**PAIN MANAGEMENT**
**238-07 Braddock Avenue Bellerose, New York 11426**
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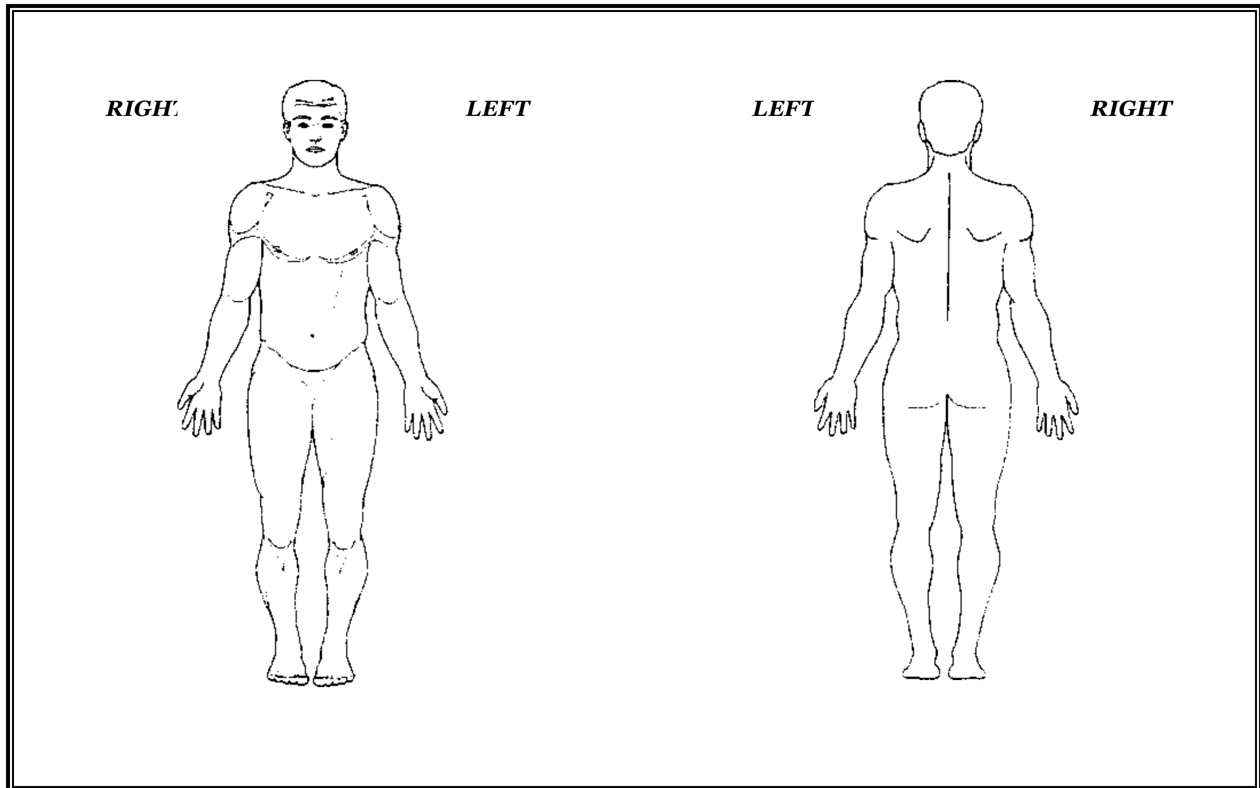
# PAIN ASSESSMENT FORM

**NAME:__________________________________ DATE:________________**

**1. WHAT IS THE EVENT OR EVENTS WHICH LED TO YOUR PRESENT PAIN?:**

| _____ ACCIDENT | _____ INJURY | _____ FOLLOWING AN OPERATION | _____ CANCER | _____ OTHER DISEASE | _____ NO OBVIOUS CAUSE |
|---|---|---|---|---|---|

**2. PLESE INDICATE THE LOCATION OF YOUR PAIN ON THE FIGURE PROVIDED:**
*PLEASE BE SPECIFIC REGARDING SIDE (RIGHT OR LEFT) OF PAIN AND LOCATION (FRONT OR BACK).*




