



CEDARS-SINAI®

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

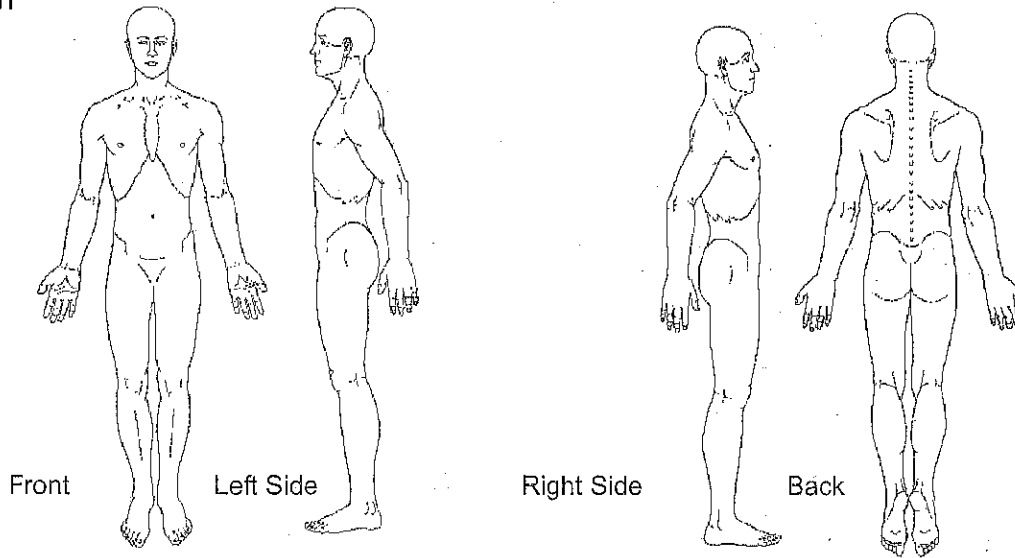
Mild pain

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: _____