**New Patient Pain Assessment Form**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_

Current Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Where is your pain located? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. When did your pain begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Does the pain radiate or travel to other areas?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Is your pain: (*please check answer)*

 Intermittent  Continuous  Both?

5. Does your pain vary in intensity?  Yes No

6. Does anything bring on or trigger your pain? \_\_\_\_\_\_\_\_\_\_\_

 If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Was there an injury or accident that caused your pain?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Please check the word(s) that descried your pain:

 Aching  Throbbing  Shooting

 Stabbing  Gnawing  Sharp

 Tender  Burning  Exhausting

 Tiring  Penetrating  Unbearable

 Numb  Miserable Squeezing

 Dull  Radiating  Knife-like

 Crampy  Deep

9. Rate the intensity of your pain:

 

10. What makes the pain feel better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. List any treatments (if Applicable) that you have

received for your pain in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Do you have or are you currently being treated for:

**Shade areas of pain**



Front Back

12. What other doctors have you seen for this problem?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. How does your pain affect your lifestyle? ($\uparrow ,\downright $ , no change)

 Sleep\_\_\_\_\_ Appetite\_\_\_\_\_ Activity\_\_\_\_\_ Energy\_\_\_\_\_

14. Are you experiencing any other symptoms?

 (*Check if applicable)*

 Nausea  Sleepiness  Weakness

 Vomiting  Confusion  Itching

 Constipation  Difficulty urinating

 Loss of bowel/bladder control

15. Are you currently taking any blood thinners?

 (i.e. Lovenox, Coumadin, Plavix, Aspirin)

 Yes  No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. Please list any allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Please list your current medications (including pain meds)

 (*If known please list dosages)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. What non-steroidal anti-inflammatories have you used?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19. List Pharmacy Preference \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. Is there a chance you are pregnant?  Yes  No

 Date of last Menses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. Do you have any Mental Health Conditions?\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

22. Family History of medical conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. List Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. Implants: (i.e. pacemaker, defibrillator) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Anemia | Yes | No | Glaucoma | Yes | No | Seizures | Yes | No |
| Arthritis | Yes | No | Headaches | Yes | No | Stroke | Yes | No |
| Asthma | Yes | No | Heart Disease  | Yes | No | Street Drug Use | Yes | No |
| Back Problems | Yes | No | Hepatitis | Yes | No | Alcohol Use | Yes | No |
| Blood Disorder-Bruising | Yes | No | High Blood Pressure | Yes | No | Stomach Ulcers  | Yes | No |
| Cancer | Yes | No | HIV | Yes | No | TB | Yes | No |
| Cataracts | Yes | No | Kidney Disease | Yes | No | Thyroid Disorders | Yes | No |
| Circulation Problems | Yes | No | Lung Disease | Yes | No | Smoke (packs a day\_\_\_\_\_) | Yes | No |
| Diabetes | Yes | No | Osteoporosis | Yes | No | Other: |   |   |

**Please complete other side**

**Do you have any of the following symptoms**

☐ Balance problems ☐ Difficulty walking

☐ Inability to control bowel (incontinence) ☐ Inability to control bladder (incontinence)

☐ The need for an assistive device to walk (cane, wheelchair or walker)

☐ Weakness ☐ Numbness or tingling, where \_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Fever/Chills

☐ I have none of these symptoms

**Review of systems**

|  |  |  |  |
| --- | --- | --- | --- |
| **Constitution**  | **Eyes** | **Gastrointestinal** | **Neurological** |
| ☐ Fever | ☐ Blurred vision | ☐ Heartburn | ☐ Dizziness |
| ☐ Chills | ☐ Double vision | ☐ Nausea | ☐ Tingling |
| ☐ Weight loss | ☐ Light sensitivity | ☐ Vomiting | ☐ Tremor |
| ☐ Fatigue | ☐ Eye pain | ☐ Diarrhea | ☐ Sensory change |
| ☐ Excessive sweating | ☐ Eye discharge | ☐ Abdominal pain | ☐ Speech change |
| ☐ N/A | ☐ Eye redness | ☐ Constipation | ☐ Focal weakness |
| **Skin** | ☐ N/A | ☐ Blood in stool | ☐ Seizures |
| ☐ Rash | **Cardiovascular** | ☐ Black stool | ☐ Loss of consciousness |
| ☐ Itching | ☐ Chest pain | ☐ N/A | ☐ N/A |
| ☐ N/A | ☐ Rapid heart rate | **Genitourinary** | **Psychiatric** |
| **Head/ENT** | ☐ Shortness of breath when laying down | ☐ Painful urination | ☐ Depression |
| ☐ Headaches | ☐ leg discomfort when walking | ☐ Sudden need to urinate | ☐ Suicidal ideation |
| ☐ Hearing loss | ☐ Leg swelling | ☐ Frequency | ☐ Substance abuse |
| ☐ Ringing in ears | ☐ Breathing difficulty at night while laying down | ☐ Blood in urine | ☐ Hallucinations |
| ☐ Ear pain | ☐ N/A | ☐ Pain in upper abdomen or back | ☐ Nervous/Anxious |
| ☐ Ear discharge | **Respiratory** | ☐ N/A | ☐ Insomnia |
| ☐ Nose bleeds | ☐ Cough | **Endo/Allergy/Heme** | ☐ Memory loss |
| ☐ Congestion | ☐ Coughing up blood | ☐ Easy bruise/bleed | ☐ N/A |
| ☐ High-pitched sound when breathing | ☐ Excessive phlegm/mucus | ☐ Environmental allergies |  |
| ☐ Sore throat | ☐ Shortness of breath | ☐ Excessive thirst |  |
| ☐ N/A | ☐ Wheezing | ☐ N/A |  |
|  | ☐ N/A |  |  |

Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_