Pain Assessment

Patient Name: ____

☐ Male ☐ Female Age: _____ years Height: _____ ft _____ in Weight: _____ lbs

Please List Any/All Allergies ____

What is the main problem for which you are seeking treatment? ____

____

When your current pain started, was there a precipitating event? (check one):

☐ Automobile accident ☐ Work Injury ☐ Surgery ☐ Sports ☐ Other ______________________

How long have you had your current pain problem? _____ years _____ months

Describe what the pain feels like: ____

How do the following affect your pain? (check one for each item)

Lying down	☐ Decrease	☐ No Effect	☐ Increase
Standing	☐ Decrease	☐ No Effect	☐ Increase
Sitting	☐ Decrease	☐ No Effect	☐ Increase
Walking	☐ Decrease	☐ No Effect	☐ Increase
Exercise (if applicable)	☐ Decrease	☐ No Effect	☐ Increase
Medication	☐ Decrease	☐ No Effect	☐ Increase

Are there other factors that make your pain...

Better? (please list) ____

Worse? (please list) ____

Please rate your pain intensity on a scale from 0 = no pain to 10 = excruciating, incapacitating worst pain possible.
Write the number (from 0-10) in the spaces below:

Your pain at its worst in the past month or since your injury _____

Your pain at its least in the past month or since your injury _____

Your current pain _____

Pain Assessment

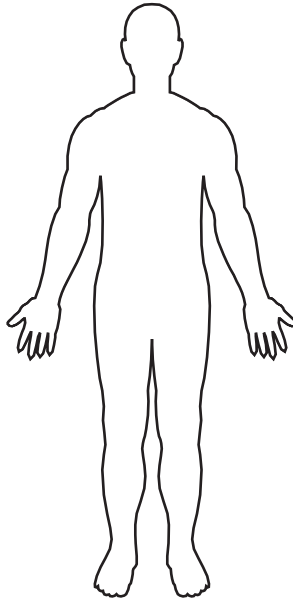
How often do you have your pain? (check one below):

☐ Constantly (100% of the time)
☐ Nearly constantly (60% to 95% of the time)
☐ Intermittently (30% to 60% of the time)
☐ Occasionally (less than 30% of the time)

Below – Please indicate the location of pain

LEFT

RIGHT



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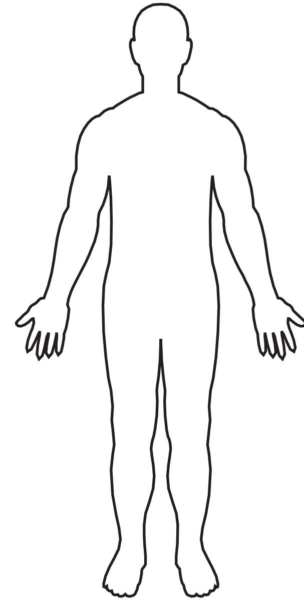


BACK

Circle the number that best describes your pain now.
0 = No Pain; 10 = Worst Imaginable Pain

0 1 2 3 4 5 6 7 8 9 10

CONFIDENTIAL

For evaluation and treatment purposes ONLY!

Coping Information

Have you ever experienced any physical, emotional or sexual abuse? ☐ Yes ☐ No
If yes, explain: ____________________

Have you ever had psychiatric, psychological, or social work evaluations for any problem, including your current pain?
☐ Yes ☐ No If yes, what and when? ____________________

Have you ever been in treatment for misuse of alcohol, illicit drugs or prescribed medications?
☐ Yes ☐ No If yes, Location: ____________________ Date: ____________________

Pain Assessment

Medication List					
Name of Medication and Dosage	Date first prescribed	Daily amount taken	Reason for medication	Physician name	Did this help with your pain? (Put "X" by all that helped)

Please check all of the treatments you have tried (or are currently using) for your pain.

