Pain Level ______________

BP________Pulse________

Resp.______Temp._______

Hgt.________Wt.________

Blood Thinner___________

Allergies

WALLACE THOMSON HOSPITAL
ADVANCED PAIN TREATMENT CENTER
Data Collection

Name: ________________________________

Date:_________________________________

Referring MD:________________

GOALS/EXPECTATIONS FOR TREATMENT:

☐**Meds only (including narcotics)** ☐**Meds and injections** ☐**Injections only** ☐**I just want relief.**

1. Sex: ☐Male ☐Female Age:_____________
2. **Chief complaint**: ____

3a. When did you first notice the pain for which you are now being treated?

Month____________Year_____________

3b. Have you had this same type of pain before?

☐Yes ☐No

3c. What were you doing when the pain began? ____

3d. Since the onset of pain, has pain: ☐decreased ☐increased ☐stayed the same?

4. How frequent is your pain?

☐Always ☐Often ☐Frequent ☐Rare

5. What time of day is your pain the worst? ☐Morning ☐Noon ☐Evening ☐Night
6. Which side is your pain mostly on?

☐Left side ☐Right Side ☐Middle ☐Both Sides.

7. Does your pain travel anywhere?

☐Yes ☐No Where? __________________________

8. How would you describe your pain?

☐Burning ☐Sharp ☐Aching

☐Throbbing ☐Shooting ☐Other (describe)__________

9. Have you had other painful conditions in the past?

☐Yes ☐No

10. Where is your pain located? Check all areas where you have pain:

☐Head ☐Neck ☐Elbow ☐Groin ☐Upper back ☐Foot/Ankle

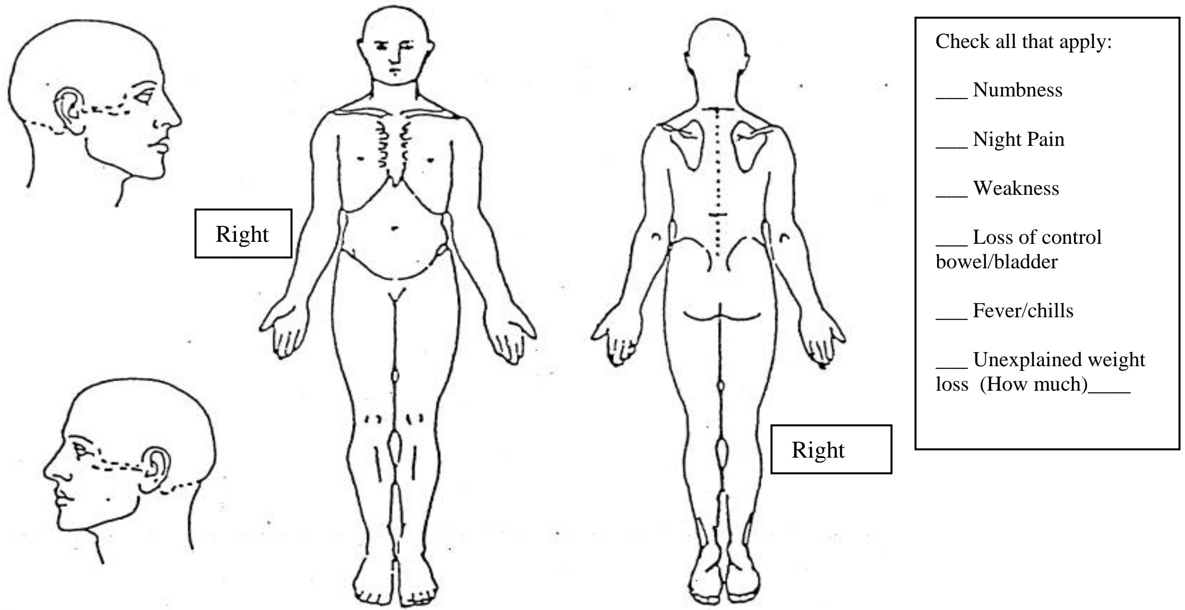
☐Face ☐Shoulder ☐Hand or Wrist ☐Knee ☐Lower back

☐Mouth/throat ☐Arm ☐Chest ☐Buttock ☐Mid Back

☐Abdomen ☐Multiple joints ☐Genitourinary ☐Calf ☐Thigh

11.Pain Location:

On the picture color in all areas of pain:



On a scale of 1-10: Your pain at its worse_____Pain at its best______ Pain right now______

12a. Maneuvers that make your pain worse:

☐ sitting ☐bending ☐lifting ☐twisting ☐driving

☐coughing ☐sneezing ☐standing ☐walking ☐lying down

☐other, explain____

12b. Things that make your pain better:

☐rest ☐bending ☐medication ☐ice or heat☐lying down☐sitting

☐other, specify:____

13. Does this pain delay your getting to sleep? ☐Every night ☐Almost every night
☐Some nights ☐Not at all

14. Does this pain awaken you from sleep?
☐Every night ☐Almost every night ☐Some nights ☐Not at all

15. Do you usually feel rested after a night's sleep?
☐Yes ☐No

16. **CURRENT PAIN MEDICATIONS:**
Please complete the Universal Medication form.

17. PAST PAIN MEDICATIONS:
Have you taken any medications in the past for your current pain problem, even if they didn't work? ☐Yes
☐No If yes, please (be sure to include any nonprescription meds such as Tylenol, Bengay, etc.)

NAME	WHY STOPPED?

Pharmacy Name:________________________ Phone#_______________________________

18. Does your pain medication:
☐Relieve all or almost all of your pain?
☐Relieve about 75% of your pain?
☐Relieve about 50% of your pain?
☐Relieve about 25% of your pain?
☐Relieve your pain only slightly?

19. For how long do you get relief from these medications? _____hours.

20. List any physicians you have seen for this pain:

NAME	ADDRESS/CITY	PHONE
1.		
2.		
3.		
4.		

21. Check any of the following tests done to evaluate your pain:

TEST	WHERE PERFORMED	WHEN	RESULTS
☐X-RAYS			
☐CT SCAN			
☐MRI SCAN			
☐DISCOGRAM			
☐MYELOGRAM			
☐ECG			
☐EKG			
☐LAB TESTS			
☐OTHER			

22. Have you had any of the following for relief of your pain? (Check all that apply)

If used, did it relieve your pain?

☐ Nerve blocks (injections) ☐Yes ☐No
☐TENS (electrical stimulation) ☐Yes ☐No
☐Biofeedback ☐Yes ☐No
☐Acupuncture ☐Yes ☐No
☐Manipulation ☐Yes ☐No
☐Heat Therapy ☐Yes ☐No
☐Bed rest ☐Yes ☐No
☐Traction ☐Yes ☐No
☐Massage Therapy ☐Yes ☐No
☐Psychotherapy/psychiatric care ☐Yes ☐No
☐Hypnosis ☐Yes ☐No
☐Ultrasound ☐Yes ☐No
☐Exercise ☐Yes ☐No
☐Other_________________

23. Have you visited an emergency room for your pain?

☐Yes ☐No Approximate # of times: ______________

24. Have you been hospitalized for your pain?

☐Yes ☐No Approximate # of times: ______________

25. Have you had surgery for your pain? ☐Yes ☐No

MEDICATION HISTORY:

26. **DRUG ALLERGIES/INTOLERANCES**

What medications are you allergic to?____

What medications do you not tolerate due to side effects?___________________________

Please list any other allergies that may be pertinent, such as Latex, IVP dye, and etc.________

Are you currently taking any blood thinning medications? ☐Yes ☐No

MEDICAL HISTORY

27. Do you have any of the following medical conditions?

☐Heart Disease ☐High Blood Pressure ☐Diabetes ☐Thyroid Problems
☐Lung Disease ☐Gastrointestinal Disease ☐Kidney Disease ☐Anxiety/Depression
☐Liver Disease ☐Arthritis ☐Neurological Disorder
☐Allergies ☐Bleeding/Bruising ☐Anemia

