

ADVANCED PAIN MEDICINE ASSOCIATES

Providing Hope for Pain Sufferers

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NEW PATIENT EVALUATION

Today's Date _____

Patient's Full Name _____

Date of Birth _____ Age _____ Sex _____ Married Single _____

Home# _____ Work# _____ Cell# _____

Address _____ City/St. _____ Zip _____

Who referred you to our practice? _____

Primary Care Physician _____ Phone# _____

Allergies/Reactions _____

Current Medications:

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Previous Surgeries: Type Date Surgeon

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Patient: _____ Date: _____

MEDICAL HISTORY

			You/Family	Who	When
Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Palpitations	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Irregular Heart Beat	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Congestive Heart Failure	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Shortness of Breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Low Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Headache	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Fainting	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Scarlet Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rheumatic Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lupus Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HIV/AIDS	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis/Jaundice	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma/Emphysema	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bronchitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chronic Cough	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lung Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pleurisy	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pneumonia	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid Disease/Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Epilepsy/Seizures/Convulsions	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney Disease/Dialysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer/Type _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Leukemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cirrhosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Swollen/Painful Joints	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Phlebitis/Blood Clots	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ulcer	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Psychiatric History	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Are you: Right handed Left handed

Domestic Situation:

With whom do you currently reside with? _____

Are there any substance abuse issues in the household? No Yes

If yes to the above, explain _____

Are you currently able to take care of yourself? No Yes

If no, please give the name and phone of your care giver _____ # _____

Patient: _____ Date: _____

Please list any tests and studies done in relation to your chronic pain.

Test/Studies	Month/Year done	Results

• Indicate which of the following describes your usual current quality of pain.

- Sharp
- Dull
- Aching
- Shooting
- Burning

• Indicate your usual level of pain

- Mild
- Uncomfortable
- Distressing
- Very Severe
- Unbearable

• How often are you confined to bed because of your pain?

- Never
- About once a week
- Daily, or more often
- Less than once a week
- Several times per week

• What makes your pain worse?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Cold and Ice |
| <input type="checkbox"/> Bending/Twisting | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Exercise |

• Does the pain stop when you quit the above activities?

- Always
- Sometimes
- Never

• What makes your pain better?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Cold and Ice |
| <input type="checkbox"/> Bending/Twisting | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Exercise |

Patient: _____ Date: _____

- Is your pain;
 - Constant
 - Intermittent
-

- Is your pain;
 - Worse in the morning after getting up
 - Worse in the evening after being up all day
 - Worse at night when trying to sleep
 - No pattern to the pain
-

- Do you experience pain;
 - Everyday
 - 1 to 2 days per week
 - 3 to 4 days per week
 - 5 to 6 days per week
 - Sometimes a week may go by with no pain
-

- What other things have you tried for your pain?
 - Physical/Occupational Therapy
 - TENS unit
 - Biofeedback
 - Anti-inflammatory pills
 - Acupuncture
 - Narcotic pills
 - Chiropractic care
-

- Do you ever experience any weakness?
 - No
 - Yes
 - If "Yes", please explain _____
-

- Have you had in the past or do you currently have any loss of control of your bowel or bladder function?
 - No
 - Yes
 - If "Yes", please explain _____
-

- Do you have any areas of numbness?
 - No
 - Yes
 - If "Yes", please explain _____
-

Patient: _____ Date: _____

- Rate your level of pain. “0” is equal to no pain and “10” is equal to the worst pain you have ever experienced.

No Pain- 0 1 2 3 4 5 6 7 8 9 10 Worst Pain-

- Using the symbols below, indicate on the diagram where you have pain.

XXXX = Shooting/Stabbing pain

///// = Numbness

+++++ = Burning Pain

***** = Achy Pain

0000 = Pins & Needles

= Other Pain

