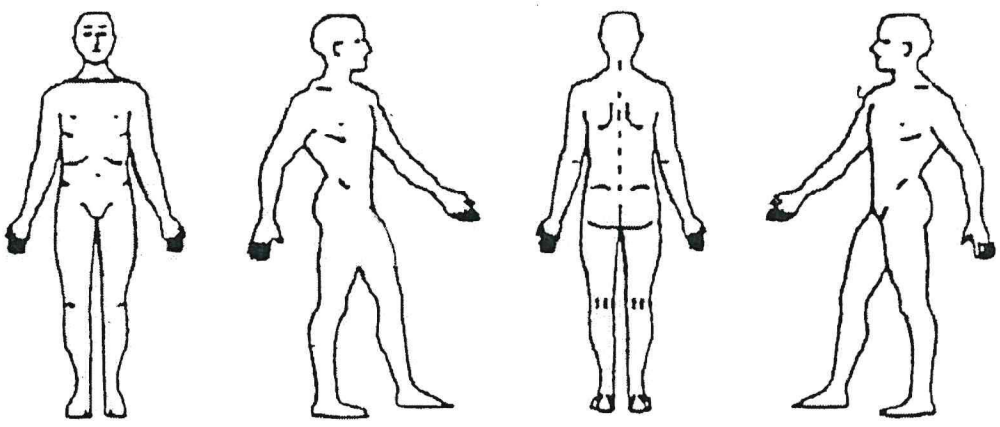
What doctors have you seen? When did you see them? What did they do?

Doctor's Name	Month/Year Seen	What was done? (for example, Doctor did physical exam, Ordered tests, prescribed medication, etc.)

What tests and studies have been done?

Tests & Studies (For example, MRI, CT Scan, X-rays, etc.	Month/Year Done	Results

On the diagram below, shade the area(s) where you feel pain. "X" the areas that 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	☐

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 you pain better or worse. Use a separate sheet for each body site.

Body site ______________________________

Circle the words that describe your 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 the 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.**

