**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: