

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. Yes, 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

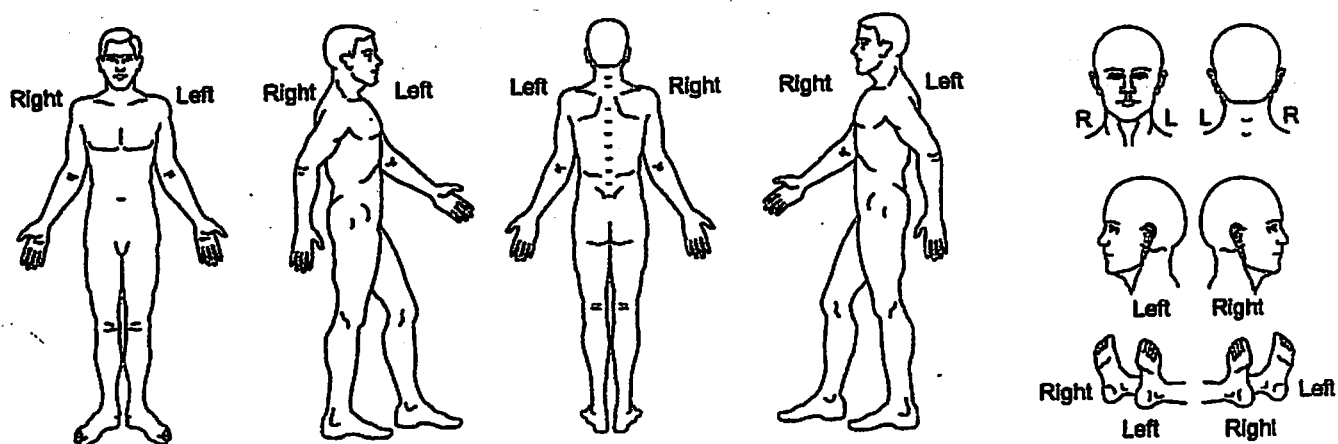
Yes, Please explain _____

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