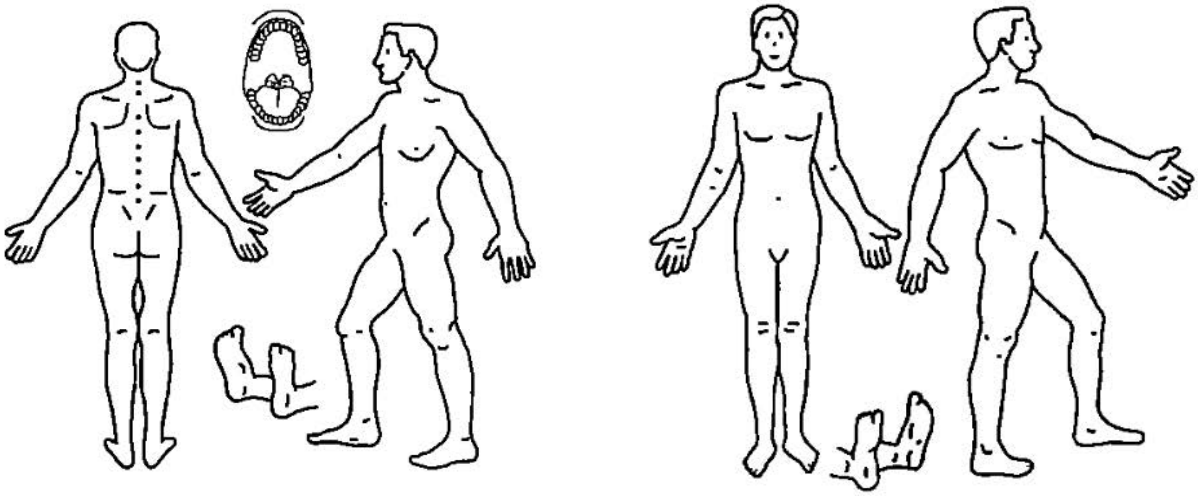
UNIVERSITY OF UTAH • PAIN MANAGEMENT CENTER • INITIAL EVALUATION

Full name (Last, first, middle initial)_____Date of Birth:_____

*** What is your main or worst pain problem?** _____
Please list any other (secondary) areas of pain _____
PAIN HISTORY: Mark or shade in the areas you have pain. **Put an "X" over the WORST area of pain.**



THE FOLLOWING QUESTIONS REFER TO YOUR MAIN OR WORST AREA OF PAIN:
How did your pain start?: □Gradual □Sudden Is the pain related to an injury? □Yes □No
Explain when and how your pain started_____
_____

Has the pain increased/changed recently? □Yes □No If yes, describe? _____

On a scale from 0 (no pain) to 10 (worst pain imaginable):
What number is your pain at its **worst**? _____ What number is your pain at its **best**? _____
What number is your pain **on average**? _____ What number is your **goal** for pain level? _____

How often do you have your pain?
□ Continuous and steady (the same all the time) □ Continuous but gets better and worse □ Intermittent (sometimes)

How would you describe your pain?

□ Aching	□ Pressure	□ Throbbing	□ Variable (changes)
□ Burning	□ Sharp	□ Tight	□ Other_____
□ Cramping	□ Shooting	□ Numbness	□ Other_____
□ Dull	□ Squeezing	□ Tingling	

Which of these activities make your pain better?

□ Distraction	□ Massage	□ Relaxation	□ Medications
□ Heat	□ Meditation	□ Rest	□ Nothing
□ Ice	□ Movement	□ Sleeep	□ Other_____

Which of these activities make your pain worse?

□ Nothing	□ Sitting	□ Stairs	□ Straining
□ Rest	□ Walking	□ Activity/Movement	□ Intercourse
□ Changing Position	□ Bending	□ Stress	□ Other _____
□ Standing	□ Twisting	□ Weather	□ Other_____

What are you currently using to treat your pain (medications, heat/ice, activity, therapies, etc)?
_____

PAIN HISTORY: Check (√) the box that best describes your past treatment and its effects on your pain

Treatment	Effect of Treatment			
	Helped	Didn't Help	Made Pain Worse	Not Tried
Physical Therapy:_____	☐	☐	☐	☐
Chiropractic	☐	☐	☐	☐
Massage	☐	☐	☐	☐
Water/Pool therapy	☐	☐	☐	☐
Acupuncture/Acupressure	☐	☐	☐	☐
TENS unit	☐	☐	☐	☐
Spine injections (type) _____	☐	☐	☐	☐
Muscle injections	☐	☐	☐	☐
Joint injection	☐	☐	☐	☐
Other nerve injection _____	☐	☐	☐	☐
Other professional treatment_____	☐	☐	☐	☐
Surgery (type and date)_____	☐	☐	☐	☐
Behavioral therapy.	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

SLEEP:

Overall quality ☐ Good ☐ Fair ☐ Poor Total hours at night _____ Total hours at a time _____

Difficulty falling asleep:	☐ Never	☐ Sometimes	☐ Always
Frequent nighttime awakenings:	☐ Never	☐ Sometimes	☐ Always
Difficulty falling asleep if awakened:	☐ Never	☐ Sometimes	☐ Always

Sleep Medications you are using:_____ Past Sleep Medications: _____

MOOD:

Please describe your general mood over the last week:

☐ Normal/neutral	☐ Depression	☐ Irritable	☐ Guilty	☐ Hopeless
☐ Generally happy	☐ Helpless	☐ Anxiety	☐ Worried	☐ Up and down
☐ Sad	☐ Lack of enjoyment	☐ Fearful	☐ Angry	☐ Other_____