PAST SURGICAL HISTORY

28. List all previous surgeries:

Date (Month/Year)	Procedures:
____________________________	____
____________________________	____
____________________________	____
____________________________	____
____________________________	____

PERSONAL/SOCIAL HISTORY

29. Do you smoke tobacco? ☐Yes ☐No

How often ______________ How much ____________ For how long? ________

30. Do you drink alcohol? ☐Yes ☐No

Do you use recreational drugs? ☐Yes ☐No

31. Is there anyone living with you to help care for you?

☐Yes ☐No

32. What is your current occupation?

☐___________________________ ☐Disabled ☐Retired

33. Are you currently employed?

☐Yes

☐No-But not because of pain

☐No-Unable to work or unemployed because of pain

34. Place of employment (if employed): ____________________________________

35. Has your job changed because of your painful condition? ☐Yes ☐No
36. Do you have an attorney for healthcare concerns? ☐Yes ☐No

PSYCHOSOCIAL HISTORY

37. Have you ever been treated for emotional/behavioral disorders? ☐Yes ☐No
38. Have you ever had treatment from any doctor for anxiety, depression or any other nervous disorder ☐Yes ☐No
39. Do you currently have ACTIVE suicidal thoughts? ☐Yes ☐No
40. Since your pain began, have you lost weight? ☐Yes ☐No Amt.___________
41. Since your pain began, have you gained weight: ☐Yes ☐No Amt.___________
42. Please check the aids or devices that you usually use:
    ☐Cane ☐Crutches ☐Walker ☐Wheelchair
43. Average number of hours you currently spend in a 24-hour day doing the following:
    Sitting____________ Lying_____________ Walking____________
    Exercising_________ Working___________

FAMILY HISTORY

Check if any of your **BLOOD** relatives have had any of the following:

DISEASE	**RELATIONSHIP TO YOU**
ASTHMA	
CANCER	
CHEMICAL DEPENDENCY	
DIABETES	
HEART DISEASE, STROKE	
HIGH BLOOD PRESSURE	
KIDNEY DISEASE	
NEUROLOGIC CONDITION	
BLEEDING DISORDER	
OTHER, PLEASE LIST	

REVIEW OF SYSTEMS

44. ☐ROS NOT OBTAINABLE BECAUSE;

Constitutional:

YES	NO	
☐	☐	Fever, night sweats, chills
☐	☐	Fatigue, anorexia
☐	☐	Weakness
☐	☐	Weight loss or gain

Skin:

YES NO

- ☐ ☐ Rashes, itching, skin breakdown
- ☐ ☐ Sores, lumps, moles

Head

- ☐ ☐ Headache
- ☐ ☐ Visual changes
- ☐ ☐ Earache, hearing loss, tinnitus
- ☐ ☐ Allergies, sinus problems, rhinorrhea
- ☐ ☐ Sore throat, hoarseness
- ☐ ☐ Cough, snoring, mouth ulcers

Respiratory:

- ☐ ☐ Shortness of breath, wheeze
- ☐ ☐ Cough, sputum
- ☐ ☐ Hemoptysis, TB

Cardiovascular:

- ☐ ☐ Chest pain, angina
- ☐ ☐ Palpitations
- ☐ ☐ Syncope, edema
- ☐ ☐ Dyspnea on exertion, PND

Gastrointestinal:

- ☐ ☐ Heartburn, dysphagia
- ☐ ☐ Nausea, Vomiting
- ☐ ☐ Diarrhea, constipation
- ☐ ☐ Melena, BRBPR
- ☐ ☐ Hematemesis
- ☐ ☐ Abdominal pain, hepatitis

Genitourinary:

- ☐ ☐ Dysuria, frequency, urgency
- ☐ ☐ Frequent UTIs
- ☐ ☐ Pain, hematuria, stones
- ☐ ☐ STDs

WOMEN: G___P___A___ LMP_____

YES NO

- ☐ ☐ Menstrual irregularities
- ☐ ☐ Vaginal discharge
- ☐ ☐ **Is there a possibility that you are pregnant?**

MEN:

- ☐ ☐ Erectile dysfunction, pain

Musculoskeletal:

YES NO

- ☐ ☐ Muscle aches, ROM
- ☐ ☐ Arthritis, Gout

Neurologic:

- ☐ ☐ Mental status changes
- ☐ ☐ Headaches

YES NO

- ☐ ☐ Dizziness, ataxia

☐ ☐ Weakness, numbness
☐ ☐ Seizures

Hematopoitic:

☐ ☐ Lymphadenopathy, anemia
☐ ☐ Bleeding tendencies, bruising

Phyciatric:

☐ ☐ Anxiety, depression
☐ ☐ Hallucination, delusions
☐ ☐ Suicide attempt

Endocrine:

☐ ☐ Diabetes, heat/cold intolerance
☐ ☐ Thyroid problems

I, the undersigned, have completed this form to the best of knowledge. The information that I have provided is true and accurate to the best of my knowledge. I understand that this information is used in the care and treatment plan while under the care of all physicians and staff of Wallace Thomson Hospital Advanced Pain Treatment Center.

______________________________ ________________
Patient/Guardian Signature Date

______________________________ ________ ________
Signature Person Collecting Data Date Time

WALLACE THOMSON HOSPITAL

ADVANCED PAIN TREATMENT CENTER

ASSESSMENT/REASSESSMENT

The patient was reassessed with no changes noted (X) **Changes Noted _____ (X or N/A)**

Date ___________ Time __________ None ________ **Changes _________________________**

____

____

Date ___________ Time __________ None ________ **Changes _________________________**

____

____

Date ___________ Time __________ None ________ **Changes _________________________**

____

____

Date ___________ Time __________ None ________ **Changes _________________________**

____

____

____ _______ ________

Registered Nurse Signature Performing Reassessment Date Time

ADVANCED PAIN TREATMENT CENTER

EXPECTATION OF CARE DOCUMENT AND NARCOTIC AGREEMENT

1. No treatment, including pain medications, will be prescribed to you on your first visit to the Advanced Pain Treatment Center. If you are in need of a prescription please make sure that your referring physicians refill it.
2. After initial evaluation by our Physician, you will be notified of our care and treatment plan.
3. After your initial evaluation, it may be decided that treatment at the Advanced Pain Treatment Center is not warranted or appropriate. In this eventuality, you will be referred back to your referring physician.
4. Once, upon completion of all evaluations, your treatment plan has been determined and agreed upon by you and our Physician, you will be expected to follow it. You have the right to refuse treatment at any time, however, if you do refuse treatment, your decision may result in your being referred back to your referring physician.
5. Patients are not allowed to take their Advanced Pain Treatment Center medications, as they deem necessary. All patients receiving medications prescribed by this center must take the meds as they are prescribed.
6. You will be asked to sign this document, which will serve as a contract before any medications will be prescribed for you. This contract outlines our expectations and your responsibilities relating to medications prescriptions.
7. Telephone calls for chronic pain complaints during evenings, nights, weekends, and holidays will not be tolerated. Patients complaining of a new pain, side effects of their medications or treatment, or true medical emergency are encouraged to visit the nearest emergency room.
8. You must agree to receive your pain medications from one pharmacy and not to receive pain medications from any other physician unless prescribed by that physician during a hospital stay or for outpatient or inpatient surgery.

9. You must be responsible for your medications. No excuses for lost medications, stolen medications, dropped medications, etc. will be accepted by the pain center. No refills will be made before the allotted time of the prescription. **NO EXCEPTIONS.**
10. By signing this contract, you are stating that you are not currently abusing illicit or prescription drugs and that you are not involved in the sale, diversion, or transport of controlled substances.
11. You must understand that this center reserves the right to order random urine drug screens at any time and request a pill count when deemed necessary.

I authorize the release of medical records from all previous physicians, including psychological reports to this pain center.
I have read this entire agreement and have had the opportunity to ask questions. All my questions have been answered satisfactorily. I consent to the use of analgesics under the terms outlined in this agreement. I will be given a copy of this agreement if I so desire.

______________________________________ ____________________

Patient Signature **Date**

______________________________________ ____________________

Patient Name, Printed **Witness Signature**