PAIN EVALUATION
GENERAL

Queensland Specialist Centre

Date:_____ Arrival Time: _____

PATIENT INFORMATION:

Name:_____ Age: _____

Daytime Phone #_____ Alternate Phone # _____

Primary language:_____ Height:_____ Weight:_____ Dominant Hand: ❑ Right ❑ Left

OTHER / REFERRING DOCTORS: please list the Doctors you would like records sent to

Name of Doctor	Specialty	Phone Number	Fax	Address

UNDERSTANDING YOUR CURRENT PAIN: *(Reason for visit)*

Describe in ***your own words*** the pain problem(s) you would like help with:

_____

_____

_____

Below is a list of words that may describe your pain. Please rate each word by placing a check mark in the column that best describes the intensity of that type of pain:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Throbbing	❑	❑	❑	❑	Heavy	❑	❑	❑	❑
Shooting	❑	❑	❑	❑	Tender	❑	❑	❑	❑
Stabbing	❑	❑	❑	❑	Splitting	❑	❑	❑	❑
Sharp	❑	❑	❑	❑	Tiring-Exhausting	❑	❑	❑	❑
Cramping	❑	❑	❑	❑	Sickening	❑	❑	❑	❑
Gnawing	❑	❑	❑	❑	Fearful	❑	❑	❑	❑
Hot-Burning	❑	❑	❑	❑	Punishing-Cruel	❑	❑	❑	❑
Aching	❑	❑	❑	❑					

Is your pain: ❑ Continuous or ❑ Intermittent*?

*If your pain is **intermittent** how often does it occur?

❑ Several times a day ❑ Several times per week ❑ Less than once per week

❑ Once per day ❑ Once per week ❑ Never

❑ Other _____

How long does your pain last? ❑ None ❑ Seconds ❑ Minutes ❑ Hours ❑ Days ❑ Weeks

Is your pain: ❑ Continuous or ❑ Intermittent*?

*If your pain is **intermittent** how often does it occur?

❑ Several times a day ❑ Several times per week ❑ Less than once per week

❑ Once per day ❑ Once per week ❑ Never

❑ Other _____

How long does your pain last? ❑ None ❑ Seconds ❑ Minutes ❑ Hours ❑ Days ❑ Weeks

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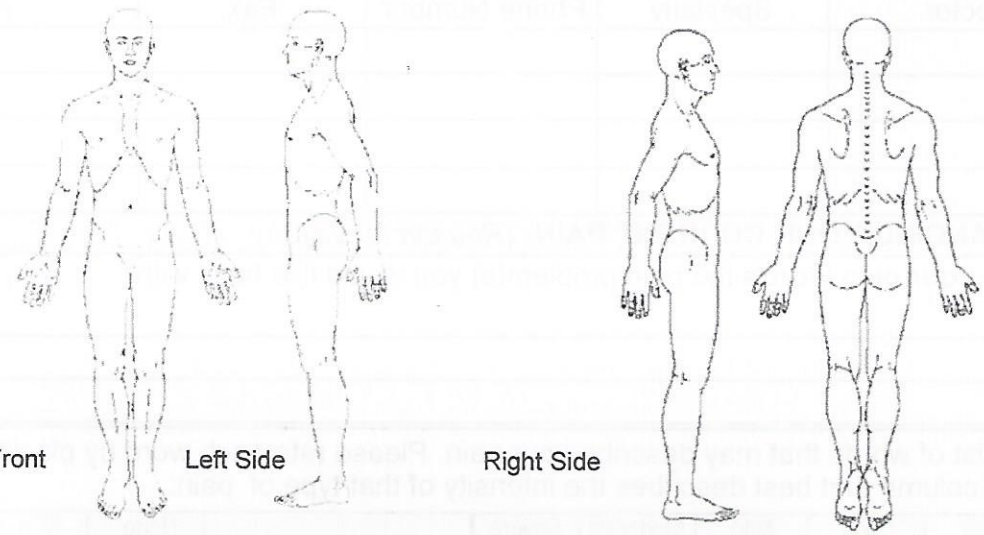
UNDERSTANDING YOUR CURRENT PAIN: *(Cont'd)*

Circle a number below to indicate your **usual** pain intensity over the past week:

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain		Moderate pain			Severe pain			Most intense pain imaginable

Please mark area(s) of pain with an (X):



Front Left Side Right Side

What makes the pain ***WORSE?*** Be Specific.

_____

_____

_____

What makes the pain ***BETTER?*** Be Specific.

_____

_____

_____

EFFECTS OF PAIN:

Circle the number to indicate how much your pain has interfered with your activities this **past week.**

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain		Moderate pain			Severe pain			Most intense pain imaginable

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CURRENT MEDICATIONS:

List all medications you are currently taking for medical and pain problems including prescribed, over-the-counter, herbs, and vitamins. Do not bring your medicines to the clinic unless you have a question to discuss with the physicians. Please use an additional sheet of paper if more room is needed.

Medication Name	Dose	Schedule	Prescribing Doctor

Pharmacy Name, Phone and FAX _____

HISTORY OF YOUR PAIN:

When did your pain start? _____

When did your pain become a problem? _____

What event(s) led to your present pain?

❑ Accident ❑ Other injury ❑ Other disease ❑ No obvious cause

❑ Cancer ❑ Following an operation ❑ Other: _____

What do **YOU** think is the cause of your pain?

_____

_____

PREVIOUS DOCTORS

List ALL of the doctors you have seen for your pain

Date	Name	Specialty	Address / Phone / Fax

DIAGNOSTIC TESTS:

Please list, in chronological order, all tests and x-rays performed to evaluate your pain:

Date	**Test**	**Results**

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PREVIOUS TREATMENTS:

Indicate which of the following treatments you have tried for your pain problem:

❑ Nerve Blocks ❑ Chiropractor ❑ Psychotherapy ❑ Relaxation Training
❑ Acupuncture ❑ Physical Therapy ❑ Biofeedback ❑ Exercise Program
❑ Other (list):_____

PREVIOUS MEDICATIONS: List all previous medications you have taken for pain:

Name of Medicine	Dose	Dates of Use	Helpful	Reason for stopping
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	

PAST MEDICAL PROBLEMS:

List any medical problems or injuries you have ever had.

Year	Describe	Hospital	Doctor

SURGICAL HISTORY:

List any medical problems or injuries you have ever had.

Year	Describe	Hospital	Doctor

ALLERGIES: ❑ No Known Allergies

Medicine	Reaction	Medicine	Reaction

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REVIEW OF SYSTEMS:

Please check if you have **or** had any of the following:

General
- ❑ Weight change
- ❑ Poor or changed appetite
- ❑ Severe fatigue / low energy
- ❑ Recent fevers
- ❑ Recent Antibiotics

Hematological
- ❑ Anemia
- ❑ Easy bruising
- ❑ Bleeding disorder
- ❑ Taking blood thinners
- ❑ Blood Transfusion
- ❑ Cancer

Skin
- ❑ Rash
- ❑ Nail changes
- ❑ Bumps / nodules

Head and Neck
- ❑ Headaches
- ❑ Visual changes
- ❑ Mouth problems
- ❑ Neck pain
- ❑ TMJ problems

Cardiac
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Heart murmurs
- ❑ High or low blood pressure
- ❑ Circulation problems
- ❑ Ankle swelling

Pulmonary
- ❑ Shortness of breath
- ❑ Cough
- ❑ Asthma or bronchitis
- ❑ Lung disease
- ❑ Sleep apnea
- ❑ Snoring

Endocrine
- ❑ Diabetes
- ❑ Thyroid problems

Gastrointestinal
- ❑ Abdominal Pain
- ❑ Nausea or vomiting
- ❑ Constipation
- ❑ Diarrhea
- ❑ History of ulcers
- ❑ Reflux
- ❑ Heartburn

Genitourinary
- ❑ Frequent or hesitant urination
- ❑ Pain with urination
- ❑ Blood in urine
- ❑ Incontinence
- ❑ Sexual dysfunction

Musculoskeletal
- ❑ Arthritis -Type:_____
- ❑ Osteoporosis
- ❑ Muscle pain
- ❑ Muscle wasting
- ❑ Fractures

Neurologic
- ❑ Numbness
- ❑ Weakness
- ❑ Falling
- ❑ Stroke
- ❑ Seizures
- ❑ Memory Loss
- ❑ Loss of balance

Infectious Diseases
(check all that apply)
- ❑ Measles ❑ Mumps
- ❑ Chicken Pox
- ❑ Rheumatic fever
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Other:_____
- ❑ HIV ❑ AIDS
- ❑ Herpes (Oral)
- ❑ Herpes (Genital)
- ❑ Shingles
- ❑ Post-herpatic neuralgia

In the last 5 years:
Received:
Pneumovax: ❑ Yes ❑ No
Flu shot: ❑ Yes ❑ No
Zoster: ❑ Yes ❑ No

Gynecologic
- ❑ Pregnant
- ❑ Post-menopausal
- ❑ Last Menstrual Period
  Date: _____

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PATIENT I.D.

PSYCHOLOGICAL HISTORY:

Describe your mood: _____

_____

Do you have problems with any of the following:

❑ Concentration ❑ Motivation ❑ Sleep ❑ Appetite ❑ Anxiety

❑ Depression ❑ Self-worth ❑ Homicidal thoughts ❑ Suicidal thoughts

Do you have a history of physical or mental abuse? ❑ Yes ❑ No

Are you currently in therapy? ❑ No ❑ Yes, who do you see?_____Phone # _____

HABITS:

Smoking: ❑ Yes ❑ No ❑ Quit Packs per day:_____ Number of years smoked: _____

Alcohol use: ❑ None ❑ Occasional ❑ Daily How much per week? _____

Are you currently using recreational drugs? ❑ No ❑ Yes: ❑ Amphetamines ❑ Cocaine

❑ Heroin ❑ Marijuana ❑ Other: _____

Have you ever used recreational drugs? ❑ Yes ❑ No ❑ Quit

Do you drink caffeine *(coffee, tea, etc.)*? How many cups per day? _____

Do you clench your teeth? ❑ Yes ❑ No

Do you grind your teeth? ❑ Yes ❑ No

Do you wear a night guard over your teeth? ❑ Yes ❑ No

EXERCISE:

Do you exercise? ❑ No ❑ Yes, what type? _____

How many days per week do you exercise? _____

How long do you exercise each time (on average)? _____

FAMILY HISTORY: Are you adopted? ❑ Yes ❑ No

Member	Deceased or Living		Age	Medical Problems
Father	❑	❑		
Mother	❑	❑		
Siblings	❑	❑		
	❑	❑		
	❑	❑		
	❑	❑		
Spouse	❑	❑		

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SOCIAL HISTORY:

Relationship Status: ❑ Single ❑ Separated ❑ Married ❑ Widowed
❑ Domestic Partner: ❑ Female ❑ Male

With whom do you live? Name:_____ Relationship: _____

Highest level of education completed: ❑ Less than High School ❑ High School ❑ Vocational
❑ College ❑ Graduate School ❑ Other: _____

Current or most recent occupation: _____

Status: ❑ Full Time ❑ Part time ❑ Self-employed ❑ Homemaker ❑ Retired_____years
❑ Unemployed_____years due to pain ❑ Unemployed_____years due to _____

Are you happy with your job? ❑ Yes ❑ No

Are you on Disability? ❑ No ❑ Yes, Date Started: _____
Reason for disability: _____

FINANCIAL INFORMATION:

Do you have any legal action pending related to this pain or any other health problem?

❑ No ❑ Yes, Attorney's name:_____Phone # _____

Address: _____

HEALTHCARE DECISIONS: *(Check boxes that apply)*

❑ Patient prefers to make own medical decisions.
❑ Medical decisions are made jointly between patient and family.
❑ Patient prefers family members to make the major medical decisions.
❑ Patient has Advance Directives: ❑ Yes* ❑ No
* If Yes, Copy of Directives given to CSMC: ❑ Yes ❑ No

Source of information if other than patient: _____

Signature of person acquiring this information: _____

Signature of patient:_____Date:_____

Evaluation reviewed by Physician:

Name of Physician (*please print*)	Signature of Physician	ID#	Date Signed

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For Clinical Use Only:

1. Blood Pressure_____/_____ Heart Rate:_____ Respiration Rate:_____
2. Counselled about: ❑ Alcohol: ❑ Yes ❑ No
   ❑ Smoking: ❑ Yes ❑ No
   ❑ Seatbelt use: ❑ Yes ❑ No %_____
3. Cultural / Spiritual Issues (See Nursing Profile) - *only if required by hospital*
   ❑ Yes, required
4. Patient / Caregiver Education (See Nursing Profile) - *only if required by hospital*
   ❑ Yes, required
5. Blood transfusion: ❑ No ❑ Yes, Reaction:_____