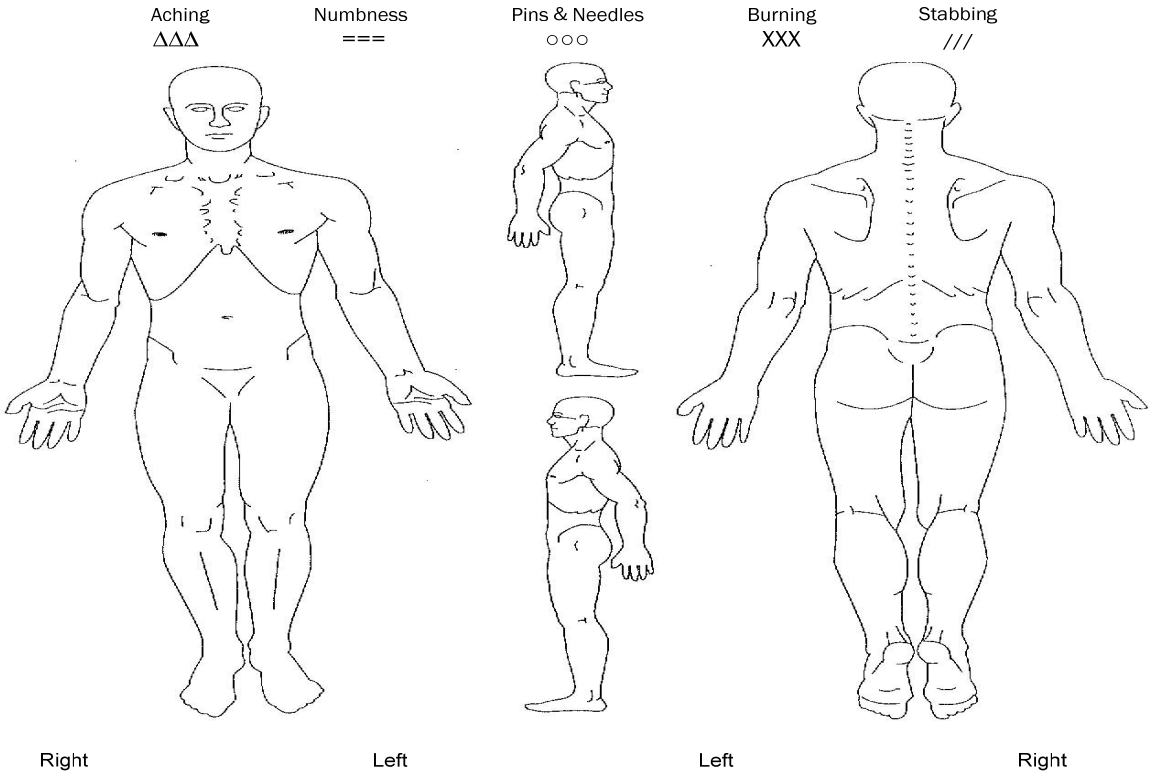
Initial Pain Assessment
Patient Completion

Name: **Date:**_____

What is the problem you would like me to help you with?

_____

Please use the following diagram to show us where you are experiencing pain and numbness:



Circle all of the following words that describe your pain:

Dull	**Shooting**	**Throbbing**	**Tingling**
Aching	**Electric**	**Sharp**	**Other:**
Burning	**Cold**	**Tight**	_____

CDCR Number, (Last, First, MI) & Date of Birth

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ATTACHMENT E (PAGE 1)

HISTORY OF PRESENT ILLNESS:

1. How long have you had this pain?

2. Please mark the event or events that led to your present pain:

_____ Accident _____ Approximate Date

_____ Cancer _____ Following an Operation

_____ Other Disease _____ No Obvious Cause

_____ Other Injury

3. How often does the pain occur?

_____ Continuously (Non-Stop)

_____ Several Times a Day

_____ Once or Twice a Day

_____ Several Times a week

_____ Less Than 3 or 4 Times per Month

4. How has the intensity of the pain changed during the time you have had it?

_____ Increased _____Decreased Stayed The Same

5. Which of the following affect your pain? Indicate better (+), worse (-) or no affect (0).

_____ Heat _____ Cold Noise

_____ Standing _____ Lying Down Walking

_____ Cough _____ Anxiety/Emotions Sitting

_____ Climate _____Massage/Emotions Fatigue

_____ Alcoholic Beverage _____Caffeinated Drinks Vibration

_____ Particular Position or Movement

Explain _____

6. Please mark on the line below where you would rate your pain on average

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Worst Possible Pain

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ATTACHMENT E (PAGE 2)

7. Currently what effect does your pain have on the following life circumstances?

a. Sleep

0 1 2 3 4 5 6 7 8 9 10

No Change Moderate Effect Major Decline

b. Walking Ability

0 1 2 3 4 5 6 7 8 9 10

No Change Moderate Effect Major Decline

c. Activities (prison job or education)

0 1 2 3 4 5 6 7 8 9 10

No Change Moderate Effect Major Decline

8. What is your current job/program assignment?

9. Do you have pending a settlement about disability, workers' compensation or a legal matter?

_____ Yes _____ No If yes, briefly explain

10. What treatments have you tried for your pain?

_____ Surgery

_____ Exercise Program

_____ Physical Therapy

_____ Relaxation Training

_____ Psychotherapy/Counseling

_____ Nerve Block

_____ TENS Unit

_____ Trigger Point Injection

_____ Acupuncture

_____ Biofeedback

_____ Chiropractic

_____ Massage

Other:

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ATTACHMENT E (PAGE 3)

10. What specialists have you seen for your pain? (Orthopedic surgeon, neurologist, etc.)

_____

_____

_____

_____

11. Previous studies done (date, area of body)

_____	MRI	_____
_____	CT	_____
_____	X-Ray	_____
_____	Sleep Study	_____
_____	EMG	_____

12. In the past what medications have you taken?

Drug:	Dose:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

13. What medications are you currently taking?

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Do you have allergies?

_____Yes No

List all of your allergies: _____

Do you have any of the following: (circle all that apply)

Headaches	Stomach Pain	Chest Pain	Fevers
Vision Problems	Nausea	Shortness of Breath	Chills
Hearing Problems	Vomiting	Urinary Problems	Night Sweats
Dizziness	Diarrhea	Rashes	Appetite Changes
Difficulty Swallowing	Constipation	Swollen Joints	Weight Loss
Color Changes in the Feet or Hands		Chronic Fatigue	

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ATTACHMENT E (PAGE 4)

PAST SURGICAL HISTORY

Please list all surgeries, surgeons and the dates of the surgeries:

Operation	Surgeon	Date

SOCIAL HISTORY:

What is your education level?

What type of work did you perform?

HABITS:

Do you smoke cigarettes? □ Yes □ No

When did you quit?

Do you use alcohol? □ Yes □ No

How frequently?

Do you use any "street drugs"? □ Yes □ No

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