Pain Consultation Form

Please answer the following questions to the best of your ability. Your Pain Consultant and the nursing staff will review these questions and answers. Use the lines provided and back of sheet if necessary to answer your questions.

1. Who is your doctor that referred you to this pain clinic? _____
2. Who is your family doctor if they are not the referring doctor? _____
3. Is the reason for your visit because of a work related injury? □ Yes □ No □ Don't Know
4. What kind of pain are you currently experiencing? _____
   _____ How Long? _____
5. How bad is your pain currently on this scale: 0 1 2 3 4 5 6 7 8 9 10
6. What makes your pain worse? _____
7. What makes your pain better? _____
8. Do you have any problems with your sleep, appetite, bowel or bladder control, or any night sweats? □ Yes □ No
   Please explain: _____
9. Do you use any assistive devices? Cane Walker Crutches Limbs Other: _____
10. What other pain treatments have you had in the past? _____
    _____
11. When was your last pain treatment? _____
12. How many times in the past year have you visited the Emergency Room? _____
13. Medication Allergies? □ Yes □ No If yes, please explain: _____
14. Are you currently taking any blood thinners? Please list: _____
15. Are you taking any pain related medications? Please list: _____
16. Are you taking any medications regularly? Please list: _____
17. Are you: Married Single Divorced Widowed
18. What is your highest level of education? 8 9 10 11 12 13 14 15 16 Master's Ph.D.
19. How many children do you have? _____ Are they available to assist you? Yes No
20. If you work, what is your job title or description? _____
21. Do you Smoke Drink Alcohol Other Drugs How much? _____
22. Have you or anyone in your family had VRE or MRSA? □ Yes □ No
23. What medical conditions or disease do you have? Please list: _____
    _____
24. What surgeries have you had? Please list: _____
    _____
25. Did you bring any x-ray or lab reports with you? □ Yes □ No □ Don't Know
26. Do you have any financial concerns related to your treatment today? _____
27. Are there any religious, psychological, emotional or physical reasons that may interfere with your pain management treatment today?
28. How tall are you? _____ What do you weigh? _____

Patient Signature: _____ Date: _____ Reviewed by: _____