Cedars Sinai

THE PAIN CENTER

PAIN EVALUATION GENERAL

PATIENT I.D.

Date: _____ Arrival time: _____

Patient Information:

Name: _____ Age: _____

Daytime phone no.: _____ Alternate phone no.: _____

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

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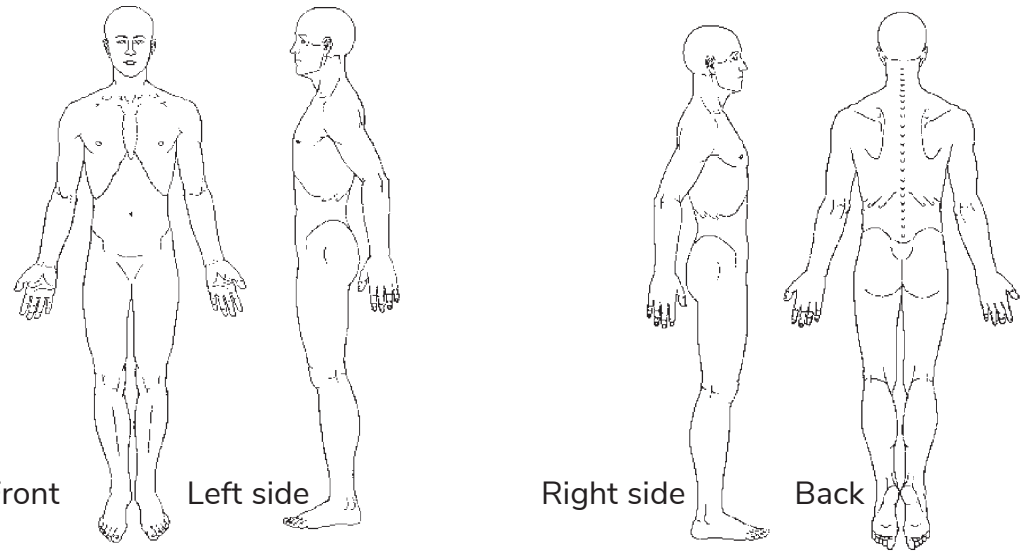
Understanding Your Current Pain: *(Cont'd)*

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

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



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
- ❑ Chickenpox
- ❑ Rheumatic fever
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Other:_____
- ❑ HIV ❑ AIDS
- ❑ Herpes (oral)
- ❑ Herpes (genital)
- ❑ Shingles
- ❑ Postherpetic neuralgia

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

Gynecologic
- ❑ Pregnant
- ❑ Postmenopausal
- ❑ Last menstrual period
  Date: _____

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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 Whom do you see? _____ Phone no. _____

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	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 no.: _____

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	I.D. no.	Date/Time

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For Clinical Use Only:

1. Blood pressure _____ / _____ Heart rate:_____ Respiration rate:_____
2. Counseled 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:_____