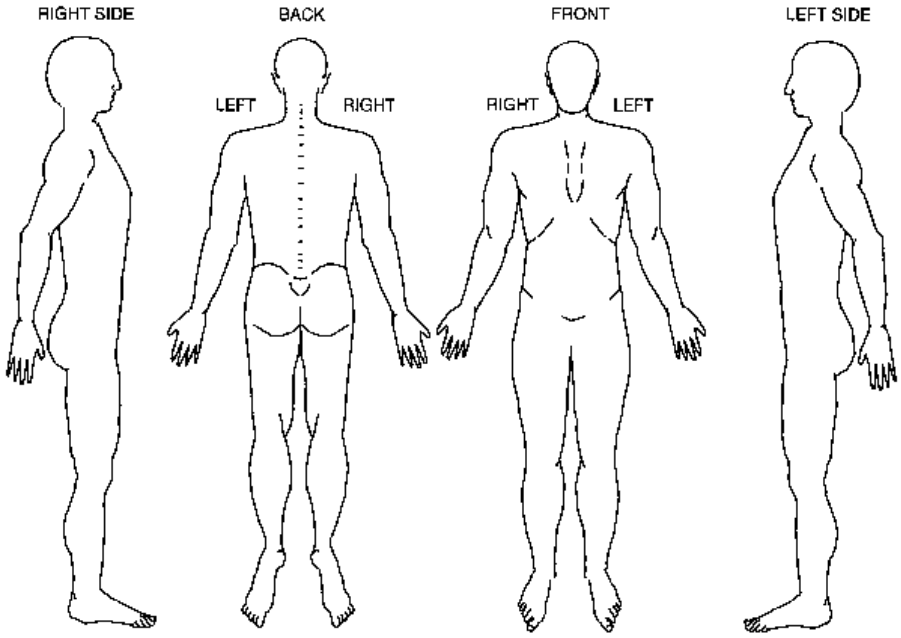
CENTRAL STATES
PAIN CLINIC℠
INNOVATIVE PERSONAL CARE

Date: _____

Name: _____ DOB: _____

Primary Care Provider: _____ Pharmacy:_____

On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts <u>the worst.</u>
PAIN XXXX NUMBNESS/TINGLING 0000 SPASM/CRAMP VVVV



Allergies:

Anticoagulants:

Any changes in LOCATION of pain since last visit?

Circle the THREE words that the best describe the pain:
Aching Boring or drilling Burning Colicky Cramping Crushing Dull Gnawing Heaviness Nagging Penetrating Pins and needles Pressure Raw Sharp Shock-like Shooting Sore Stabbing Stinging Throbbing Tightness

REVIEW OF SYSTEMS: (CIRCLE all that apply)
Constitutional Symptoms: chills, fever
Cardiovascular: chest pain, palpitations
Respiratory: shortness of breath or difficulty breathing
Gastrointestinal: constipation, nausea
Neurological: change in alertness, difficulty with balance, headache, loss of bladder control, loss of bowel control, numbness, tingling or "pins and needles" sensation, weakness
Psychiatric: anxiety, feeling sad more than usual (depressed), suicidal thoughts
Hematologic/Lymphatic: excessive bleeding after injury or minor surgery.
Other problems:

Circle the number below to indicate your **average pain intensity** over the past week: **(P)**

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Most

Circle the number below to indicate your **pain intensity right now**:

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Most

How much relief have **pain medication(s)** provided? (if applicable)
Circle the percentage below that most shows how much **relief** you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
None										Complete relief

Circle the number below that describes how, during the past week, pain has interfered with your **general activity. (G)**

0	1	2	3	4	5	6	7	8	9	10
None		Mild		Moderate			Severe			Completely

Circle the number below that describes how, during the past week, pain has interfered with your **enjoyment of life. (E)**

0	1	2	3	4	5	6	7	8	9	10
None		Mild		Moderate			Severe			Completely

How much relief has **procedure** provided? (if applicable)
Circle the percentage below that most shows how much **relief** you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
None										Complete relief

Other:

Any side effects of prescribed medication(s) since last visit? (if applicable)

Any changes in medications since last visit?

Any diagnostic tests since last visit?

Any changes in your health since your last visit?

Do you need any other medications refilled?

Over the **past two weeks**, how often have you been bothered by any of the following problems?

	Not at all			Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3