

PAIN MANAGEMENT INITIAL CONSULTATION

Please complete this form as fully as possible. The information you provide helps the clinician understand your pain, prior treatment, overall health, and treatment goals. If a question does not apply, write N/A.

Patient Name _____ Date of Birth _____ Date _____
 Preferred Phone _____ Email _____

CURRENT CARE TEAM

	Primary Care Clinician	Referring Clinician / Practice
Name		
Phone		
Address		

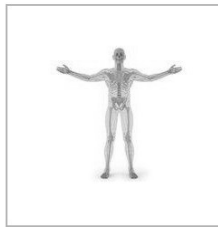
PAIN HISTORY

1. Where do you hurt most? Describe the main location or locations.

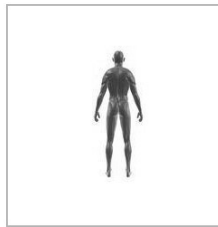
2. When did this pain problem begin? If it followed an injury, include the date and explain what happened.

3. How did the pain first begin? For example, was it gradual, after a fall, a motor vehicle collision, a work injury, surgery, or another event?

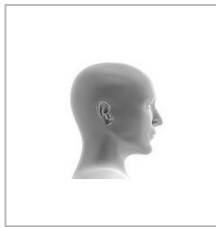
Mark the areas where you have pain, numbness, tingling, burning, or other symptoms.



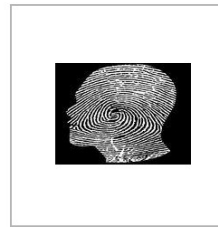
Front



Back



Side



Head

4. Rate your pain on a 0-10 scale, where 0 means no pain and 10 means the worst pain you can imagine.

Average Pain _____ Worst Pain _____ Acceptable Pain _____

5. How often is the pain present?

☐ Constant

☐ Daily but not constant

☐ Intermittent / occasional

6. Which words best describe your pain or related symptoms? Check all that apply.

☐ Dull

☐ Sharp

☐ Shooting

☐ Stabbing

☐ Burning

☐ Electric / shock-like

☐ Aching

☐ Numbness

☐ Tingling

☐ Weakness

☐ Cold sensation

☐ Muscle spasm

☐ Tightness / pressure

☐ Other

ACTIVITIES AND FACTORS THAT AFFECT PAIN

Activity / Factor	Worse	Better	No Change	Comments
Stairs	☐	☐	☐	
Exercise	☐	☐	☐	
Walking	☐	☐	☐	
Massage	☐	☐	☐	
Sitting	☐	☐	☐	

PAIN MANAGEMENT INITIAL CONSULTATION

Activity / Factor	Worse	Better	No Change	Comments
Standing	☐	☐	☐	
Heat	☐	☐	☐	
Cold	☐	☐	☐	
Weather changes	☐	☐	☐	
Emotional stress	☐	☐	☐	
Sexual activity	☐	☐	☐	
Medication	☐	☐	☐	
Other	☐	☐	☐	

PREVIOUS PAIN TREATMENT

List pain medicines you have used in the past. Indicate whether each medicine helped and note important side effects or concerns.

Medication	Helpful	Not Helpful	Comments / Side Effects
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Check treatments you have tried and indicate whether they were helpful.

Treatment	Helpful	Not Helpful	Comments
Surgery	☐	☐	
Nerve block	☐	☐	
Steroid injection	☐	☐	
Acupuncture	☐	☐	
Trigger-point injection	☐	☐	
TENS unit	☐	☐	
Heat / ice	☐	☐	
Biofeedback	☐	☐	
Hypnosis	☐	☐	
Relaxation training	☐	☐	
Counseling	☐	☐	
Physical therapy	☐	☐	
Other	☐	☐	

MEDICAL HISTORY

Check any condition you currently have or have had in the past.

- | | | |
|---|---|--|
| ☐ Diabetes | ☐ Arthritis | ☐ Cancer |
| ☐ Ulcer / gastritis | ☐ Heart disease | ☐ Bleeding disorder |
| ☐ Kidney disease | ☐ COPD / asthma | ☐ Seizures |
| ☐ Infectious disease | ☐ Neurologic condition | ☐ High blood pressure |
| ☐ Other | | |

Have you ever been treated by another pain specialist? ☐ No ☐ Yes

Clinician / Practice:

Current work status:

- ☐ Full-time
 ☐ Part-time
 ☐ Not working

PAIN MANAGEMENT INITIAL CONSULTATION

☐ Retired

☐ Student

☐ Homemaker

Current or Previous Occupation:

Is this pain related to a workers' compensation claim? ☐ No ☐ Yes

Are you receiving or applying for disability benefits because of this condition? ☐ No ☐ Yes

Is there current or anticipated legal action related to this pain problem? ☐ No ☐ Yes

Tests completed within the past 24 months: ☐ X-ray ☐ CT ☐ MRI ☐ EMG / nerve study ☐ None

List major surgeries or significant medical procedures.

Year	Surgery / Procedure / Reason

List medication or substance allergies and the reaction you experienced.

Medication / Substance	Reaction

MENTAL HEALTH AND SLEEP

Check any condition for which you have been diagnosed or treated.

☐ Major depression

☐ Anxiety disorder

☐ Bipolar disorder

☐ Insomnia

☐ Obsessive-compulsive disorder

☐ Panic disorder

☐ Anorexia / eating disorder

☐ Bulimia / eating disorder

☐ Alcohol dependence

☐ Drug dependence

☐ Other

Average sleep:

☐ 7-8 hours/night

☐ 9-11 hours/night

☐ 12+ hours/night

☐ 5-6 hours/night

☐ 3-4 hours/night

☐ Severe sleep difficulty

GENERAL HEALTH REVIEW

For each item, check Yes if you currently have the problem or have had it recently. Leave blank if No.

Yes	Symptom / Condition	Yes	Symptom / Condition
☐	Blurry vision	☐	Glaucoma
☐	Ringing in the ears	☐	Teeth clenching / grinding
☐	Chest pain or tightness	☐	Heart disease / irregular heartbeat
☐	Need to sleep upright to breathe	☐	Shortness of breath
☐	Emphysema / asthma	☐	Abdominal pain
☐	Ulcer / gastritis	☐	Irregular bowel habits
☐	Irritable bowel symptoms	☐	Blood in stool
☐	Pelvic pain	☐	Frequent urination
☐	Difficulty urinating	☐	Seizures

PAIN MANAGEMENT INITIAL CONSULTATION

Yes	Symptom / Condition	Yes	Symptom / Condition
☐	Frequent headaches	☐	Blackouts / fainting
☐	Unexplained fever	☐	Excessive fatigue
☐	Trouble falling or staying asleep	☐	Rash
☐	Rheumatoid arthritis / lupus / similar autoimmune condition	☐	Diabetes
☐	Thyroid disorder	☐	Depression
☐	Anxiety		

EXERCISE AND ACTIVITY HISTORY

At what period of your life were you most physically active?

- ☐ Childhood
 ☐ Teenage years
 ☐ Young adulthood (21-39)
 ☐ Mid-adulthood (40-60)
 ☐ Later adulthood (over 60)
 ☐ Never regularly active

What is your current activity level?

- ☐ Sedentary
 ☐ Mildly active
 ☐ Moderately active
 ☐ Very active

What barriers make physical activity difficult for you?

- ☐ Medical
 ☐ Social
 ☐ Physical
 ☐ Family
 ☐ Work-related
 ☐ Other

Describe your usual exercise or planned physical activity.

Activity	Minutes / Day	Days / Week

Describe regular non-exercise activity such as housework, yard work, walking for errands, or caregiving.

Activity	Minutes / Day	Days / Week

SOCIAL HISTORY

Tobacco / nicotine use: ☐ No ☐ Yes

- ☐ Up to 1/2 pack per day
 ☐ 1/2-1 pack per day
 ☐ More than 1 pack per day
 ☐ Other amount / nicotine product

Details:

Alcohol use: ☐ No ☐ Yes

- ☐ Rare (less than 6 times/year)
 ☐ Occasional (1-2 times/month)
 ☐ Weekends only
 ☐ Regular (2-3 times/week)
 ☐ Daily (1-3 drinks/day)
 ☐ Heavy (more than 3 drinks/day)

Current or past non-prescribed / illegal drug use: ☐ No ☐ Yes

- ☐ Marijuana / cannabis
 ☐ Opiates
 ☐ Benzodiazepines
 ☐ Hallucinogens
 ☐ Amphetamines
 ☐ Inhalants
 ☐ Other

Type / Amount:

Relationship / household status:

- ☐ Single
 ☐ Married / partnered
 ☐ Divorced
 ☐ Separated
 ☐ Widowed
 ☐ Cohabiting

Work situation:

- ☐ Homemaker
 ☐ Part-time
 ☐ Full-time
 ☐ Unemployed
 ☐ Retired
 ☐ Student

Typical work hours each week:

- ☐ None
 ☐ Under 20
 ☐ 20-39

☐ 40☐ 41-60☐ More than 60**FAMILY MEDICAL HISTORY**

List important medical problems for the family members below, if known.

Family Member	Important Medical Problems
Father	
Mother	
Brother(s)	
Sister(s)	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	

REVIEW OF SYSTEMS - PAST 6 MONTHS

Check symptoms you have experienced during the past six months. If none apply in a category, check None.

