WESTCHESTER MEDICAL CENTER
Pain Management Center
Westchester Medical Center
19 Bradhust Avenue, Suite 1700s
Hawthorne, NY 10532

Initial Evaluation

PATIENT INFORMATION

(1) _____ (2) Sex: M / F (3) Age: _____
Last Name First M.I.

(4) Appointment Date: _____ (5) Referring Physician:_____

ABOUT YOUR PAIN

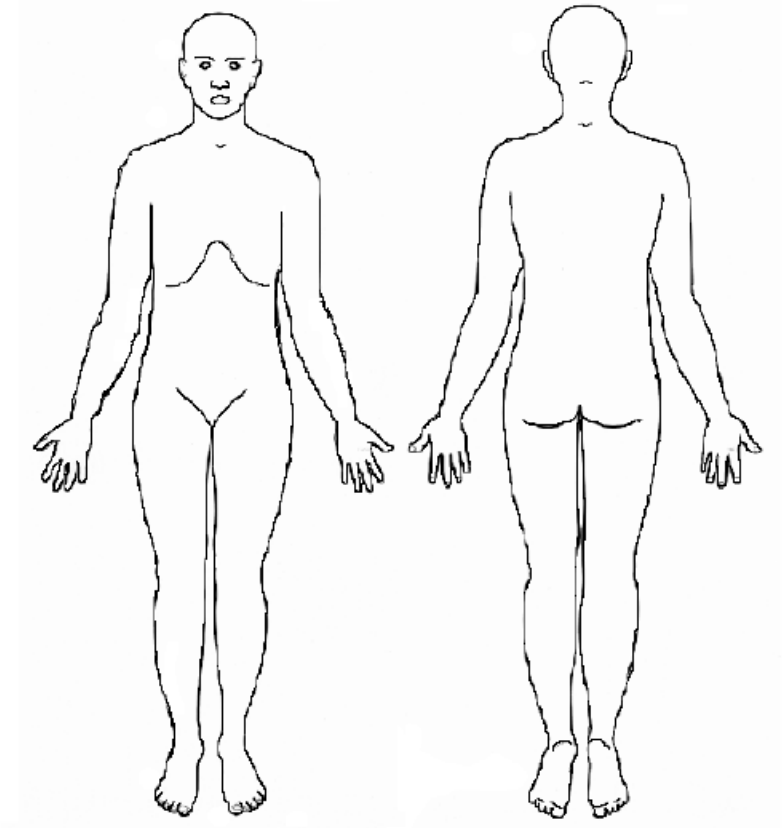
(6) What is the *main* problem for which you are seeking treatment?

_____

_____

_____

Please mark the area(s) in which your pain is located:



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ONSET OF PAIN AND DURATION

(7) Briefly describe when and how your current pain started?

_____

_____

_____

TIMING OF PAIN

(8) How often do you have your pain (please check one)?

□ Constantly (100% of the time) □ Frequently (75%) □ Intermittently (50%) □ Occasionally (25%)

PAIN QUALITY

(9) How would you describe the pain (choose as many adjectives as are applicable)?

□ Burning □ Sharp □ Cutting □ Throbbing □ Cramping □ Numbness

□ Dull, aching □ Pressure □ Pins and needles □ Shooting □ Electric-like □ Other

PAIN INTENSITY

(10) Circle your **current pain intensity** with "0" representing no pain and "10" representing the most severe pain imaginable:

0 1 2 3 4 5 6 7 8 9 10

(11) Circle your **average pain** the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

(12) Circle your **best pain** score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

(13) Circle your **worst pain** score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

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RELIEVING AND AGGRAVATING FACTORS

How do the following affect your pain (please check one for each item)?

	(14) Decrease	(15) Increase	(16) No Change
Lying down			
Standing			
Sitting			
Walking			
Exercise (if applicable)			
Medications			
Relaxation			
Coughing/Sneezing			
Urination			
Bowel movements			

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

Treatment	Date (approx.)	(17) Excellent Relief	(18) Moderate Relief	(19) No Relief
Hospital/bed rest				
Traction				
Surgery				
Hypnosis				
Acupuncture				
Nerve block/injections				
TENS				
Physical therapy				
Exercise				
Heat treatment				
Biofeedback				
Psychotherapy				
Chiropractic				
Other				

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FUNCTIONAL LIMITATIONS

(20) During the past month, place a check mark next to the activities that you avoided because of pain:

□Going to work □Performing household chores □Doing yard work or shopping
□Socializing □Participating in recreation □Sexual relations
□Physical exercise □Driving □Caring for self

(21) How many blocks can you walk before having to stop due to pain? _____

(22) How long can you sit before having to get up and move about? _____

(23) How long can you stand before you have to sit down? _____

(24) How often during the day do you lie down because of pain?

