INITIAL PAIN ASSESSMENT
David Herson MD PA
Pain Management Physician

NAME_____
DATE_____
Date of Birth_____ SEX: (A) Male (B) Female Marital Status _____
Home phone _____Cell Phone _____Work_____

COMPLAINT (What are you being seen for?)

A. Neck Pain
B. Neck Pain with headaches
C. Upper Back Pain
D. Lower Back Pain
E. Right Leg Pain
F. Left Leg Pain
G. Right Arm Pain
H. Left Arm Pain
I. Other Pain (where?)_____

Do you have any (if so which part of the body and where?)

A. Weakness_____
B. Numbness_____
C. Tingling_____

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 you pain (i.e., the diagnosis)?_____

_____

_____

When did you first notice your pain?_____

_____

_____

If problem was caused from an injury, what is the date of injury?_____
Was the injury job related? Yes_____ No_____

How did the injury occur? e.g. job, MVA, fall, sports injury
If motor vehicle accident, were you:

A. Driver
B. Front seat passenger
C. Rear seat passenger
D. Motorcycle driver
E. Motorcycle passenger
F. Other_____

Were you wearing a seat belt? Yes_____ No_____

Regarding your pain:
What doctors have you seen? 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?

What tests and studies have been done? (for example: MRI, CT Scan, X-Rays, etc.)

Test	Month/Year Done	Results

List the body sites where you experience pain and circle the words that best describe the pain at the site. Also, indicate the intensity of the pain and those things that make your pain better or worse. Use a separate sheet for each body site.

Body Site _____

Circle the words below that describe your pain.

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

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 that 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

In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the percentage that most shows how much RELIEF you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No relief Complete relief

Other than prescription medicine, does anything else relieve the pain?

____NO ____YES (circle any that you use below)

Non-prescription drugs (e.g., acetaminophen, ibuprofen)
Herbal remedies
Hot or cold packs
Exercise
Changing position (such as lying down or elevating your legs)
Physical therapy
Massage
Acupuncture
Rest
Psychological counseling
Talk to trusted friend, family, clergy
Prayer, meditation, guided imagery
Relaxation technique (hypnosis, biofeedback)
Other (e.g., specific chiropractic manipulation, osteopathic treatments)

If you take your pain medicine for persistent pain as scheduled, are there times during the day that you experience unrelieved breakthrough pain? ____Yes ____No

How many times does this happen a day? _____

Does any specific activity start your breakthrough pain? ___No ___Yes What activities? _____

What aggravates the pain? (circle those that apply)
Walking Standing Sitting Lying down Activity in general Stooping/bending
Nothing in particular Other/comments_____

What makes the pain better? (circle those that apply)
Sitting Lying down Walking Standing Nothing in particular
Other/comments_____

What treatments have you already received for this condition?
A. Medications (list)_____
When was each medication last taken?_____
B. Physical therapy (how many weeks?) _____
C. Chiropractic care (how many weeks?)_____
D. Epidural injections: How many injections?_____ When was the last?_____
Facet blocks or any other interventional pain procedures?_____

Since the pain/condition began it:
A. Has improved
B. Has worsened
C. Has stayed the same
D. Comes and goes

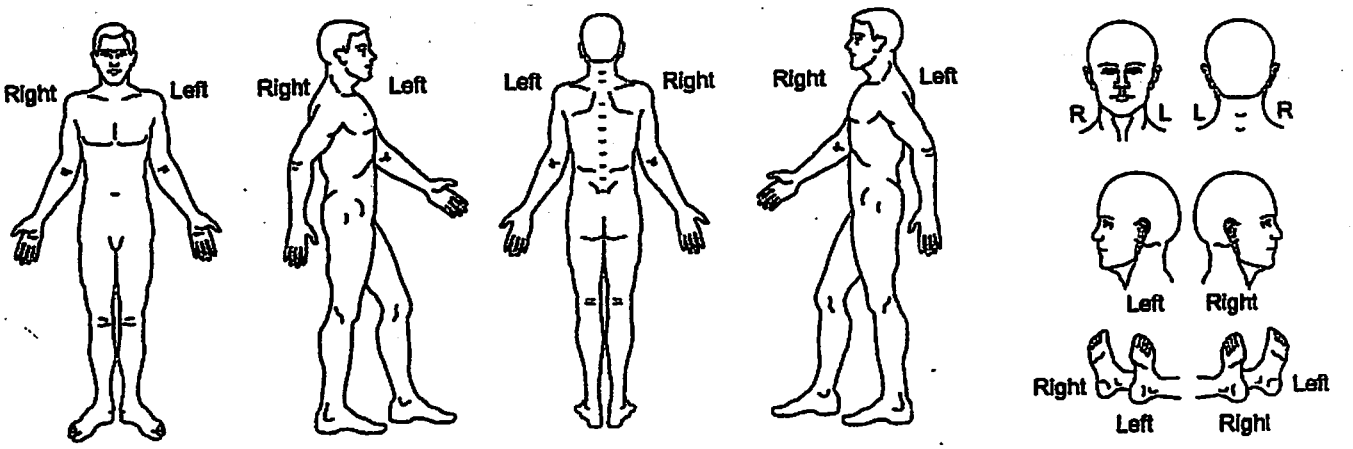
What time of the day is the pain most intense?
A. On the first arising in the morning
B. During the daytime or while at work
C. At the end of the day before bedtime
D. During the night

Do you have any difficulty walking?
A. No
B. Yes, can walk unlimited distances
C. Yes, can walk less than a mile
D. Yes, can walk only 1-2 blocks
E. Ye, can walk less than 1 block
F. Yes, cannot walk
G. Other_____

Have you had any problems with bowel (diarrhea, constipation), bladder (incontinence), or sexual functions since this condition began?
No
Yes , Please explain_____
_____

Do you exercise regularly?
No
Yes, How often?_____

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



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

Appetite

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

Hobbies or Sports

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

Chores or duties around the house, errands

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

Does not interfere Completely interferes

Ability to take care of one self e.g. showering, dressing, combing hair, bathing

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

Effect on sex life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

Occupation-ability to work

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

Social activities

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes