



CEDARS-SINAI MEDICAL CENTER.
THE PAIN CENTER

**PAIN EVALUATION
GENERAL**

PATIENT I.D. _____

Date: _____ Arrival Time: _____

PATIENT INFORMATION:

Name: _____ Age: _____

Daytime Phone # _____ Alternate Phone # _____

Primary language: _____ Height: _____ Weight: _____ Dominant Hand: Right Left

OTHER / REFERRING DOCTORS: please list the Doctors you would like records sent to

Name of Doctor	Specialty	Phone Number	Fax	Address

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:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shooting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stabbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Splitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tiring-Exhausting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gnawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot-Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Punishing-Cruel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Is your pain: Continuous or 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



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UNDERSTANDING YOUR CURRENT PAIN: (Cont'd)

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

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

No pain

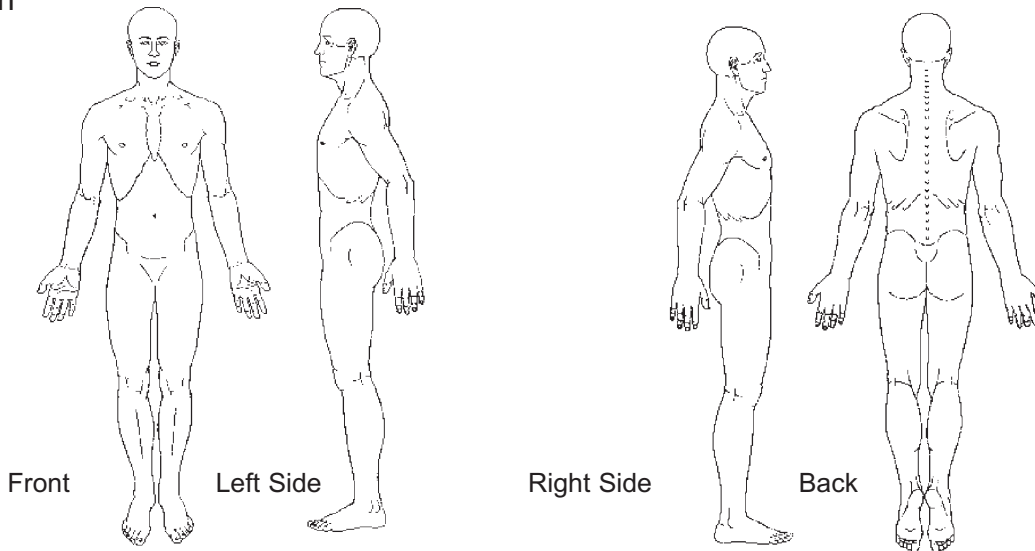
Mild pain

Moderate pain

Severe pain

Most intense pain imaginable

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**.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

No pain

Mild pain

Moderate pain

Severe pain

Most intense pain imaginable



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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.

Medication Name	Dose	Schedule	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Date	Name	Specialty	Address / Phone / Fax
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DIAGNOSTIC TESTS:

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

Date	Test	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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PREVIOUS TREATMENTS:

Indicate which of the following treatments you have tried for your pain problem:

- Nerve Blocks Chiropractor Psychotherapy Relaxation Training
 Acupuncture Physical Therapy Biofeedback Exercise Program
 Other (list): _____

PREVIOUS MEDICATIONS: List all previous medications you have taken for pain:

Name of Medicine	Dose	Dates of Use	Helpful	Reason for stopping
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

PAST MEDICAL PROBLEMS:

List any medical problems or injuries you have ever had.

Year	Describe	Hospital	Doctor

SURGICAL HISTORY:

List any medical problems or injuries you have ever had.

Year	Describe	Hospital	Doctor

ALLERGIES: No Known Allergies

Medicine	Reaction	Medicine	Reaction



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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

Genitourinary

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

Musculoskeletal

- Arthritis -Type: _____
- Osteoporosis
- Muscle pain
- Muscle wasting
- Fractures

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-herpetic neuralgia

In the last 5 years:

Received:

Pneumovax: Yes No

Flu shot: Yes No

Zoster: Yes No

Gynecologic

- Pregnant
- Post-menopausal
- Last Menstrual Period
Date: _____



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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

Member	Deceased or Living		Age	Medical Problems
Father	<input type="checkbox"/>	<input type="checkbox"/>		
Mother	<input type="checkbox"/>	<input type="checkbox"/>		
Siblings	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
Spouse	<input type="checkbox"/>	<input type="checkbox"/>		



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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? No Yes, Date Started: _____

Reason for disability: _____

FINANCIAL INFORMATION:

Do you have any legal action pending related to this pain or any other health problem?

No 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* No

* If Yes, Copy of Directives given to CSMC: Yes No

Source of information if other than patient: _____

Signature of person acquiring this information: _____

Signature of patient: _____ Date: _____

Evaluation reviewed by Physician:

 Name of Physician (please print) Signature of Physician ID# Date Signed



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For Clinical Use Only:

1. Blood Pressure _____ / _____ Heart Rate: _____ Respiration Rate: _____

2. Counseled 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: _____