**3. HOW LONG HAVE YOU HAD THIS PAIN?________________**

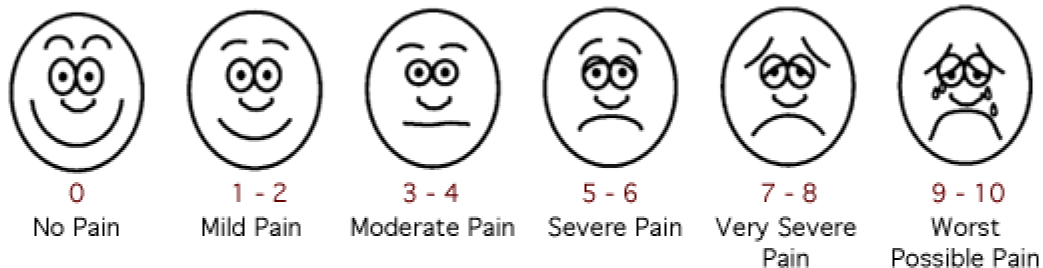
**4. HOW OFTEN DOES THE PAIN OCCUR?**

| |
|---|
| **1.________CONTINUOUSLY (NON-STOP)** |
| **2.________SEVERAL TIMES A DAY** |
| **3.________ONCE OR TWICE A DAY** |
| **4.________SEVERAL TIMES A WEEK** |
| **5.________LESS THAN 3 OR 4 TIMES PER MONTH** |

**5. CIRCLE THE WORDS THAT DESCRIBE YOUR PAIN** ***(CIRCLE AS MANY AS YOU NEED):***

| | | | | | | |
|---|---|---|---|---|---|---|
| BORING | BURNING | CRAMPING | CRUSHING | CUTTING | DULL ACHE | ELECTRIC |
| FLICKING | GNAWING | ITCHING | NAGGING | PINCHING | PRESSING | PRICKING |
| PULSING | SHARP | SHOOTING | SQUEEZING | STABBING | STINGING | TINGLING |

**6. PLEASE RATE YOUR PAIN OVER THE PAST 24 HOURS BY USING THE 0-10 PAIN SCALE.**




**AT IT'S LEAST ________ AT IT'S AVERAGE _______ AT IT'S WORST ______**

**7. DOES THE PAIN AFFECT YOUR ACTIVITY IN THESE DIFFERENT AREAS?**

| | | | | | |
|---|---|---|---|---|---|
| HOUSEHOLD CHORES ___ | LEISURE ___ | SCHOOL ___ | SEXUAL ACTIVITY ___ | SOCIAL INTERACTIONS____ | WORK ___ |

**8. DOES THE PAIN AFFECT YOUR ABILITY TO:**

_______FALL ASLEE ______SLEEP THROUGH THE NIGHT

**9. WHICH MEDICATIONS HAVE YOU TRIED FOR YOUR PAIN? ARE THEY HELPFUL? FOR HOW LONG? AND WHICH ONES ARE YOU CURRENTLY TAKING?**

| MEDICATIONS | NO HELP | SOME HELP | GREAT HELP | HOW LONG | NOW TAKING | CURRENT DOSE |
|---|---|---|---|---|---|---|
| ACTIQ | | | | | | |
| ASPIRIN | | | | | | |
| ATIVAN (LORAZEPAM) | | | | | | |
| BACLOFEN (LIORESAL) | | | | | | |
| BEXTRA (VALDECOXIB) | | | | | | |
| BUSPAR | | | | | | |
| CALCITONIN (MIACOLCE) | | | | | | |
| CELEBREX (CELECOXIB) | | | | | | |
| CLONIDINE (CATAPRES) | | | | | | |
| CODEÍNE | | | | | | |
| DARVON (PROPOXYPHENE) | | | | | | |
| DEMEROL (MEPERIDINE) | | | | | | |
| DILANTIN (PHENYTOIN) | | | | | | |
| DILAUDID (HYDROMORPHONE) | | | | | | |
| DOXEPIN (SINEQUAN) | | | | | | |
| DURAGESIC (FENTANYL) | | | | | | |
| ELAVIL (AMITRIPTYLINE) | | | | | | |
| FLEXERIL (CYCLOBENZAPRINE) | | | | | | |
| GABRITRIL | | | | | | |
| HALDOL (HALOPERIDOL) | | | | | | |
| IMIPRAMINE (TOFRANIL) | | | | | | |
| KADIAN | | | | | | |
| KLONOPIN (CLONAZEPAM) | | | | | | |
| LAMOTRIGINE (LAMICTAL) | | | | | | |
| LEVO-DROMORAN (LEVORPHANOL) | | | | | | |
| LIDODERM 5% PATCH | | | | | | |
| METHADONE | | | | | | |
| MEXILETINE (MEXITIL) | | | | | | |
| MOBIC (MELOXICAM) | | | | | | |
| MORPHINE | | | | | | |
| MOTRIN, ADVIL (IBUPROFEN) | | | | | | |
| MSCONTIN | | | | | | |
| NAPROSYN (NAPROXEN) | | | | | | |
| NEURONTIN (GABAPENTIN) | | | | | | |
| NORPRAMINE (DESIPRAMINE) | | | | | | |
| OXYCONTIN | | | | | | |
| PAMELOR (NORTRIPTYLINE) | | | | | | |
| PAROXETINA (PAXIL) | | | | | | |
| PERCOCET (OXICODONE) | | | | | | |
| PHENERGAN (PROMETHAZINE) | | | | | | |
| PROZAC (FLUOXETINE) | | | | | | |
| RELAFEN (NABUMETONE) | | | | | | |
| SKELAXIN (METAXALONE) | | | | | | |
| SOMA (CARISOPRODOL) | | | | | | |
| STADOL (BUTORPHANOL) | | | | | | |
| TALWIN (PENTAZOCINE) | | | | | | |
| TEGRETOL (CARBAMAZEPINE) | | | | | | |
| TOPIRAMATE | | | | | | |
| TORADOL (KETOROLAC) | | | | | | |
| TRILISATE | | | | | | |
| TYLENOL (ACETAMINOPHEN) | | | | | | |
| TYLENOL W/CODEÍN | | | | | | |
| ULTRAM / ULTRACET | | | | | | |
| VALIUM (DIAZEPAM) | | | | | | |
| VALPROLC ACID (DEPAKENE) | | | | | | |
| VICODIN (HIDROCODONE) | | | | | | |
| VIOXX (ROFECOXIB) | | | | | | |
| ZANAFLEX (TIZANADIC) | | | | | | |
| OTHERS | | | | | | |

