PAIN & WELLNESS CLINIC NEW PATIENT EVALUATION FORM
This form is sent to all new patients attending the pain clinic. However, if you wish, it can be downloaded and completed AND BROUGHT WITH YOU.
DO NOT COMPLETE AND SEND THIS FORM VIA THE INTERNET

Name_____SSN_____Date____/____/_____ Age_____
Main Pain Complaints(s):

1)_____ 2)_____3)_____
Have you had any surgeries: **NO YES**
If yes, please write the month and year of the operation and what kind of operation was performed:

_____
Are you allergic to any medications? If yes, please list below
_____
Write down ALL your medications and doses you take. Please include medicines that are not taken for pain AND any over the counter medications.

_____

_____

Social History
Are you: □married □single □widowed □divorced
Do you smoke? □No □Yes If yes:□ Less then ½ to 1 pack per day □1 or more packs per day
Are you a former smoker? □No □Yes; If yes, when did you stop? _____
Do you drink alcohol? □Not at all □Occasional □Regularly 2-3 □drinks or more per day
If you drink, do you drink to relieve your pain? □No □Yes
Have you ever used street drugs? □No □Yes
Have you or your physician ever thought you had a problem controlling your pain medications? □No □Yes
Occupation _____
□Employed full time /part time □Homemaker □In school or training □Retired □Leave of absence or sick leave □Unemployed because of pain □Retired because of pain □Unemployed □On disability

Review of Systems
Have you had any of the following conditions? Please mark the conditions you have
Heart
□High Blood Pressure □High Cholesterol □Angina □Heart Attack □Heart by-pass-surgery □Congestive Heart Failure □Irregular Heart Beat □Pacemaker
Lungs
□Smoker □Bronchitis □Asthma □Tuberculosis □Shortness of breath □Chronic Lung Disease
Liver/Kidneys
□Hepatitis □Liver Problems □Kidney Problems □Bladder Problems
Metabolic/Digestive
□Diabetes □Thyroid Disease □Acid Reflux □Ulcer
Nervous System
□Seizures □Stroke □Paralysis □Peripheral Neuropathy

Musculoskeletal
□Neck/Back Problems □Arthritis □Artificial Joints
Coagulation
□Anemia □Clotting Problems
Other
□Cancer □Are you pregnant now? □HIV □Psychiatric Disorder

Pain History
In the last year have you been treated at the emergency room for pain? □YES □NO
If yes, how many times? 1 2 3 4 5 more than 5
Please circle the number that best describes your baseline or constant level of pain over the past few days **0 1 2 3 4 5 6 7 8 9 10**
How many times did your worst pain flare up during the last 24 hours?
□1-2 □3-4 □5-6 □7-8 □More than 8?
Please circle the number that best describes your worst pain that comes and goes or flares.
0 1 2 3 4 5 6 7 8 9 10
Has pain interfered with your sleep? Yes No
Has pain interfered with your general activity? Yes No
Has pain interfered with your mood? Yes No
Has pain interfered with your work? Yes No

Do you have an attorney involved with your auto/work injury claim?
□Yes □No □Not Applicable
Overall, on a scale of 0-10 how close are you to returning to work (10 means fully recovered and ready to return fulltime. 0 means you are not even close to work at any job.)
0 1 2 3 4 5 6 7 8 9 10
Do you think you will be able to return to the same type of work that you were doing before your pain?
□Yes □No □Not Applicable
Are you actively considering a change of employment or in a retraining program?
□Yes □No □Not Applicable
How many hours did you work last week? _____ The week before? _____ Not Applicable ____

Briefly describe how and when your pain started:
Circle those activities that make your pain worse:
Lying down flat on back Heat Standing Sitting Bending
Other: _____
Circle what makes your pain better:
Medications Standing Sitting Lying Cold(ice) Heat
Other: _____
What medications have you tried in the past **FOR YOUR PAIN**?

_____

_____
If you are on narcotics for your pain have they improved your general activity and level of function? No A Little A Moderate Amount A Lot

Treatment History
Have you ever had the following types of treatment for your pain and what was the result?
Occupational Therapy. Date of the last therapy____/____/20___; duration:_____weeks
Body Mechanics No Yes Improved No Change Worse
Work Hardening No Yes Improved No Change Worse

Physical Therapy. Date of the last therapy____/____/20___; duration:_____weeks
No Yes Improved No Change Worse

Chiropractic. Date of the last therapy____/____/20___; duration:_____weeks
No Yes Improved No Change Worse

Deep Tissue Massage No Yes Improved No Change Worse

Acupuncture No Yes Improved No Change Worse

Trigger Point Injections No Yes Improved No Change Worse

TENS No Yes Improved No Change Worse

Psychological / Psychiatric Counseling for Pain
No Yes Improved No Change Worse

Epidural Steroid Injections No Yes Improved No Change Worse

Nerve Blocks: No Yes Types: _____ Improved No Change Worse

Have you ever had any of the following to investigate your pain problem?
X-Rays No Yes; **MRI** No Yes; **CAT Scan** No Yes; **EMG** No Yes; **Bone Scan** No Yes;
Myelogram No Yes