Center for Interventional PAIN & SPINE

ABINGTON SURGERY CENTER
2701 Blair Mill Road Ste. 35
Willow Grove, PA 19090
P: 215-957-1108
F: 215-443-9318

THE HELEN F. GRAHAM CANCER CENTER
4701 Ogletown Stanton Rd., Ste. 2131
Newark, DE 19713
P: 302-266-7800
F: 302-266-7851

BRANDYWINE TOWN CENTER
3401 Brandywine Pkwy Ste. 202
Wilmington, DE 19803
P: 302-477-1706
F: 302-477-1708

MAIN LINE HEALTH & FITNESS BLDG
931 E. Haverford Road Ste. 202
Bryn Mawr, PA 19010
P: 610-525-8200
F: 610-525-8201

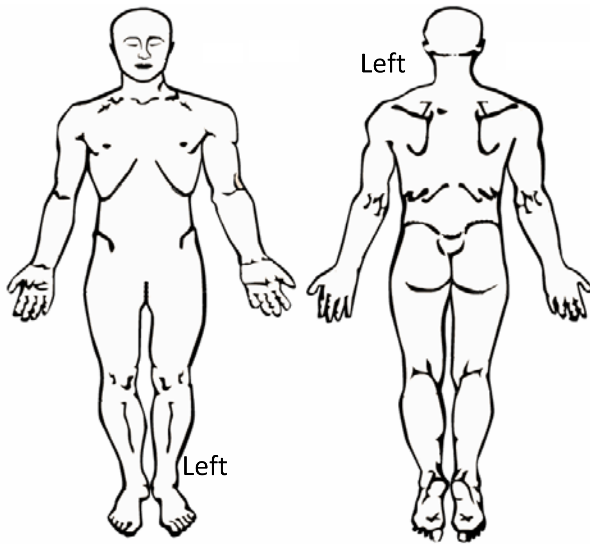
INITIAL ASSESSMENT FORM

Name: ______________________ BP: _____/_____ HR: ______

Wt: __________ Ht: _________

Date: ___________ Temp: __________

Location of pain: Please **shade** your area of pain



Please check what describes your pain:

☐aching ☐throbbing ☐dull ☐sharp ☐stabbing
☐shooting ☐burning ☐ other:_______________________

Please check if you have associated symptoms:
☐numbness ☐tingling ☐muscle spasm ☐weakness
☐bowel or bladder incontinence ☐pins and needles

What worsens your pain? ☐coughing ☐straining ☐ standing
☐bending ☐walking ☐ sitting ☐ driving ☐ touch
☐cold ☐ Other: ______________________

What makes your pain better? ☐rest ☐ cold ☐ warmth ☐ sitting ☐ standing ☐ medication
☐other:____________________________

Indicate the one NUMBER between 0-10 that best describes your pain:

No pain *moderate pain* *severe pain* *unbearable*
0 1 2 3 4 5 6 7 8 9 10

_______ Pain at its worst ________ Pain at its least
_______ Average pain ________ Pain now

History of present illness: Is your injury ☐work related or ☐ auto accident? Date of injury ______________________________

Describe the incident: ____

____

____

Review of systems

General
☐fatigue
☐fever
☐weight loss/gain

Eyes
☐vision loss

Head/Ears/Nose/Throat
☐hearing loss
☐nose bleed
☐sore throat

Cardiovascular
☐chest pain
☐palpitations

Respiratory
☐cough
☐shortness of breath

Gastrointestinal
☐vomiting blood

Genitourinary
☐loss of bladder control

Musculoskeletal
☐joint pain/swelling
☐spasms
☐weakness

Skin
☐color changes

Neurological
☐paralysis
☐seizures

Psychiatric
☐depressed mood
☐hallucination

Endocrine
☐elevated blood sugar

Hematology/Lymphatic
☐bleeding

☐bruising

Previous treatment

Did you have previous pain management? With who? __________________________ Treatments: ______________________________________

Did you have injections? ☐No ☐Yes, if so any relief? __________

Did you have any alternative therapies: ☐chiropractor ☐acupuncture ☐physical therapy ☐Other________________________
If so any relief? __________

Relative surgical history

☐Back surgery ☐Neck surgery ☐ Spinal cord stimulator ☐IT Pain pump ☐Defibrillator/Pacemaker

☐Other: ____

Current medications ____

____

Blood thinners☐Aspirin ☐Plavix ☐Warfarin ☐Lovenox☐Pradaxa☐Ticlid☐Pletal

Previous pain medication

☐Vicodin☐Percocet ☐Dilaudid ☐Oxycontin ☐Oxycodone ☐Fentanyl

☐Suboxone ☐Methadone ☐ MS Contin ☐Other: ____________________________

Medication allergies

☐ No known drug allergies ☐ Betadine/Iodine ☐Contrast dye☐ Latex☐ Medication allergies: ______________________________________

Past medical history (please check all that apply)

☐ AIDS/HIV ☐ Diabetes ☐ Cancer: _____________ ☐Hepatitis B / C ☐ Heart Disease

☐Bleeding Disorder ☐ Stroke/Mini-Stroke ☐ Multiple Sclerosis ☐ Liver Disease ☐ Kidney Disease

☐ COPD ☐ Stomach/Intestinal Ulcers ☐ High Blood Pressure ☐ Obstructive Sleep Apnea ☐Other: ____________________

☐Alcoholism ☐ Previous Addiction ☐Drug Abuse ☐Bipolar Disorder ☐Generalized Anxiety Disorder

Family history

Is your Mother living? ☐Yes ☐ No If no, agedeceased___________cause of death____

Is your Father living? ☐Yes ☐ No If no, agedeceased___________cause of death____

Family history related conditions

☐arthritis ☐cancer ☐Anklloysis spondylosis ☐ other_______________________

☐back Pain ☐Multiple sclerosis ☐ osteoporosis

Occupation

☐employed ☐ currently unemployed ☐ disabled ☐retired Position (former/current):___________________________

Physician Notes Only: