SPINETEAM Spokane

PATIENT PAIN ASSESSMENT

Patient Name _____ Date / 2017

Is your condition: related to a **work** injury? ☐ NO ☐ YES, Date: _____

related to **auto accident**? ☐ NO ☐ YES, Date: _____

involved in a **lawsuit**? ☐ NO ☐ YES, Attorney: _____

Current Primary Care Physician _____ Date of last visit _____

Current Claims Manager (if applicable) _____

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Which problem would you like to focus on?

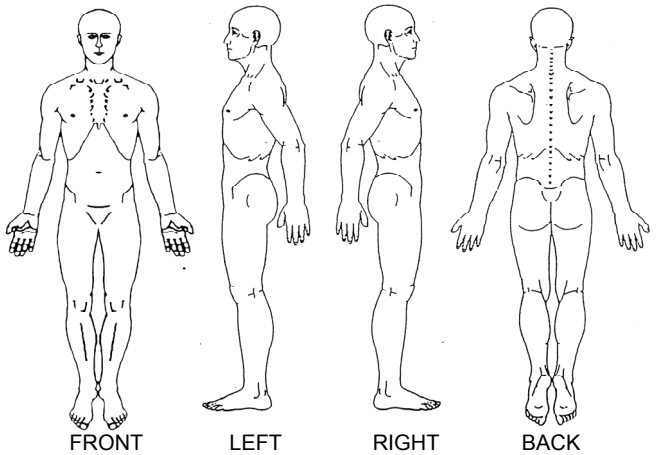
HPI

☐ Back ☐ Hip(s) ☐ Neck ☐ Hand(s) ☐ Shoulder(s)
☐ Leg(s) ☐ Buttocks ☐ Arm(s) ☐ Headache ☐ Other: _____

How and when did your pain begin?_____

Describe the pain and show where it hurts:

sharp ☐
radiating ☐
burning ☐
dull ☐
other ☐ _____



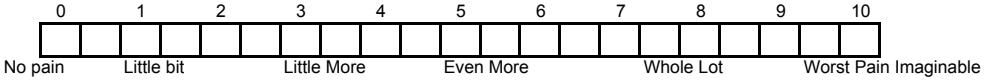
Is your pain:

improving ☐
worsening ☐
constant ☐
gone ☐
off and on ☐ how often _____

N + -
T + -
W + -

To show your pain levels, place each letter (P, W, L, M) in the appropriate box on the graph below:

P = your present pain **L** = the least the pain gets
W = the worst the pain gets **M** = the pain you are at most of the time



Do you also experience:	YES, in my arms/hands	YES, in my legs/ankles/feet	NO
Weakness of muscles?	☐	☐	☐
Numbness (loss of feeling)?	☐	☐	☐
Tingling ("falling asleep")?	☐	☐	☐

What makes your pain **worse**? (check all that apply)

☐ Standing ☐ Walking ☐ Morning ☐ Stress / Worry
☐ Bending ☐ Sitting/Driving ☐ Night ☐ Cold Weather
☐ Exercise ☐ Climbing Stairs ☐ Touching Skin
☐ Other/Explain _____

What makes your pain **better**? (check all that apply)

☐ Medication ☐ Injections ☐ Walking ☐ Heat
☐ Street Drugs ☐ Sitting ☐ Exercise ☐ Bath / Shower
☐ Alcohol ☐ Standing ☐ Sleeping ☐ Lying Down: # ____hrs during day NOT sleeping
☐ Other/Explain _____

Patient Signature

Physician Signature Date

Patient Name _____ Date _____

How many **hours** of sleep do you get at night?_____

	YES	NO
Do you have trouble **falling** asleep?	☐	☐
Do you have trouble **staying** asleep?	☐	☐
Does the pain **wake** you up?	☐	☐

ACTIVITIES were you able to do in the past that you **cannot** do now because of the pain:

_____

CURRENT MEDICATIONS you get from another physician:

Name of pill	Dose	Qty# / Day	How Often (# hours)	How Long (#mos/yrs)	Doctor's Name

	YES	NO
Have you had any **tests, treatment, surgery, therapy, medications,** etc. since your last visit?	☐	☐

If yes, where/when? _____

_____

	YES	NO
Have you developed any NEW **allergies** or intolerances to medications?	☐	☐

If yes, please explain: _____

ROS

Do you have any of the following medical problems? (Check all that apply.)

☐ Heart / Chest Pains	☐ Bleeding Disorders	☐ Diabetes	☐ Headaches
☐ High Blood Pressure	☐ Blood Thinness	☐ Nausea / Vomiting	☐ Eyes, vision, spots
☐ Strokes / TIA's	☐ Arthritis	☐ Stomach Disorders	☐ Depression
☐ Seizures	☐ Cancer	☐ Muscle Spasms	☐ Anxiety
☐ Kidney / Liver	☐ Bowel or Bladder	☐ Achy muscles	☐ Mental Disorder
☐ Lungs / Breathing	☐ Constipation / Diarrhea	☐ Insomnia	☐ Other _____

Women Only - Are you pregnant or planning to be in the near future? ☐ YES ☐ NO

PFMSHx

Describe any **change in your job**, trade, or occupation since your last visit: _____

Describe any **NEW** family medical problems since your last visit: _____

Do you **smoke**? ☐ NO ☐ YES If yes, how much per day? _____

how many years? _____

If you used to smoke but don't anymore, when did you quit?_____

Do you drink **alcohol**? ☐ NO ☐ YES If yes, how much per day? _____

how many years? _____

If you used to drink alcohol but don't anymore, when did you quit?_____

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