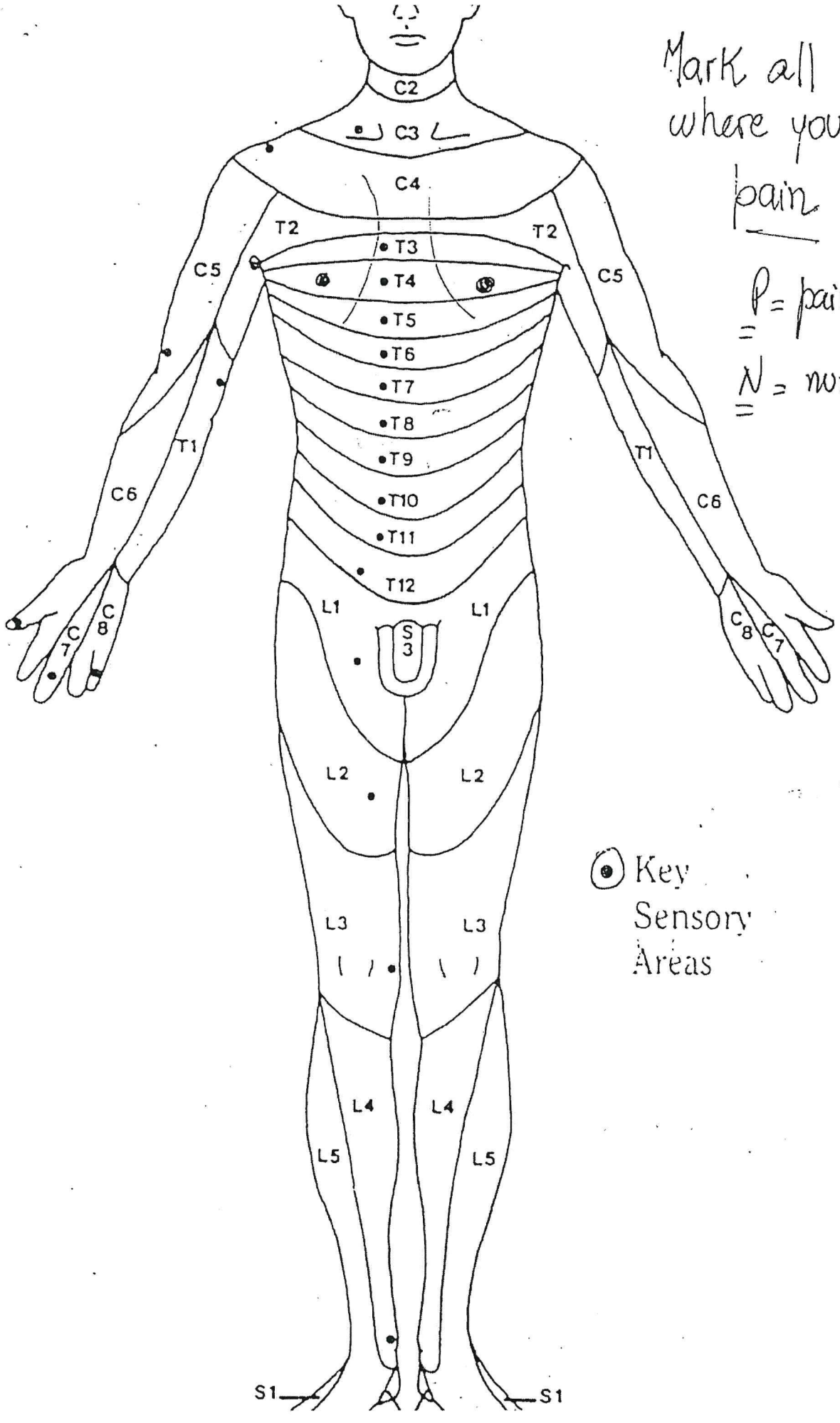
0 1 2 3 4 5 6 7 8 9 10

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

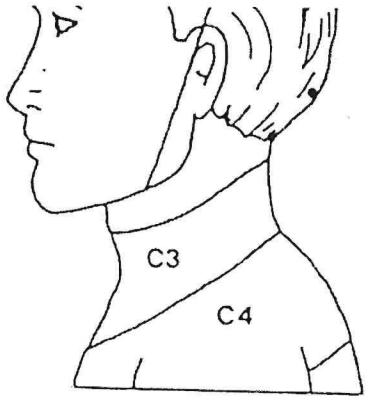


Mark all areas where you have pain.

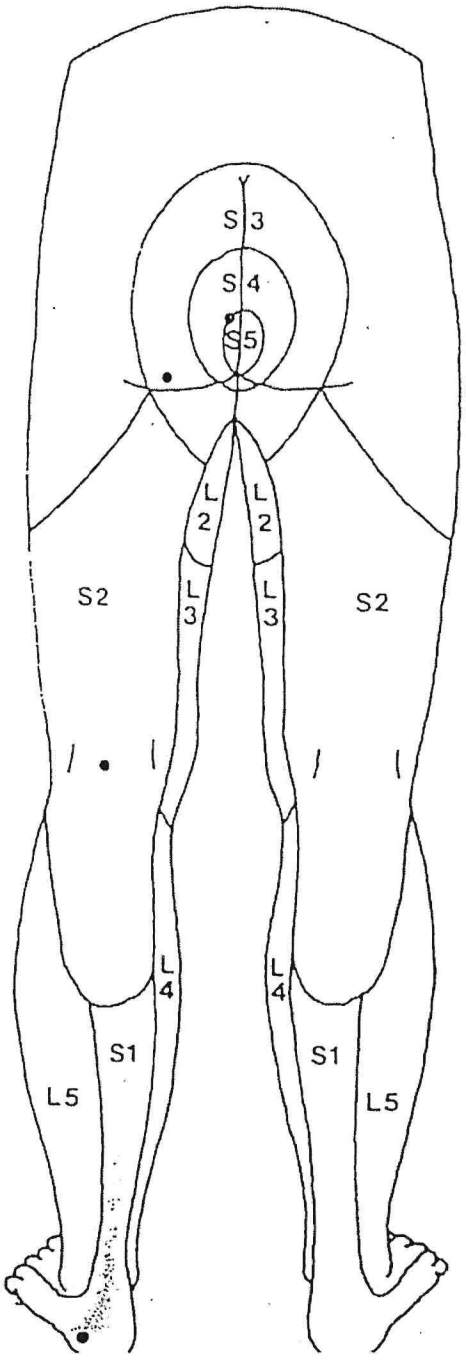
P = pain

N = numbness.

Key Sensory Areas



Mark all areas where you have pain (P) or numbness (N)



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?)

_____

_____

_____

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

Level of Stress

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

Domestic Situation

With whom do you live?_____

Are ther any substance abuse issues in the household? Yes_____ No_____

If yes, please 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 Abuse

Which of the following drugs or substances, if any, have you used in the <u>past</u>? (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 _____	Barbituates_____	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 _____	Barbituates_____	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 many packs do (did) you smoke a day? _____ For how many years? _____