**10. WHAT IS THE SPECIALTY AND NAME OF PHYSICIANS YOU HAVE SEEN FOR YOUR PAIN (E.G. ORTHOPEDIC SURGEON, NEUROLOGIST, NEUROSURGEON, PSYCHIATRIST, PHYSIATRIST)?**

| *NAME* | *ADDRESS* | *TELEPHONE* |
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**11. WHAT TREATMENTS HAVE YOU ALREADY TRIED FOR YOUR PAIN? ARE THEY HELPFUL? FOR HOW LONG? WHICH ONES ARE YOU CURRENTLY UTILIZING?**

| PROCEDURES | NO HELP | SOME HELP | GREAT HELP | HOW LONG | NOW USING |
|---|---|---|---|---|---|
| SURGERY | | | | | |
| NERVE BLOCKS | | | | | |
| EPIDURAL INJECTIONS | | | | | |
| PCA PUMP | | | | | |
| TENS UNIT | | | | | |
| TRIGGER POINT INJECTIONS | | | | | |
| ETHYL CHLORIDE SPRAY | | | | | |
| BRACE | | | | | |
| EXERCISE | | | | | |
| PHYSICAL THERAPY | | | | | |
| ACUPUNCTURE | | | | | |
| RELAXATION TRAINING | | | | | |
| CHIROPRACTIC THERAPY | | | | | |
| BIOFEEDBACK | | | | | |
| HYPNOSIS | | | | | |
| MASSAGE | | | | | |
| PSYCHOLOGICAL COUNSELING | | | | | |
| OTHERS: | | | | | |

**12. WHAT MAKES YOUR PAIN BETTER?**________________________________________

**13. WHAT MAKES YOUR PAIN WORSE?**____________________________________

**14. DO YOU TAKE ANY ANTI COAGULANTS (BLOOD THINNERS)?**

| CLOPIDOGREL (PLAVIX)____ | COUMADIN (WARFARIN)____ | FRAGMIN (DALTEPARIN)____ | LOVENOX____ |
|---|---|---|---|

**15. ARE YOUR BOWEL MOVEMENTS:**

____***REGULAR*** ____***IRREGULAR*** _____***CONSTIPATED***

**16. HAVE YOU HAD ANY PREVIOUS SURGERIES?** _____**YES / NO**____

***IF YES, PLEASE SPECIFY:***

| *SURGERY* | *YEAR* |
|---|---|
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**17. WHAT OTHER MEDICAL PROBLEMS DO YOU HAVE (E.G. ANGINA, BRONCHITIS, DIABETES, DEPRESSION, HIGH BLOOD PRESSURE, ASTHMA, ETC.)?**

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| |

**18. WHAT MEDICATIONS ARE YOU TAKING FOR THESE MEDICAL PROBLEMS?**

| DRUG | DOSE | FREQUENCY |
|---|---|---|
| A. | | |
| B. | | |
| C. | | |
| D. | | |
| E. | | |
| F. | | |

**19. DO YOU, OR HAVE YOU USED TOBACCO AND OR ALCOHOL? ______YES / NO _____**

*IF YES HOW MANY PACKS PER DAY? ____________, FOR HOW MANY YEARS?*___________________

**20. DO YOU, OR HAVE YOU USED ILLICIT DRUGS? ____YES / NO_____**

*IF YES, WHAT DRUGS?* ________________________________________________________________

**21. ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? __YES / NO_______**

*IF YES PLEASE DESCRIBE*: ________________________________________________________________

**22. WHAT IS YOUR CURRENT EMPLOYMENT STATUS? ____________________________**

**23. DO YOU HAVE PENDING; SETTLEMENT ABOUT DISABILITY, WORKERS COMPENSATION OR ANY LEGAL MATTER? _________YES / NO____**