- ☐ Physical Therapy
- ☐ Acupuncture
- ☐ Massage Therapy
- ☐ TENS Unit *(Transcutaneous Electrical Nerve Stimulation)*
- ☐ Chiropractor
- ☐ Surgery
- ☐ Spinal Cord Stimulator
- ☐ Cognitive Behavior Therapy
- ☐ Biofeedback
- ☐ Hypnosis
- ☐ Nerve Block
- ☐ Trigger Point Injections
- ☐ Rehabilitation
- ☐ Radio Frequency Lesioning
- ☐ Nutritional Supplements
- ☐ Dietary Changes

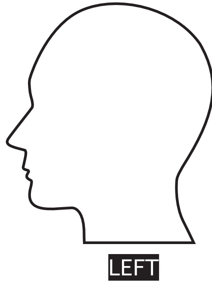
Other:____

Initial Consultation Form

Date: ______________________________

Patient Name: ____

Below – Please indicate the location of pain



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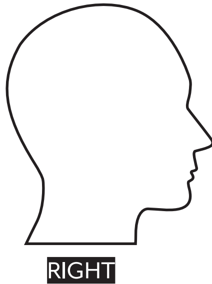

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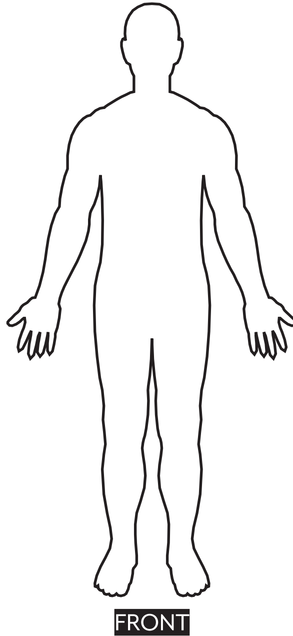

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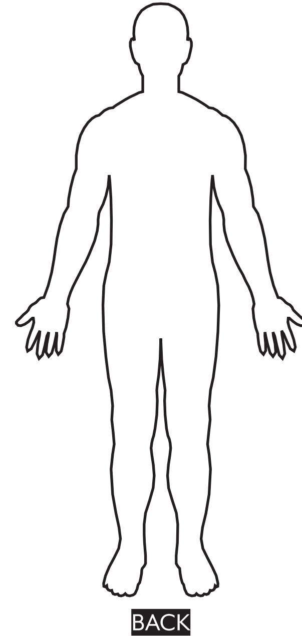

BACK

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0 1 2 3 4 5 6 7 8 9 10

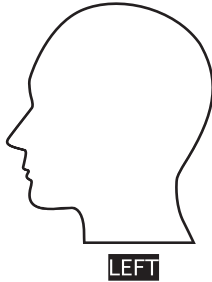
Therapy Instructions/Adjustments: ____

Patient Re-Evaluation Form

Date: ______________________________

Patient Name: ____

Below – Please indicate the location of pain



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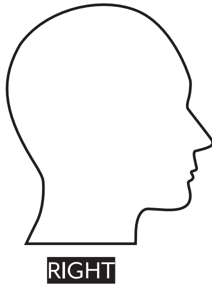

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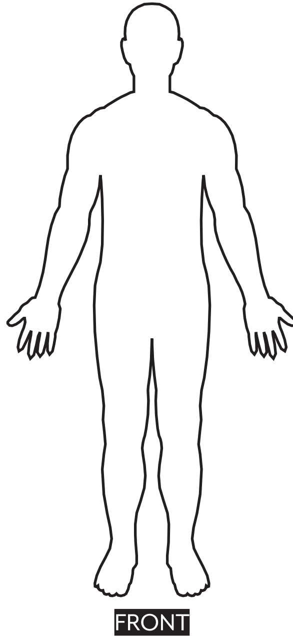

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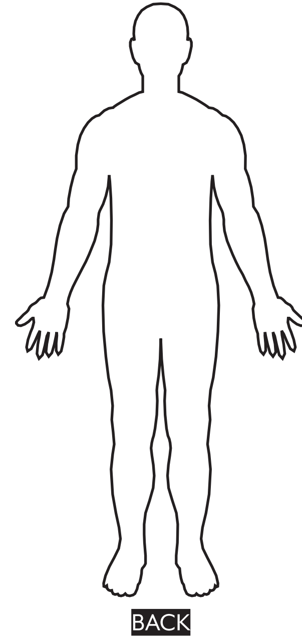

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Therapy Instructions/Adjustments: ____