□Never □Seldom □Sometimes □Often □Constantly

Allergies

(25) Do you have symptoms such as red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following?

□Dye □Iodine □Shellfish □Latex □Rubber*
□Medications: _____
□Foods: _____
□No Known Allergy

After doctor/dental visits *

MEDICATIONS

(26) Please list your current medications with dosages:

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(27) Please list any previously taken pain medications that you stopped taking and the reason for stopping:

_____

_____

_____

PAST MEDICAL HISTORY

(28) Have you or do you have any of the following health problems? (please check all that apply)

☐High blood pressure ☐Diabetes ☐Kidney disease ☐Angina ☐Stroke
☐Liver disease ☐Heart attack ☐Cancer ☐Arthritis ☐Chronic cough
☐Psychological or psychiatric problems ☐HIV ☐Hepatitis

Please explain any medical conditions checked above:

_____

_____

_____

Other health problems (please specify):

_____

PAST SURGERIES

(29) Please list, with approximate date and type of operation:

_____

_____

_____

Have you had any previous back surgeries (please specify)?

_____

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PSYCHOSOCIAL HISTORY

(30) Your highest educational level achieved:

□Graduate or professional training □College graduate (obtained degree)
□Partial college training □High school graduate
□GED or trade-technical school graduate □Partial high school (10th-12th grade)

PSYCHOLOGICAL TREATMENT

(31) Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? □Yes □No

If yes, when? _____

(32) Have you ever considered suicide? □Yes □No

SUBSTANCE USE (all information is kept confidential)

(33) Are you suffering from or do you have a history or alcoholism? □Yes □No

Any illicit drug use? □Yes □No

Have you ever been in a detoxification program for drug abuse? □Yes □No

(34) Do you or did you ever smoke cigarettes or use tobacco? □Yes □No

How many years have you smoked/did you smoke? _____

How many packs per day do you/did you smoke? _____

Have you quit using tobacco, and if so how long ago? _____

(35) How many drinks of each of the following do you consume in **one week**?

Beer _____ Wine _____ Liquor _____

FAMILY LIFE

(36) "I currently am":

□Living alone □Living with friends □Living with children
□Living with spouse/partner □Living with spouse/partner and children

(37) Do you have members of your immediate family who have had psychiatric illnesses? □Yes □No

(38) Have any of your relatives had substance abuse problems, including alcohol? □Yes □No

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PREVIOUS DIAGNOSTIC STUDIES

(39) Please indicate approximate date and results, if known:

MRI _____

CT _____

X-rays _____

EMG _____

REVIEW OF SYSTEMS

(40) Fill out and/or check all that apply to your health:

Respiratory	Heart	Elimination	
❑ Shortness of Breath ❑ at rest ❑ with activity ❑ Home oxygen (Supplier:_____) ❑ Breathing medications ❑ BIPAP/CPAP ❑ Sleep Apnea/Disorder ❑ TB ❑ Lung Problem: _____ ❑ No Problem	❑ Bruising/Bleeding ❑ Heart Attack ❑ Palpitations ❑ Heart Problem: _____ ❑ Other:_____ ❑ No Problem	Urinary ❑ Catheter ❑ Burning ❑ Bleeding ❑ Ostomy ❑ Unusual Frequency ❑ Discomfort ❑ Up at night to urinate? # Times:_____ ❑ Loss of control ❑ No Problem	Bowel Last BM_____ Freq of BM_____ ❑ Ostomy ❑ Loss of control ❑ Diarrhea/Colitis ❑ Constipation ❑ Use laxatives ❑ Ulcers/Hiatal Hernia ❑ No Problem

Neurological	Skeletal/Muscle	Nutrition
❑ Memory loss/ Forgetfulness ❑ Stroke ❑ Fainting spells/ Dizziness ❑ Epilepsy, seizures, convulsions ❑ Mental illness ❑ Headaches ❑ No problem	❑ Arthritis ❑ Numbness/Tingling ❑ Back pain ❑ Muscle weakness ❑ Blood clots in legs ❑ Pain in legs with activity ❑ Skin disorder ❑ Neck pain ❑ No problem	❑ Weight Loss > 10 lbs/last 6 months _____ ❑ Nausea Appetite ❑ good ❑ fair ❑ poor ❑ Vomiting ❑ Dentures Fit properly? ❑ yes ❑ no ❑ Heartburn/ Reflux ❑ Chewing problems ❑ Swallowing problems ❑ Indigestion ❑ No problems ❑ Sores in mouth ❑ Foods you CANNOT eat. Explain: _____ _____

Endocrine	
❑ Thyroid problems ❑ Other:_____ _____ ❑ No problem	Do you have any implanted devices? ❑ Screws, pins, plates ❑ AICD ❑ Aneurysm Clip ❑ Venous Access Device ❑ None Where?_____ ❑ IUD ❑ Pacemaker ❑ Type _____