COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

P.O. Box 501724, San Diego, CA 92150
Phone 858.453.7700 Fax 858.798.1225

INITIAL EVALUATION

1. Referring Physician: _____
2. Patient ID #_____
3. Your appointment is with:
   □ Dr. Chisholm □ Dr. Chong □ Dr. Wagner □ Dr. Sigmon

PATIENT INFORMATION

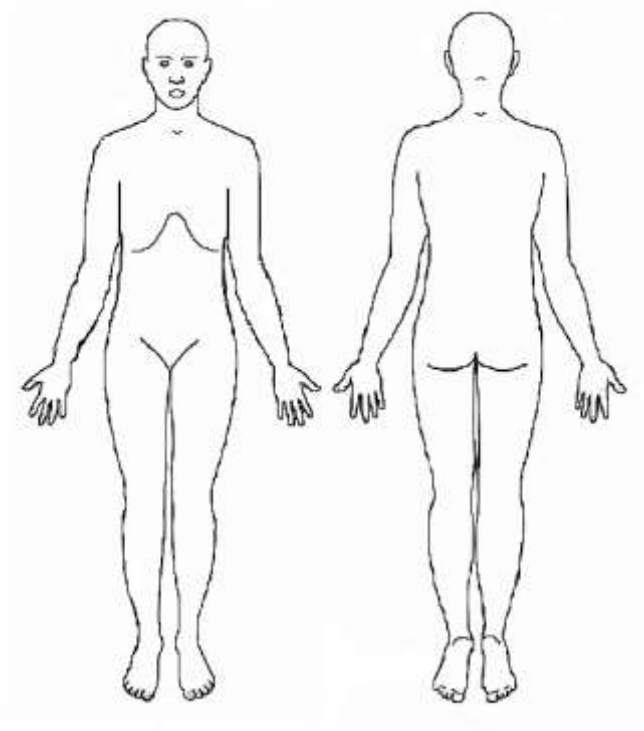
4. _____ _____ _____
   Last Name First M.I.
5. Sex: □Male □Female
6. Appointment Date_____
7. Date of Birth (mm/dd/yyyy): _____
8. Age _____
9. Primary Care Physician (if not the same): _____

ABOUT YOUR PAIN

10. What is the main problem for which you are seeking treatment with Comprehensive Pain Management Specialists?

_____
_____
_____

Please mark the area(s) in which your pain is located:



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For office use only: C: C/PT: _____ C/TDD: _____

ONSET OF PAIN AND DURATION

11. Briefly describe when and how your current pain started?

_____
_____
_____
_____

TIMING OF PAIN

12. How often do you have your pain (please check one)?

- □ Constantly (100% of the time)
- □ Frequently (75% of the time)
- □ Intermittently (50% of the time)
- □ Occasionally (25% of the time)

PAIN QUALITY

13. How would you describe the pain (choose as many adjectives as are applicable)?

□ Burning	□ Sharp	□ Cutting
□ Throbbing	□ Cramping	□ Numbness
□ Dull, aching	□ Pressure	□ Pins and needles
□ Shooting	□ Electric-like	□ Other _____

PAIN INTENSITY

14. Circle your current pain intensity with “0” representing no pain and “10” representing the most severe pain imaginable:

0 1 2 3 4 5 6 7 8 9 10

15. Circle your average pain the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

16. Circle your best pain score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

17. Circle your worst pain score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

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RELIEVING AND AGGRAVATING FACTORS

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

	18 Decrease	19 Increase	20 No Change
Lying down			
Standing			
Sitting			
Walking			
Exercise (if applicable)			
Medications			
Relaxation			
Thinking about something else			
Coughing/Sneezing			
Urination			
Bowel movements			

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

Treatment	**Date (approx.)**	21 **Excellent Relief**	22 **Moderate Relief**	23 **No Relief**
Hospital bed rest				
Traction				
Surgery				
Hypnosis				
Acupuncture				
Nerve block/injections				
TENS				
Physical therapy				
Exercise				
Heat treatment				
Biofeedback				
Psychotherapy				
Chiropractic				
Other				

FUNCTIONAL LIMITATIONS

24. During the past month, place a check mark next to the activities that you avoided because of pain:

- ☐ Going to work
- ☐ Doing yard work or shopping
- ☐ Participating in recreation
- ☐ Performing household chores
- ☐ Socializing with friends
- ☐ Having sexual relations

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□ Physically exercising □ Driving □ Caring for self

25. How many blocks can you walk before having to stop due to pain? _____
26. How many minutes or hours can you sit before having to get up and move about?
_____ minutes _____ hours
27. How many minutes or hours can you stand before you have to sit down?
_____ minutes _____ hours
28. How often during the day do you lie down because of pain?
□ Never □ Seldom □ Sometimes □ Often □ Constantly

Allergies

29. Do you have symptoms like red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following?

□ Dye
□ Iodine
□ Medications: _____
Describe: _____
□ Shellfish
□ Foods:
□ **Latex**
□ **Rubber (Band-aids, tape, spandex, balloons) ***
□ **Kiwis, chestnuts, bananas, avocado ***
□ **No Known Allergy**
□ **After doctor/dental visits ***

