

Initial Patient Assessment Form

Patient Name: _____ Date: _____

Date of Birth: _____ Sex: Male Female

Referring Physician Name: _____ Phone #: _____

Primary Care Physician Name: _____ Phone #: _____

Please check if you brought the following: Medical Records Films Test Results Other

Chief Complaint (reason for your visit today): _____

Nature / Mechanism of injury: _____ Date of Injury _____

HPI (History of Present Illness) Please provide a brief overview of your pain history:

Location: _____

Severity: (check one) MILD MODERATE SEVERE

Duration: (check one) CONSTANT INTERMITTANT

Modifying Factors / Relieved with: (check all that apply) SITTING STANDING LYING WALKING

Worse with: (check all that apply) SITTING STANDING LYING WALKING

Associated Symptoms: _____

1. Rate your pain by selecting ONE NUMBER that best describes your pain at it's **worst**:

0 1 2 3 4 5 6 7 8 9 10

No pain

Moderate Pain

Pain as bad as you can imagine

2. Rate your pain by selecting ONE NUMBER that best describes your pain at it's **least**:

0 1 2 3 4 5 6 7 8 9 10

No pain

Moderate Pain

Pain as bad as you can imagine

3. Rate your pain by selecting ONE NUMBER that best describes your pain right **now**:

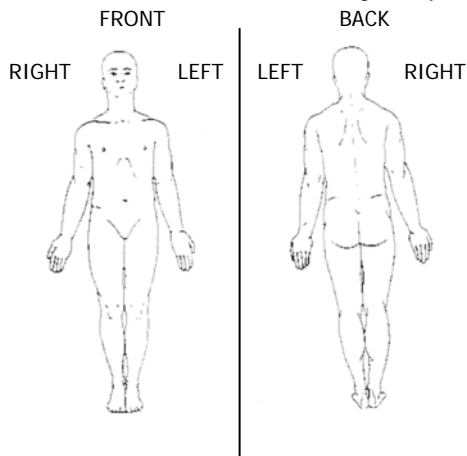
0 1 2 3 4 5 6 7 8 9 10

No pain

Moderate Pain

Pain as bad as you can imagine

Please indicate the location of your pain below



Please check the qualities of your pain below:

YES NO

- Throbbing
- Shooting
- Stabbing
- Sharp
- Cramping
- Burning
- Aching
- Pressure
- Tender
- Numbness
- Pins and Needles

Review of Systems: To your knowledge, do you now have or have you ever had any of the following:

Please check or add

- **Constitutional** fever weight loss sweats other_____
- **Eyes** visual disturbance eye pain other_____
- **Ears, Nose, Mouth Throat** pain hearing loss loss of smell difficulty swallowing other_____
- **Cardiovascular** chest pain palpitations other_____
- **Respiratory** cough sputum shortness of breath wheezing other_____
- **Gastrointestinal** abdominal pain diarrhea constipation nausea vomiting other_____
- **Musculoskeletal** weakness or paralysis in arms or legs pain other_____
- **Integumentary** skin rashes lesions ulcers other_____
- **Neurological** Headache seizure dizziness other_____
- **Psychiatric** depression anxiety psychosis other_____
- **Endocrine** increased nighttime urination nighttime thirst heat or cold intolerance other_____
- **Hematologic / Lymphatic** enlarged lymph nodes excessive bleeding other_____
- Are you currently **pregnant** or considering getting pregnant YES NO

Past Medical History Do you currently have, or have you ever had any of the following? (Please check all that apply)

Diabetes	High Blood Pressure	Heart Attack	Heart Failure	Fibromyalgia
Blood/Bleeding Disorder	Phlebitis or Blood Clots	Taking Anticoagulants	Ulcer	Hepatitis
Stroke	Cancer	Emphysema	Asthma	Headaches / Migraines
Kidney Disease	Significant Injuries	Anesthesia Complications	Epilepsy	Thyroid Disorder
Seizure	Liver Disease	Sleep Apnea	Cold Hands/Feet	Depression
Rheumatologic Disease	Skin Condition	Other (specify):		

Previous Medications Check the medications you have used for your current pain problem:

Narcotics : Demorol Morphine Dilaudid MS Contin Methadone Darvocet Percocet Vicodin
Codeine Tylenol 3 Fentanyl Patch Oxycontin Avinza

NSAIDs: Aspirin Motrin Ibuprofin Dolobid Advil Naprosyn Relafen Mobic Voltarin Lodine

Sedatives/Relaxants: Ativan Xanax Valium Flexeril Parafon Forte

Sleep Medicine: Halcion Ambien Restoril Benadryl

Antidepressants: Elavil Pamelor Desipramine Effexor Desyrel Prozac Zoloft Paxil Serzone
Remeron Cymbalta

Anticonvulsants: Neurontin Klonopin Tegretol Dilantin Lyrica Topamax

Neuropathic Pain Medications: Baclofen Phenoxybenzamine Ultram Prazosin

ANY OTHER NOT LISTED: _____

Have you been treated by any other Pain Specialist or Clinic: YES NO

If Yes, name of specialist or clinic: _____ Date last seen: _____

Previous Treatments

Check all that apply: acupuncture traction TENS unit Chiropractor Ice / Heat
Physical therapy biofeedback massage psychologist

List all hospitalizations (surgery, childbirth, medical illness) Attach additional page if necessary.

Date (approx. year)	Reason	Place (hospital or city)

