Ford Center for Pain Management

PATIENT NAME_____ **DATE**_____

Home phone_____ **Cell phone**_____

What is your chief complaint today?

_____

_____

List any allergies you may have:

_____

_____

List any blood thinners that you have taken in the last seven days:

_____

_____

Activities of Daily Living

Please indicate whether your functioning with the current pain therapy and medications is Better, the Same, or Worse since your last assessment.

	Better	Same	Worse
1. Physical functioning	☐	☐	☐
2. Family relationships	☐	☐	☐
3. Social relationships	☐	☐	☐
4. Mood	☐	☐	☐
5. Sleep patterns	☐	☐	☐
6. Overall functioning	☐	☐	☐

Is the amount of pain relief you are now receiving from your current pain therapy and medications enough to make a real difference in your life?

☐ Yes ☐ No

Pain Level

If zero indicates "no pain" and ten indicates, "Pain as bad as it can be," on a scale of 0 to 10, answer the following questions:

1. What is your pain level today?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain**

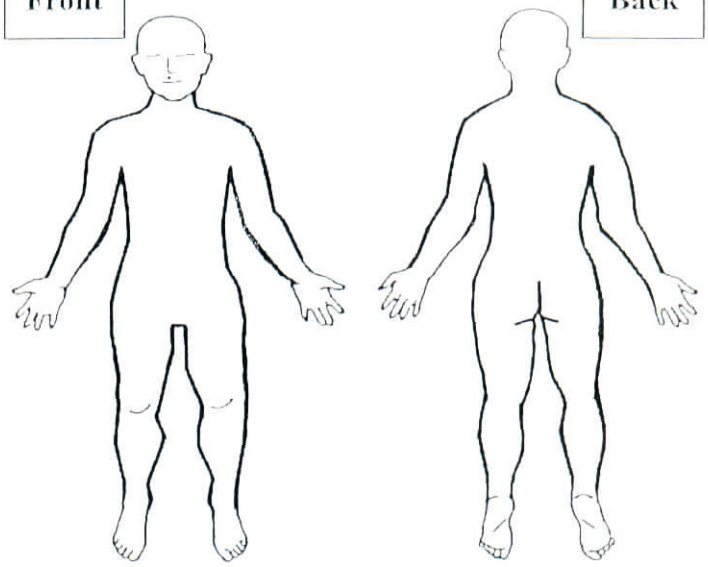
2. What was your lowest pain level during the past month?(Please circle one.)

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain**

3. What was your pain level at its worst during the past month?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain**

Please mark the location of your Pain



OVER PLEASE ...

PATIENT NAME_____ DATE_____

Please circle any of the following that you experience:

Itching, chills, fever, mental cloudiness, fatigue, drowsiness, glasses, contacts, blurred vision, eye drainage, eye pain, hearing difficulties, ringing in ears, sinus congestion, frequent nosebleeds chest pain, swelling in ankles or feet, irregular heart rate, shortness of breath difficulty breathing, cough (chronic), exposure to TB, wheezing diarrhea, nausea, vomiting, constipation, abdominal pain, heartburn, bloating, loss of appetite, acid reflux, difficulty swallowing, hemorrhoids urinary incontinence, blood in urine, frequent UTIs, history of abuse back pain, joint stiffness, joint pain, muscle pain, leg pain, arm pain, neck pain dizziness, fainting, headaches, numbness, weakness, tingling, seizures memory loss, easy bruising, excessive bleeding, heat intolerance, hair loss cold intolerance, excessive sweating, hot flashes, depression, anxiety

Please list all medications that you currently take: