



College Park Family Care Center, P.A.

Pain Management

PAIN CLINIC – INITIAL ASSESSMENT

Patient Name: _____ DOB: _____ Date: _____

Sex: M / F Ht: _____ Wt: _____ Status: Married Single Widowed Divorced

Reason for your visit to the Pain Clinic: _____

Referring Dr/PCP: _____ Office Phone # (____) _____

Allergies – Reactions: *Please list/select items and add type of reaction you experienced.*

Drug allergies: _____	Food: <input type="checkbox"/> Peanuts <input type="checkbox"/> Eggs	Latex: <input type="checkbox"/> No <input type="checkbox"/> Yes
_____	<input type="checkbox"/> Soy <input type="checkbox"/> Citrus	Adhesive Tape: <input type="checkbox"/> No <input type="checkbox"/> Yes
_____	<input type="checkbox"/> _____	Metals: <input type="checkbox"/> No <input type="checkbox"/> Yes
_____		Iodine: <input type="checkbox"/> No <input type="checkbox"/> Yes

Medications: None *Please include over the counter medications.*

Name	Dose	How Taken

Past Surgeries:

	Yr:		Yr:
	Yr:		Yr:
	Yr:		Yr:

Please mark any medical conditions you have now or have had in the past:

- Chest pains Coronary Artery Disease High Blood Pressure Congestive Heart Failure
 Heart Attack Neurological Disorders Autoimmune Disease Lung Disease
 Metabolic Disorder Asthma Pneumonia Kidney Disease Liver Disease Seizures
 Stroke Ulcer Disease Arthritis Hyperactive Thyroid Disease Hypoactive Thyroid Disease
 Anemia Bleeding disorder Bipolar Depression
 Diabetes: Insulin Medication Controlled Diet Controlled
 Cancer of the _____
 I am pregnant. I am trying to get pregnant. I am nursing an infant.

Patient Name: _____

Family History:

Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Age: _____	<input type="checkbox"/> Stroke <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Age: _____	<input type="checkbox"/> Stroke <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes
Siblings	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Age: _____	<input type="checkbox"/> Stroke <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes

Work History:

Occupation: _____

Are you presently working? Yes: Where? _____

No: Why Not? _____

Is your plan to return to work? Yes No

Are you considered disabled? Yes No Temporarily? _____ Permanently? _____

Reason for Disability: _____

Pain History:

When did the pain first start? _____

How did the pain start? _____

Was this the result of: Accident? Injury? Workman's compensation injury?

Are you involved in a lawsuit resulting from this injury? Yes No

What part of your body hurts the most? _____

Does your pain radiate from this area to another area? Yes No Where? _____

Describe your pain by checking one or more of the following:

Sharp Burning Dull Aching Shooting "Electrical" Constant Intermittent

If Intermittent, when is it usually worse? _____

Do you have any numbness or tingling associated with your pain? Yes No

If so, where? _____

What makes your pain better? _____

What positions or activities make your pain worse? _____

What doctors have you seen for this pain? _____

Have you ever been seen in another pain center or pain clinic? Yes No

Where? _____

What was done for you? _____

Why are you no longer being treated there? _____

Have you had MRI or X-rays done for this condition? Yes No Where? _____

Has a doctor discussed results with you? Yes No Who? _____

Patient Name: _____

Treatment History:

Surgery: Surgeon? _____ When? _____ Where? _____

Steroid Injections: When? _____ Where? _____

Medications: _____

Chiropractor: _____ When? _____ Where? _____

Acupuncture: When? _____ Where? _____

Biofeedback: _____

Physical Therapy: _____

Other Treatments: _____

Do you smoke? Yes No # of packs/day? _____

Do you have a smoke related disease?

Do you drink alcohol? Yes No # of drinks/day? _____

Do you have an alcohol related disease? _____

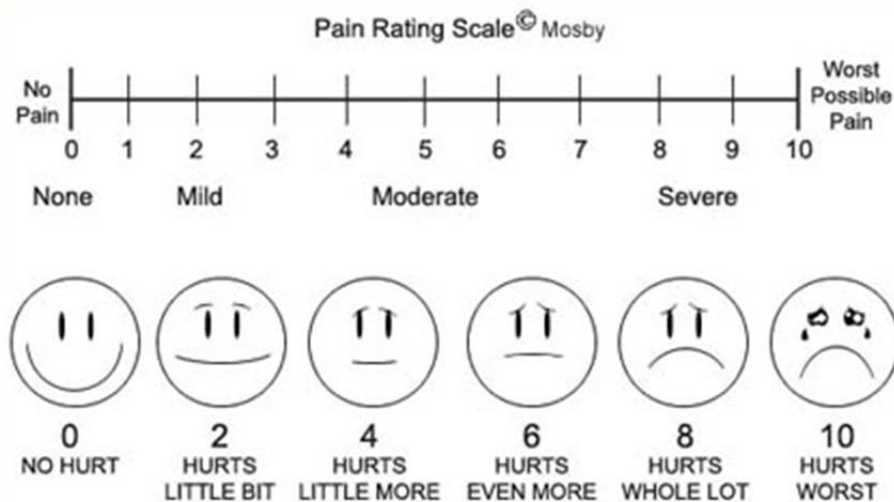
Do you ever use any of the following:

Marijuana Cocaine Heroin Other illegal drugs _____

Last time used: _____

What is your preferred pharmacy? _____ Phone # (____) _____ - _____

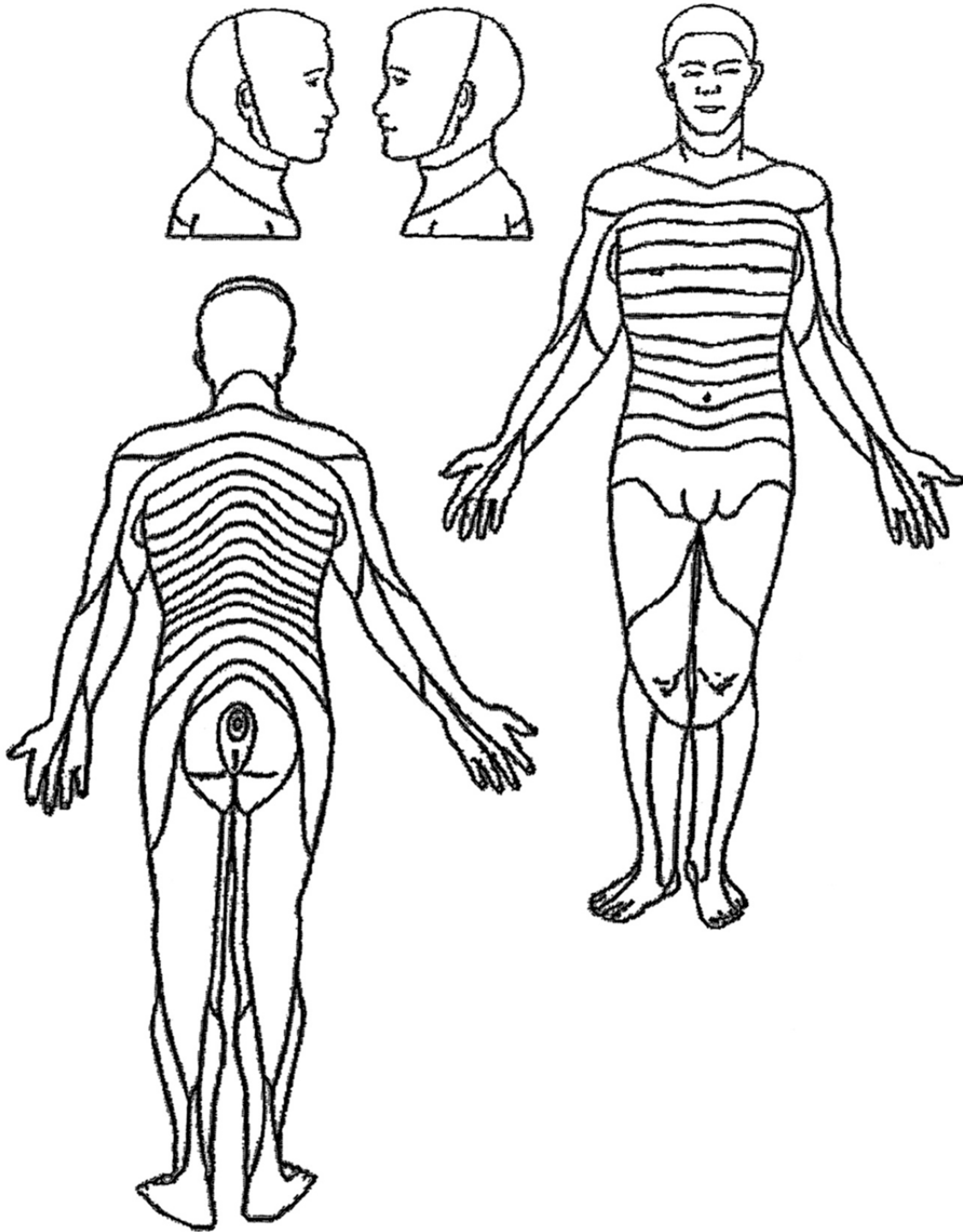
Please rate your pain using the pain scale provided below:



Pain right now: _____ Pain when resting: _____ Pain with activity: _____

Patient Name: _____

Please use the drawing below to mark your painful areas with an 'X'.



Date reviewed with patient: _____ By: _____ RN

Reviewed by: _____ MD, on _____