Do you have a history of mood problems (anxiety, depression, other)? _____
Are you currently being treated for mood problems?_____ By who?_____

Medications for mood you are currently using:_____
Past Mood Medications: _____

FUNCTION

Currently I am able to:

Care for my basic needs (bathe, dress, feed)	☐ Always	☐ Most of the time	☐ Sometimes	☐ Never
Care for myself at home (cook, clean, laundry)	☐ Always	☐ Most of the time	☐ Sometimes	☐ Never
Drive short distances and run errands	☐ Always	☐ Most of the time	☐ Sometimes	☐ Never
Do light activity (yard work, walk 15 minutes)	☐ Always	☐ Most of the time	☐ Sometimes	☐ Never
Do moderate activity (30 minutes or more)	☐ Always	☐ Most of the time	☐ Sometimes	☐ Never

On a scale from 0 (bed-bound) to 100 (doing everything you want to do) please rate your overall function:_____%

Please list any activity restrictions _____
Do you do any regular physical activity? _____ Please describe _____

My goal is to be able to_____

***PAIN MEDICATIONS** Please list medications and doses you are currently using for your pain:________________________

____

____

Previous Pain Medications	Did it help	Why was it stopped
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:

Medication Goal____

***PHARMACY** Name, Address and Phone Number of your preferred pharmacy:_____________________________________

____

***PAST MEDICAL HISTORY** Check (√) any major medical problems you presently have or have had:

☐ Alcohol abuse	☐ Congestive heart failure	☐ Hiatal hernia	☐ Seizure
☐ Anesthesia problems	☐ COPD/Emphysema	☐ High blood pressure	☐ Stroke
☐ Anxiety	☐ Depression	☐ HIV	☐ Thyroid
☐ Arthritis	☐ Diabetes	☐ Irregular heartbeat	☐ TIA (mini-stroke)
☐ Asthma	☐ Dizziness	☐ Kidney problems	☐ Transfusion
☐ Bleeding disorder	☐ Fainting	☐ Liver problems	☐ Ulcer
☐ Bowel problems	☐ Heart attack	☐ Migraine/ Headaches	☐ Urinary problems
☐ Cancer	☐ Heart valve problems	☐ Reflux disease	☐ Other________
☐ Chest pain	☐ Hepatitis	☐ Pancreatitis	☐ Other________

***PAST SURGICAL HISTORY**

☐ Appendectomy	☐ Hernia repair	☐ Joint surgery____________	☐ Other_____________
☐ Coronary bypass	☐ Hysterectomy	☐ Joint replacement:________	☐ Other_____________
☐ Gall bladder removed	☐ Tonsils & Adenoids	☐ Spine Surgery:___________	☐ Other_____________

***FAMILY HISTORY** List illnesses that run in your family

Family (Name)	Living / Dead	Major Illnesses
Father		
Mother		
Siblings - # sisters______ brothers______		
Children - #daughters______ sons______		

DIAGNOSTIC TESTS: Which of the following tests for this pain have been done (if more than one list most recent test)?

Diagnostic Test	Body Part	Approximate Date	Where was it done?
X-Rays			
CT scan			
MRI scan			
EMG/Nerve study			
Other______________			

***SOCIAL / OCCUPATIONAL HISTORY**

Do you smoke or use tobacco? ☐ No ☐ Yes ☐ Quit How much?_____ For how long?_____
Do you drink alcohol? ☐ No ☐ Yes ☐ Quit How much?_____ For how long?_____
Do you use illegal drugs? ☐ No ☐ Yes ☐ Quit What type?_____ For how long?_____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried
Children: ☐ None #daughters_____ #sons_____ # people living in the home_____
Living Situation ☐ Alone ☐ With spouse ☐ With family ☐ With child(ren ☐ With parents ☐ Roomates

Employment: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disability since_____ ☐ Retired ☐ Homemaker
Employer_____ For this pain are you involved in ☐ Litigation ☐ Workers Compensation
If you are not working, do you plan to: ☐ Return to your old job ☐ Take a different job ☐ Not return to work

Please list any other concerns or things we should know about your pain_____

REVIEW OF SYSTEMS: In the last month have you had:

General	**YES**	**NO**
Activity change	☐	☐
Appetite change	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Unexpected weight change	☐	☐
Head/Neck:		
Neck Pain	☐	☐
Neck Stiffness	☐	☐
Hearing Loss	☐	☐
Ringing in your ears	☐	☐
Eyes		
Eye Discharge	☐	☐
Eye Pain	☐	☐
Eye Redness	☐	☐
Respiratory		
Chest Tightness	☐	☐
Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Cardiovascular		
Chest Pain	☐	☐
Leg Swelling	☐	☐
Palpitations	☐	☐
GI		
Abdominal Pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Nausea	☐	☐
Vomiting	☐	☐

Endocrine	**YES**	**NO**
Cold Intolerance	☐	☐
Heat Intolerance	☐	☐
Genitourinary		
Difficulty Urinating	☐	☐
Painful Urination	☐	☐
Flank Pain	☐	☐
Musculoskeletal		
Joint Pain	☐	☐
Back Pain	☐	☐
Joint Swelling	☐	☐
Muscle Pain	☐	☐
Skin		
Color Change	☐	☐
Rash	☐	☐
Wound	☐	☐
Neurological		
Dizziness	☐	☐
Headaches	☐	☐
Numbness	☐	☐
Seizures	☐	☐
Weakness	☐	☐
Hematologic		
Easy bruising	☐	☐
Swollen lymph nodes	☐	☐
Psychiatric		
Confusion	☐	☐
Depressed mood	☐	☐
Nervous/anxious	☐	☐