Constitutional

- | | | | |
|----------------------------------|-------------------------------------|---|-----------------------------------|
| ☐ None | ☐ Fever | ☐ Chills | ☐ Sweating |
| ☐ Fatigue | ☐ Body aches | ☐ General feeling of illness | |

Head / Eyes / Ears / Nose / Throat

- | | | | |
|--|---|-------------------------------------|--------------------------------------|
| ☐ None | ☐ Hearing change | ☐ Ear pain | ☐ Eye pain |
| ☐ Vision change | ☐ Runny nose | ☐ Nosebleeds | ☐ Sore throat |
| ☐ Mouth sores | | | |

Neck

- | | | | |
|--|-----------------------------------|------------------------------------|-------------------------------|
| ☐ None | ☐ Swelling | ☐ Stiffness | ☐ Pain |
| ☐ Knots / tight muscles | | | |

Respiratory

- | | | | |
|--|---|--|--|
| ☐ None | ☐ Cough | ☐ Shortness of breath | ☐ Wheezing |
| ☐ Chest tightness | ☐ Coughing blood | ☐ Congestion | ☐ Heavy snoring |
| ☐ Slow breathing | | | |

Cardiovascular

- | | | | |
|--|--|---|--|
| ☐ None | ☐ Chest pain | ☐ Racing heart | ☐ Palpitations |
| ☐ Chest pressure | ☐ Chest tightness | ☐ Varicose veins | ☐ Slow heart rate |
| ☐ Fast heart rate | | | |

Gastrointestinal

- | | | | |
|---------------------------------------|---|-----------------------------------|---|
| ☐ None | ☐ Nausea | ☐ Vomiting | ☐ Abdominal pain |
| ☐ Heartburn | ☐ Blood in stool | ☐ Gas | ☐ Diarrhea |
| ☐ Constipation | | | |

Genitourinary

- | | | | |
|---------------------------------------|--|--|--|
| ☐ None | ☐ Painful urination | ☐ Frequent urination | ☐ Blood in urine |
| ☐ Incontinence | ☐ Difficulty starting urine | ☐ Incomplete emptying | ☐ Nighttime urination |

Female Genital

- | | | | |
|---|--|---|--|
| ☐ None | ☐ Blisters | ☐ Discharge | ☐ Painful periods |
| ☐ Absent periods | ☐ Irregular periods | ☐ Itching / rash | ☐ Spotting |
| ☐ Pelvic pain | | | |

Male Genital

- | | | | |
|-------------------------------|-----------------------------------|------------------------------------|--|
| ☐ None | ☐ Blisters | ☐ Discharge | ☐ Testicular lump |
|-------------------------------|-----------------------------------|------------------------------------|--|

PAIN MANAGEMENT INITIAL CONSULTATION

- ☐ Testicular swelling
☐ Itching / rash
- ☐ Testicular pain
- ☐ Scrotal lump
- ☐ Scrotal swelling

Musculoskeletal

- ☐ None
☐ Foot pain
☐ Joint aches
- ☐ Knee pain
☐ Leg swelling
- ☐ Back pain
☐ Foot swelling
- ☐ Hip pain
☐ Ankle swelling

Endocrine

- ☐ None
☐ Dizziness
☐ Dry skin
☐ Facial hair change
- ☐ Increased thirst
☐ Thinning hair
☐ Depressed mood
☐ Voice change
- ☐ Increased appetite
☐ Cold intolerance
☐ Neck fullness
☐ Acne
- ☐ Frequent urination
☐ Heat intolerance
☐ Infertility

Blood / Immune

- ☐ None
☐ Weakness
☐ Frequent infections
- ☐ Pale skin
☐ Itchy skin
- ☐ Fatigue
☐ Itchy eyes / ears / nose
- ☐ Easy bruising
☐ Swollen lymph nodes

Neurologic

- ☐ None
☐ Leg numbness
- ☐ Headaches
☐ Hand numbness
- ☐ Dizziness
☐ Tremor
- ☐ Foot numbness

Mental / Emotional

- ☐ None
☐ Difficulty concentrating
☐ Too much sleep
☐ Panic attacks
- ☐ Sadness
☐ Reduced interest / pleasure
☐ Anxiety
☐ Low energy
- ☐ Low mood
☐ Reduced sex drive
☐ Excessive worry
☐ Thoughts of self-harm
- ☐ Crying spells
☐ Too little sleep
☐ Irritability

Skin

- ☐ None
☐ Skin-fold rash
- ☐ Frequent boils
☐ Rash under breasts
- ☐ Lower-leg rash
☐ Infected skin / leg rash
- ☐ Groin rash

Clinician review completed with patient: _____

Clinician Signature _____

Date / Time _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I understand that my health information may be used or shared as permitted by law for treatment, payment, and routine health care operations. This can include coordinating care with health professionals involved in my treatment, obtaining payment when applicable, and carrying out normal clinical and administrative activities.

I acknowledge that I have been offered or given access to the Notice of Privacy Practices, which explains how protected health information may be used and disclosed and describes patient privacy rights.

I understand that the Notice of Privacy Practices may be updated from time to time and that I may request a current copy. I may ask in writing for limits on certain uses or disclosures of my information. I understand that a requested restriction is not always required to be accepted, but an accepted restriction will be followed as required by law.

By signing below, I acknowledge receipt or availability of the Notice of Privacy Practices and confirm that I have had an opportunity to ask questions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

Office Use Only - If the acknowledgment could not be obtained, document the reason below.

Date	Staff Initials	Reason Signature Was Not Obtained