**Date:** ________________  
**Arrival Time:** ________________

### PATIENT INFORMATION:

- **Name:** ________________  
- **Age:** ________________  
- **Daytime Phone #:** ________________  
- **Alternate Phone #:** ________________  
- **Primary language:** ________________  
- **Height:** ___  
- **Weight:** ___  
- **Dominant Hand:** ☐ Right ☐ Left

### OTHER / REFERRING DOCTORS:

<table>
<thead>
<tr>
<th>Name of Doctor</th>
<th>Specialty</th>
<th>Phone Number</th>
<th>Fax</th>
<th>Address</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

### UNDERSTANDING YOUR CURRENT PAIN: *(Reason for visit)*

Describe in your own words the pain problem(s) you would like help with:

__________________________________________________________

__________________________________________________________

Below is a list of words that may describe your pain. Please rate each word by placing a check mark in the column that best describes the intensity of that type of pain:

<table>
<thead>
<tr>
<th>Throbbing</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>shooter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>stabbing</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>sharp</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>cramping</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>gnawing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hot-burning</td>
<td></td>
<td></td>
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<tr>
<td>aching</td>
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</tbody>
</table>

| Is your pain: ☐ Continuous  ☐ Intermittent*? |

*If your pain is intermittent how often does it occur?*

- ☐ Several times a day
- ☐ Several times per week
- ☐ Less than once per week
- ☐ Once per day
- ☐ Once per week
- ☐ Never
- ☐ Other _______________________

How long does your pain last? ☐ None ☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐ Weeks
UNDERSTANDING YOUR CURRENT PAIN: (Cont’d)

Circle a number below to indicate your **usual** pain intensity over the past week:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Mild pain</td>
<td>Moderate pain</td>
<td>Severe pain</td>
<td>Most intense pain imaginable</td>
<td></td>
<td></td>
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</tbody>
</table>

Please mark area(s) of pain with an (X):

What makes the pain **WORSE**? Be Specific.

What makes the pain **BETTER**? Be Specific.

**EFFECTS OF PAIN:**

Circle the number to indicate how much your pain has interfered with your activities this **past week**.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
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<td>No pain</td>
<td>Mild pain</td>
<td>Moderate pain</td>
<td>Severe pain</td>
<td>Most intense pain imaginable</td>
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<td></td>
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</tr>
</tbody>
</table>
CURRENT MEDICATIONS:
List all medications you are currently taking for medical and pain problems including prescribed, over-the-counter, herbs, and vitamins. Do not bring your medicines to the clinic unless you have a question to discuss with the physicians. Please use an additional sheet of paper if more room is needed.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Schedule</th>
<th>Prescribing Doctor</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Pharmacy Name, Phone and FAX ______________________________

HISTORY OF YOUR PAIN:
When did your pain start? ____________________________
When did your pain become a problem? ____________________________
What event(s) led to your present pain?

- ✗ Accident
- ✗ Other injury
- ✗ Other disease
- ✗ No obvious cause
- ✗ Cancer
- ✗ Following an operation
- ✗ Other: ____________________________

What do YOU think is the cause of your pain? ____________________________

PREVIOUS DOCTORS
List ALL of the doctors you have seen for your pain

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Specialty</th>
<th>Address / Phone / Fax</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

DIAGNOSTIC TESTS:
Please list, in chronological order, all tests and x-rays performed to evaluate your pain:

<table>
<thead>
<tr>
<th>Date</th>
<th>Test</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
**PREVIOUS MEDICATIONS:** List all previous medications you have taken for pain:

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Dose</th>
<th>Dates of Use</th>
<th>Helpful</th>
<th>Reason for stopping</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>❑ Yes</td>
<td>❑ No</td>
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<td>❑ Yes</td>
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<td>❑ No</td>
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<td></td>
<td>❑ Yes</td>
<td>❑ No</td>
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</tbody>
</table>

**PAST MEDICAL PROBLEMS:**
List any medical problems or injuries you have ever had.

<table>
<thead>
<tr>
<th>Year</th>
<th>Describe</th>
<th>Hospital</th>
<th>Doctor</th>
</tr>
</thead>
<tbody>
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</table>

**SURGICAL HISTORY:**
List any medical problems or injuries you have ever had.

<table>
<thead>
<tr>
<th>Year</th>
<th>Describe</th>
<th>Hospital</th>
<th>Doctor</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

**ALLERGIES:** ❑ No Known Allergies

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Reaction</th>
<th>Medicine</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
### REVIEW OF SYSTEMS:

**Please check if you have or had any of the following:**

#### General
- Weight change
- Poor or changed appetite
- Severe fatigue / low energy
- Recent fevers
- Recent Antibiotics

#### Hematological
- Anemia
- Easy bruising
- Bleeding disorder
- Taking blood thinners
- Blood Transfusion
- Cancer

#### Skin
- Rash
- Nail changes
- Bumps / nodules

#### Head and Neck
- Headaches
- Visual changes
- Mouth problems
- Neck pain
- TMJ problems

#### Cardiac
- Chest pain
- Irregular heartbeat
- Heart murmurs
- High or low blood pressure
- Circulation problems
- Ankle swelling

#### Pulmonary
- Shortness of breath
- Cough
- Asthma or bronchitis
- Lung disease
- Sleep apnea
- Snoring

#### Endocrine
- Diabetes
- Thyroid problems

#### Gastrointestinal
- Abdominal Pain
- Nausea or vomiting
- Constipation
- Diarrhea
- History of ulcers
- Reflux
- Heartburn

#### Neurologic
- Numbness
- Weakness
- Falling
- Stroke
- Seizures
- Memory Loss
- Loss of balance

#### Infectious Diseases
*(check all that apply)*
- Measles
- Mumps
- Chicken Pox
- Rheumatic fever
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Other: __________________________
- HIV
- AIDS
- Herpes (Oral)
- Herpes (Genital)
- Shingles
- Post-herpatic neuralgia

**In the last 5 years:**

**Received:**
- Pneumovax: Yes No
- Flu shot: Yes No
- Zoster: Yes No

#### Genitourinary
- Frequent or hesitant urination
- Pain with urination
- Blood in urine
- Incontinence
- Sexual dysfunction

#### Musculoskeletal
- Arthritis - Type: __________________________
- Osteoporosis
- Muscle pain
- Muscle wasting
- Fractures

#### Gynecologic
- Pregnant
- Post-menopausal
- Last Menstrual Period
  - Date: __________________________
PSYCHOLOGICAL HISTORY:
Describe your mood: ____________________________

Do you have problems with any of the following:
- [ ] Concentration
- [ ] Motivation
- [ ] Sleep
- [ ] Appetite
- [ ] Anxiety
- [ ] Depression
- [ ] Self-worth
- [ ] Homicidal thoughts
- [ ] Suicidal thoughts

Do you have a history of physical or mental abuse? [ ] Yes [ ] No
Are you currently in therapy? [ ] No [ ] Yes, who do you see? _______ Phone # _______

HABITS:
Smoking: [ ] Yes [ ] No [ ] Quit  Packs per day: _____ Number of years smoked: _____
Alcohol use: [ ] None [ ] Occasional [ ] Daily  How much per week? _______
Are you currently using recreational drugs? [ ] No [ ] Yes: [ ] Amphetamines [ ] Cocaine
- [ ] Heroin
- [ ] Marijuana
- [ ] Other: __________________________
Have you ever used recreational drugs? [ ] Yes [ ] No [ ] Quit
Do you drink caffeine (coffee, tea, etc.)?  How many cups per day? _______
Do you clench your teeth? [ ] Yes [ ] No
Do you grind your teeth? [ ] Yes [ ] No
Do you wear a night guard over your teeth? [ ] Yes [ ] No

EXERCISE:
Do you exercise? [ ] No [ ] Yes, what type? __________________________
How many days per week do you exercise? __________________
How long do you exercise each time (on average)? __________________

FAMILY HISTORY: Are you adopted? [ ] Yes [ ] No

<table>
<thead>
<tr>
<th>Member</th>
<th>Deceased or Living</th>
<th>Age</th>
<th>Medical Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Siblings</td>
<td></td>
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<tr>
<td>Spouse</td>
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</tr>
</tbody>
</table>
### SOCIAL HISTORY:

- **Relationship Status:**
  - Single
  - Separated
  - Married
  - Widowed
  - Domestic Partner: Female, Male

- **With whom do you live?**
  - Name: _____________________
  - Relationship: _____________________

- **Highest level of education completed:**
  - Less than High School
  - High School
  - Vocational
  - College
  - Graduate School
  - Other: _____________________

- **Current or most recent occupation:** _____________________
  - Status: Full Time, Part Time, Self-employed, Homemaker, Retired __ years
  - Unemployed __ years due to pain
  - Unemployed __ years due to _____________________

- **Are you happy with your job?**
  - Yes
  - No

- **Are you on Disability?**
  - Yes, Date Started: _____________________
  - Reason for disability: _____________________

### FINANCIAL INFORMATION:

- **Do you have any legal action pending related to this pain or any other health problem?**
  - Yes
  - Attorney’s name: _____________________
  - Phone #: _____________________
  - Address: _____________________

### HEALTHCARE DECISIONS: (Check boxes that apply)

- Patient prefers to make own medical decisions.
- Medical decisions are made jointly between patient and family.
- Patient prefers family members to make the major medical decisions.
- Patient has Advance Directives: Yes

* If Yes, Copy of Directives given to CSMC: Yes

- Source of information if other than patient: _____________________

- Signature of person acquiring this information: _____________________

- Signature of patient: _____________________

### Evaluation reviewed by Physician:

- Name of Physician (please print) _____________________
- Signature of Physician: _____________________
- ID# _____________________
- Date Signed: _____________________
For Clinical Use Only:

1. Blood Pressure ________ / ________  Heart Rate:_______  Respiration Rate:_______

2. Counselling about:
   - Alcohol: □ Yes □ No
   - Smoking: □ Yes □ No
   - Seatbelt use: □ Yes □ No  %________

3. Cultural / Spiritual Issues (See Nursing Profile) - only if required by hospital
   □ Yes, required

4. Patient / Caregiver Education (See Nursing Profile) - only if required by hospital
   □ Yes, required

5. Blood transfusion: □ No  □ Yes, Reaction:__________________________