LAKESHORE ANESTHESIA LTD.
PH: 312.809.6500

Name : _____

Age : ___ Sex: ☐ M ☐ F Height:_____ Weight:____

Address : _____

_____

Phone : (____) _____

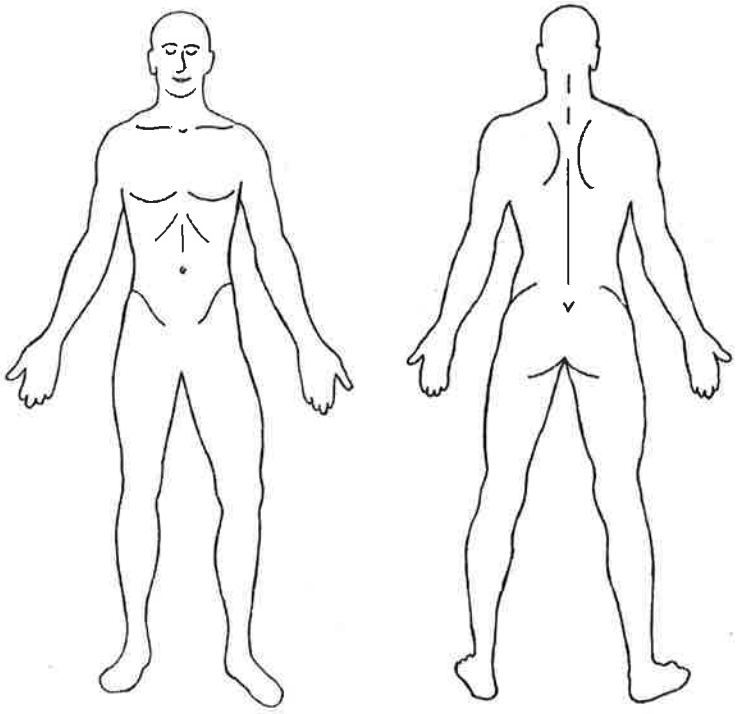
Initial Pain History And Evaluation Form

The purpose of this form is to facilitate your initial visit to the Pain Center by giving us as much information about you and your condition as possible. Many of the questions will not make any sense bacause they may not apply to your condition. Answer those that do to the best of your ability - you will not be graded for accuracy or completeness. **Please bring this form (completed) to your first visit**.

1. Presenting Painful Condition:

a. Location.

Please shade areas of your body that have pain in **RED** and numbness in **BLUE**.
Please label the most painful area **1**, the next most painful **2**, and so on.



b. Intensity of Pain.

Please rate the intensity of your pain on a scale from 1 to 10, both at rest and when you move.

☺ 1 2 3 4 5 6 7 8 9 10 ☹
No Pain Severe Pain

Pain #1: At Rest: ___/10 Moving: ___/10
Pain #2: At Rest: ___/10 Moving: ___/10
Pain #3: At Rest: ___/10 Moving: ___/10
Pain #4: At Rest: ___/10 Moving: ___/10
Pain #5: At Rest: ___/10 Moving: ___/10
Pain #6: At Rest: ___/10 Moving: ___/10

c. Quality, Duration & Variations.

1. How often does the pain occur? ☐ Constant. ☐ Frequent. ☐ Occasional. ☐ Rare.
2. Duration of episodes of pain. ☐ Minutes. ☐ Hours. ☐ Days. ☐ Longer.
3. Qualities of the pain. (Check all that apply)
   ☐ Burning ☐ Stabbing ☐ Sharp ☐ Dull / Diffuse
   ☐ Throbbing ☐ Cramping ☐ Tingling ☐ Numbness
   ☐ Shooting ☐ Heaviness ☐ Aching
4. What part of the day is worst? _____
   _____
5. What part of the day is best? _____
   _____

2/...

d. History Of The Pain.

1. How long have you had the present pain? ☐ Days ☐ Weeks ☐ Months ☐ Years
2. How did the pain begin? ☐ Spontaneous ☐ Accident ☐ Lifting object ☐ After surgery
3. How has the pain been treated? ☐ Medicines ☐ Physical therapy ☐ Surgery ☐ Chiropractor
4. Aggravating factors. ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down ☐ Twisting

   Other factors that aggravate the pain: _____
5. Who referred you to our pain clinic? _____
6. Have you been treated in a pain clinic before? ☐ No ☐ Yes: Where? _____

   When? _____ What treatment did you receive? _____
7. What therapy has helped the pain so far? _____

   _____
8. What therapy has not helped the pain? _____

   _____

e. Medical History.

(Your existing medical problems affect decisions about pain management)

1. Cardiac Disease: ☐ Hypertension ☐ Coronary disease ☐ Heart Failure ☐ Poor Circulation
2. Pulmonary Disease: ☐ Asthma ☐ Emphysema ☐ Bronchitis ☐ Lung Cancer
3. Other Major Diseases: ☐ Diabetes ☐ Arthritis ☐ Kidney Disease ☐ Ulcers / Reflux

   ☐ Thyroid disease ☐ Siezures ☐ Liver Disease ☐ Depression ☐ Anxiety

   ☐ Substance Abuse ☐ Cancer ☐ Shingles ☐ Other: _____
4. Do you: Smoke ☐ No ☐ Yes ___pk/day Drink ☐ No ☐ Yes _____drinks/day
5. Have you had any recent infections? ☐ No ☐ Yes Please elaborate: _____

   _____
6. Please list any previous operations:

	Year		Year

f. Medications.

Please list all medications that you are currently taking (including herbal medicines).

Medication	Dose	Times Per Day	Medication	Dose	Times Per Day

Are you on a blood thinner? (Coumadin, Plavix, Lovenox, Pletal, Aggrenox) ☐ **Yes** ☐ **No**

Do you have any drug allergies? ☐ No ☐ Yes: _____

g. Diagnostic Studies.

Have you had any of the following studies, and if so, then where were they performed?

Test	Yes	No	Date	Institution	Test	Yes	No	Date	Institution
X-Rays					EMG				
CAT Scan					Myelogram				
MRI Scan					Discogram				

h. Social History.

Please describe your "home situation".

1. Living arrangements: ☐ Live alone ☐ Live with others / family ☐ Stairs or steps.
2. Are you able to take care of yourself at home? ☐ Yes ☐ No
3. Occupation: _____ Currenly working? ☐ Yes ☐ No
4. Not Working: ☐ N/A ☐ On Worker's Comp. ☐ Disabled ☐ Legal Proceeding Pending
5. How active are you? ☐ Swim ☐ Walk ☐ Stretch Exercise ☐ Run
5. Do you have any additional information that might help us to understand your problem?

_____

_____

_____Signed:_____ Date:____/____/200__

Thank you very much