MEDICATIONS

30. Please list your current medications with dosages:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

31. Please list any previously taken pain medications that you stopped taking and the reason for stopping:

_____
_____
_____
_____
_____
_____

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PAST MEDICAL HISTORY

32. Have you had any of the following health problems (please check all that apply)?

□ High blood pressure	□ Diabetes	□ Kidney disease
□ Angina	□ Stroke	□ Liver disease
□ Heart attack	□ Cancer	□ Arthritis
□ Chronic cough	□ Psychological or psychiatric problems	
□ HIV	□ Hepatitis	

Please explain any medical conditions checked above:

_____
_____
_____

□ Other (please specify): _____

ALL PAST SURGERIES

33. Please list, with approximate date and type of operation:

_____
_____
_____

Have you had any previous back surgeries (please specify)?

_____
_____

PSYCHOSOCIAL HISTORY

34. Your highest educational level achieved:
    - □ Graduate or professional training (obtained degree)
    - □ College graduate (obtained degree)
    - □ Partial college training
    - □ High school graduate
    - □ GED or trade-technical school graduate
    - □ Partial high school (10th grade through partial 12th)

LEGAL ISSUES

35. Have you filed any legal claims related to your pain problem?
    □ No □ Yes (please explain): _____

PSYCHOLOGICAL TREATMENT

36. Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? □ Yes □ No
    If yes, when? _____
37. Have you ever considered suicide? □ Yes □ No

SUBSTANCE USE

38. Y 39. N

Are you suffering from or do you have a history or alcoholism?	□ Yes □ No
Any illicit drug use?	□ Yes □ No
Have you ever been in a detoxification program for drug abuse?	□ Yes □ No
Alcoholics Anonymous?	□ Yes □ No

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Narcotics Anonymous? □ Yes □ No

40. Do you or did you ever smoke cigarettes or use tobacco? □ Yes □ No

How many years have you smoked/did you smoke? _____

How many packs per day do you/did you smoke? _____

Have you quit using tobacco, and if so how long ago? _____

41. How many drinks of each of the following do you consume in one week?

Beer _____

Wine _____

Liquor _____

FAMILY LIFE

42. "I currently am":

□ Living alone
□ Living with friends
□ Living with children
□ Living with spouse/partner
□ Living with spouse/partner and children

43. N 44. Y

Do you have members of your family who have committed suicide?

□ Yes □ No

Do you have members of your family who have had psychiatric illnesses?

□ Yes □ No

Have any of your blood relatives had substance abuse problems, including alcohol?

□ Yes □ No

PREVIOUS DIAGNOSTIC STUDIES

45. Please indicate approximate date and results, if known:

MRI _____

CT _____

X-rays _____

EMG _____

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REVIEW OF SYSTEMS

Fill out and/or check all that apply to your health:

Respiratory	Heart	Elimination	
❑ Shortness of Breath ❑ at rest ❑ with activity ❑ Home oxygen (Supplier:_____) ❑ Breathing medications ❑ BIPAP/CPAP ❑ Sleep Apnea/Disorder ❑ TB ❑ Lung Problem:_____ ❑ No Problem	❑ Bruising/Bleeding ❑ Heart Attack ❑ Palpitations ❑ Heart Problem: _____ ❑ Other: _____ ❑ No Problem	Urinary ❑ Catheter ❑ Burning ❑ Bleeding ❑ Ostomy ❑ Unusual Frequency ❑ Discomfort ❑ Up at night to urinate? # Times: _____ ❑ Loss of control ❑ No Problem	Bowel Last BM_____ Freq of BM_____ ❑ Ostomy ❑ Loss of control ❑ Diarrhea/Colitis ❑ Constipation ❑ Use laxatives ❑ Ulcers/Hiatal Hernia ❑ No Problem

Neurological	Skeletal/Muscle	Nutrition
❑ Memory loss/ Forgetfulness ❑ Stroke ❑ Fainting spells/ Dizziness ❑ Epilepsy, seizures, convulsions ❑ Mental illness ❑ Headaches ❑ No problem	❑ Arthritis ❑ Numbness/Tingling ❑ Back pain ❑ Muscle weakness ❑ Blood clots in legs ❑ Pain in legs with activity ❑ Skin disorder ❑ Neck pain ❑ No problem	❑ Weight Loss > 10 lbs/last 6 months _____ ❑ Nausea Appetite ❑ good ❑ fair ❑ poor ❑ Vomiting ❑ Dentures Fit properly? ❑ yes ❑ no ❑ Heartburn/ Reflux ❑ Chewing problems ❑ Swallowing problems ❑ Indigestion ❑ No problems ❑ Sores in mouth ❑ Foods you CANNOT eat. Explain: _____ _____

Endocrine	
❑ Thyroid problems ❑ Other: _____ _____ ❑ No problem	Do you have any implanted devices? ❑ Screws, pins, plates ❑ AICD ❑ Aneurysm Clip ❑ Venous Access Device ❑ None Where?_____ ❑ IUD ❑ Pacemaker ❑ Type _____

Do you have a history of “passing out” with needles, medical procedures etc.? If yes, please explain.

_____
_____
_____

Positives 46. Negatives 47.

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