Pain Management Scan

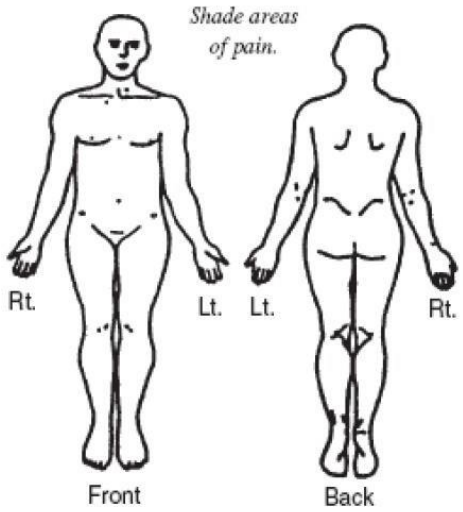
UnityPoint Health
St. Luke's Hospital

Pain Management Services Pain Assessment

1. Where is your worst pain located? _____
2. Does it spread, and if so, where? _____

_____

SHADE AREAS OF PAIN



3. **When** did your pain begin? _____
4. When did it get worse? _____
5. Is your pain related to an injury or accident?

_____

6. Is your pain continuous, or does it come and go?_____
7. Describe in your own words what your pain feels like:

_____

8. Rate your pain today:_____(0-10)
9. Indicate the **range** of your pain:
   0 1 2 3 4 5 6 7 8 9 10
   No pain Worst Pain Imaginable
10. Best position for comfort:
    (circle) lying standing sitting
11. Most painful position:
    (circle) lying standing sitting
12. What makes your pain better? _____

_____

13. What makes your pain worse? _____

_____

14. Current pain medications: _____

_____

15. What **treatment(s)/surgeries** have you received for this pain in the past? _____

_____

16. Previous x-ray scans, related to present pain:
    MRI/CT/XRAY: _____
    Where: _____
17. Does your pain effect your: (if yes, how?)
    - Sleep: No / Yes, _____
    - Appetite: No / Yes, _____
    - Physical Activity: No / Yes, _____
    - Social Activity: No / Yes, _____
18. Working: (circle) NO YES
    - Occupation: _____
    - Restrictions: _____
    - Have you missed work: _____
    - Last day worked: _____
    - Is this a Workmen's Compensation claim?
      NO YES
    - If yes, who is your case manager? _____
    - Case Manager's phone number: _____
19. Following your last visit to the Pain Clinic:
    - Was there an improvement in your pain?

      _____
    - Indicate best pain score or percent improvement

      _____
    - If so, how long did the improvement last?

      _____
    - Has your activity level changed?

      _____
    - Has your pain changed since your last visit?

      _____
20. Have you had a **new** MRI/CT/XRAY since your last visit? _____
21. **New** tests since last seen? _____

_____

22. List any changes in medications or medical history since **last** visit: _____

_____

23. As a result of your previous treatment, has there been improvement in your quality of life?

_____

24. If applicable, have you been able to return to work?

_____

PATIENT LABEL

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25. Change in control of bowel or bladder? _____
_____
26. Unexplained weight loss or gain? _____
_____
27. Do you have any bleeding problems? _____
_____
28. Do you have any of the following: (circle)
Fever Productive Cough Sore Throat
Sinus Infection Burning with Urination
29. Are you on an antibiotic? _____

30. Do you take a blood thinner or aspirin? (circle) NO YES
- List blood thinner: NAME LAST TAKEN
1. _____
2. _____

31. Is there a chance you are pregnant? (circle) NO YES
32. Use of tobacco products:
(circle) NO YES,_____packs/day
33. Use alcohol: (circle) NO YES,_____drinks/day
34. Have you had a drug/alcohol problem? _____
35. Use illegal drugs: (circle) NO YES, _____

Fill this section out if ** first visit for current issue

Medical History

Do you have or are you currently being treated for:
(Circle No or Yes: Check if applicable)

			New	History Of
Anemia	No	Yes	___	____
Arthritis	No	Yes	___	____
Asthma	No	Yes	___	____
Back Problems	No	Yes	___	____
Blood Disorder	No	Yes	___	____
Bruising	No	Yes	___	____
Cancer	No	Yes	___	____
Cataracts	No	Yes	___	____
Circulation Problems	No	Yes	___	____
Diabetes	No	Yes	___	____
Glaucoma	No	Yes	___	____
Headaches	No	Yes	___	____
Heart Disease	No	Yes	___	____
Heart Failure	No	Yes	___	____
High Blood Pressure	No	Yes	___	____
HIV	No	Yes	___	____
Kidney Disease	No	Yes	___	____
Lung Disease	No	Yes	___	____
Osteoporosis	No	Yes	___	____
Seizures	No	Yes	___	____
Stroke	No	Yes	___	____
Stomach Ulcers	No	Yes	___	____
TB	No	Yes	___	____
Thyroid Disorder	No	Yes	___	____
Spine Disease	No	Yes	___	____

Family History:

Spine Disease	No	Yes	Who: _____
Drug/Alcohol Abuse	No	Yes	Who: _____

Surgical History: _____
_____
_____

See Medication List

Review of Systems

Presently experiencing any of the following symptoms?
(Circle No or Yes)

Constitutional Symptom:			**Ear/Nose/ Throat/Mouth:**		
Fever	No	Yes	Ear Pain	No	Yes
Chills	No	Yes	Decreased Hearing	No	Yes
Headaches	No	Yes			
Other: _____			Other: _____		
Eyes:			**Cardiovascular:**		
Blurred Vision	No	Yes	Chest Pain	No	Yes
Double Vision	No	Yes	Fluid Retention	No	Yes
Other: _____			Other: _____		
Pulmonary:			**Gastrointestinal:**		
Wheezing	No	Yes	Abdominal Pain	No	Yes
Frequent Cough	No	Yes	Nausea/Vomiting	No	Yes
Shortness of Breath	No	Yes	Indigestion/ Heartburn	No	Yes
Other: _____			Other: _____		
Neurological:			**Musculoskeletal:**		
Weakness	No	Yes	Joint Pain	No	Yes
Dizziness	No	Yes	Swelling	No	Yes
Numbness/ Tingling	No	Yes	Neck Pain	No	Yes
			Joint Stiffness	No	Yes
Other: _____			Other: _____		
Psychological:			**Hematological:**		
Severe Depression	No	Yes	Swollen Glands	No	Yes
Suicidal Thoughts	No	Yes	Bruising	No	Yes
Confusion	No	Yes	Unusual Bleeding	No	Yes
Sleep Disturbance	No	Yes	Rectal Bleeding	No	Yes
			Frequent Infection	No	Yes
Other: _____			Other: _____		
Genitourinary:					
Painful Urination	No	Yes			
Blood in Urine	No	Yes			
Other: _____					

Patient Signature: _____

PATIENT LABEL