Excellence
MEDICAL GROUP

Initial Pain Assessment

Name: _____ Birthdate: _____ Date: _____

Circle all that apply regarding your pain:

Approximate date of onset of pain: _____

How did or what (i.e surgeries, accidents, etc.) caused your pain to begin:

_____

_____

_____

_____

How would you rate your current pain on a scale of 1-10 (0 for no pain, 10 for worst): _____

How would you rate your average day to day pain on a scale of 1-10 (0 for no pain, 10 for worst): _____

Location of pain: Back Arm Neck Head Leg Other_____

Quality of pain: Aching Burning Cramping Dull Numbness Pins & Needles Sharp Shooting Stabbing Stiffness Swelling Throbbing Tingling Other _____

Does the pain radiate (spread): No Yes: Legs Arms Other _____ Right Left Bilateral

The pain is: Intermittent Constant - **And lasts for:** Minutes Hours Days

What makes the pain better? Rest Pain Meds Ice Heat Massage Nothing Other _____

What makes the pain worse? Bending Head turning Sitting Standing Twisting Other _____

Which activities does the pain effect: Bathing/Showering Cooking Cleaning Home Exercising Family Activities Hobbies (Which?_____) Shopping Sleep Social Activities Walking Working Other _____

What medications do you currently take for pain (prescribed and over the counter) with dose and frequency:

_____

_____

What percentage of pain is relieved with pain medication (0-100): _____

Which medications have you tried and stopped in the past with approximate date and reason it was discontinued:

_____

_____

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What interventions have you tried in the past/currently to help with the pain? Acupuncture Chiropractic Counseling Home Exercise Program Injections (types, when, & with whom):_____ Meditation Surgery TENS unit Physical Therapy Tai-chi Yoga

Do you currently see any other doctors for your pain? If so, whom and what for?

_____

Since your pain has started, the pain has gotten: Worse Better Same Other _____

What are your goals with pain treatment? _____

_____

_____

PATIENT HEALTH QUESTIONNAIRE-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3

7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING _____ + _____ + _____ + _____

=Total Score: _____

Interpretation:
1-4: minimal
5-9: mild
10-14: moderate
15-19: moderately severe
20-27: severe

OPIOID RISK ASSESSMENT

Please check each that apply.		FOR OFFICE CODING F	M
1. Family History of Substance Abuse:	Alcohol [ ]	1	3
	Illegal Drugs [ ]	2	3
	Prescription Drugs [ ]	4	4
2. Personal History of Substance Abuse:	Alcohol [ ]	3	3
	Illegal Drugs [ ]	4	4
	Prescription Drugs [ ]	5	5
3. Age	between age 16-45 [ ]	1	1
4. History of Preadolescent Sexual Abuse	[ ]	3	0
5. History of Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
6. History of Depression	[ ]	1	1
	Total:		

Interpretation:
0-3: low
4-7: mod
>8: High

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Smoking status: Never Former Current – Frequency & Amount: _____

Alcohol status: Never Former Current – Frequency & Amount: _____

Please circle all the symptoms you have recently experienced, if any:

Constitutional: Changes in appetite Fatigue Fever Sleeping disturbances

Respiratory: Cough Shortness of breath Wheezing

Cardiovascular: Blacking out Fainting Chest pain Irregular heartbeats

Neurologic: Changes in alertness Seizures

Psychiatric: Hallucinations Anxiety Depressed mood Suicidal thoughts

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FOR OFFICE USE ONLY: MA Name _____

Wt _____ Ht _____ BP _____ P _____ O2 _____ CURES _____ Contract _____ UDS _____