Pain Management Scan

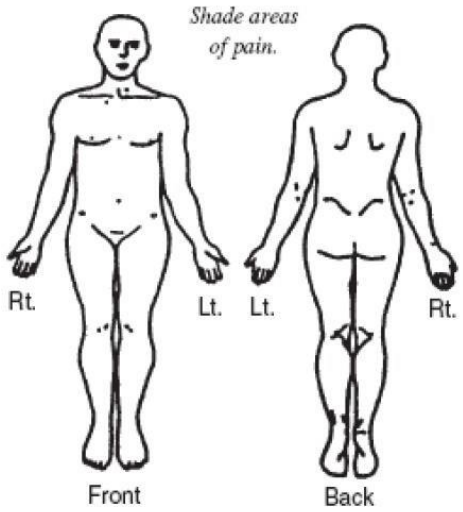
UnityPoint Health
St. Luke's Hospital

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: Pain Level

   0 1 2 3 4 5 6 7 8 9 10

   No pain Worst Pain Imaginable
10. Best position for comfort:

    ☐ lying ☐ standing ☐ sitting
11. Most painful position:

    ☐ 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: Yes, or No _____
    - Appetite: Yes, or No _____
    - Physical Activity: Yes, or No , _____
    - Social Activity: Yes, or No , _____
18. Working: Yes, or No
    - Occupation: _____
    - Restrictions: _____
    - Have you missed work: _____
    - Last day worked: _____
    - Is this a Workmen's Compensation claim? Yes, or No
    - 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?

_____

_____
PATIENTNAME:

_____
DOB:

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: (click)
☐ *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? (click) ☐NO ☐YES
- List blood thinner: NAME LAST TAKEN
1. _____
2. _____

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

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

Do you have or are you currently being treated for:
(Click 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?
(Click No or Yes)

Constitutional Symptom:
Fever ☐No ☐Yes
Chills ☐No ☐Yes
Headaches ☐No ☐Yes
Other: _____

Eyes:
Blurred Vision ☐No ☐Yes
Double Vision ☐No ☐Yes
Other: _____

Pulmonary:
Wheezing ☐No ☐Yes
Frequent Cough ☐No ☐Yes
Shortness of Breath ☐No ☐Yes
Other: _____

Neurological:
Weakness ☐No ☐Yes
Dizziness ☐No ☐Yes
Numbness/ Tingling ☐No ☐Yes
Other: _____

Psychological:
Severe Depression ☐No ☐Yes
Suicidal Thoughts ☐No ☐Yes
Confusion ☐No ☐Yes
Sleep Disturbance ☐No ☐Yes
Other: _____

Genitourinary:
Painful Urination ☐No ☐Yes
Blood in Urine ☐No ☐Yes
Other: _____

Ear/Nose/ Throat/Mouth:
Ear Pain ☐No ☐Yes
Decreased Hearing ☐No ☐Yes
Other: _____

Cardiovascular:
Chest Pain ☐No ☐Yes
Fluid Retention ☐No ☐Yes
Other: _____

Gastrointestinal:
Abdominal Pain ☐No ☐Yes
Nausea/Vomiting ☐No ☐Yes
Indigestion/ Heartburn ☐No ☐Yes
Other: _____

Musculoskeletal:
Joint Pain ☐No ☐Yes
Swelling ☐No ☐Yes
Neck Pain ☐No ☐Yes
Joint Stiffness No Yes
Other: _____

Hematological:
Swollen Glands ☐No ☐Yes
Bruising ☐No ☐Yes
Unusual Bleeding ☐No ☐Yes
Rectal Bleeding ☐No ☐Yes
Frequent Infection ☐No ☐Yes
Other: _____

Patient Signature: _____

_____
PATIENTNAME:

_____
DOB:

PAIN ASSESSMENT