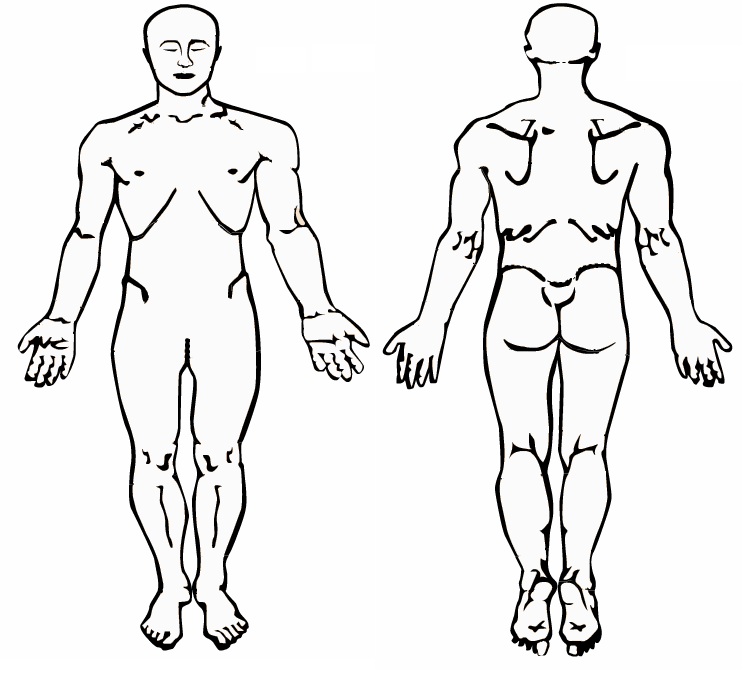
**INITIAL ASSESSMENT FORM**

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Right

Left

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:

Left

Right

*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 \_\_\_\_\_\_\_\_ State injury occurred \_\_\_\_\_\_

Describe the incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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, age deceased\_\_\_\_\_\_\_\_\_\_\_\_cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your Father living? Yes  No If no, age deceased\_\_\_\_\_\_\_\_\_\_\_\_cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history related conditions

arthritis  cancer  ankloysis spondylosis  other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

back pain  Multiple Sclerosis  osteoporosis

**Occupation**

employed  currently unemployed  disabled  retired Position (former/current):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Notes Only: