Advanced Spine & Pain Clinics of MN
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Initial Assessment **Date:**_____

Patient Name: _____Phone:_____
Date of Birth: _____ Age: _____ Sex: F M Marital Status: M D W S
Occupation:_____Work Status:_____
Pharmacy: _____Pharm phone:_____

Pain History:
Current pain issue/reason for consult:_____
When was the **most recent** onset of pain?_____
How did the pain start? _____
Was it a result of work injury/accident? _____
What part of your body hurts the most?_____
If the pain radiates from this area to another part on your body, where?_____
_____

Describe your pain symptoms: (circle all that apply)

Sharp Burning Dull Aching "Electrical"

Radiating Constant Intermittent Numbness Tingling

What makes your pain better? _____
What positions or activities make your pain worse? _____
_____

Have you had a MRI, CT, X-Ray or other imaging done for this condition? YES NO
If yes, where?_____

Treatment History:
What treatments have you tried that **HELPED** for this pain? (please check all that apply)

__ Aqua therapy __ Biofeedback __ TENS unit __ **Bracing (knee, back)**
__ Acupuncture __ Chiropractic __ Physical therapy __ **Cervical Traction**
__ Occupational therapy __ Surgery __ Steroid injections

What have you tried that did **NOT HELP** for this pain?_____

What medications have you tried for your pain that **HELPED:**_____
_____

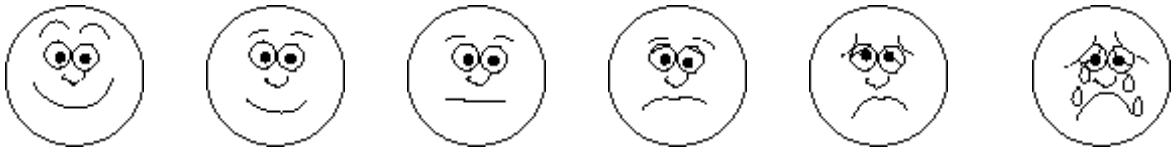
What medications have you tried that **DID NOT HELP:**_____
_____
Where did you have **Physical therapy and how long ago?** If you have not had PT, please state:

List other clinics you've seen for this condition:_____
_____

Use the Pain Faces Scale below to answer the following:

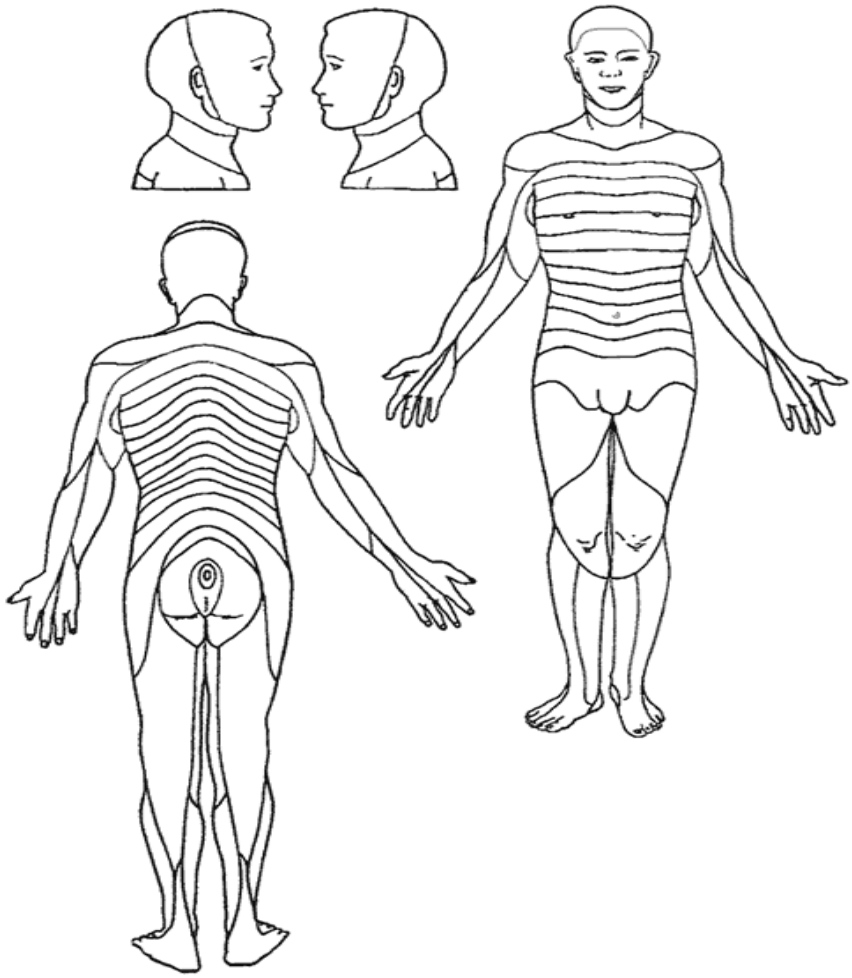
What is your pain level today? __/ 10
What is your pain level when it is the most painful? __/ 10
What is your pain level when it is the least painful? __/ 10

Pain Faces Scale



0	2	4	6	8	10
Very happy, no hurt	Hurts just a little bit	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts as much as you can imagine (don't have to be crying to feel this much pain)

Please mark area(s) where you experience pain on the diagram(s) below:



Past Medical History:

Are you pregnant, trying to become pregnant or nursing at this time? YES NO

Please tell us about any diseases you have or have had in the past: (check all that apply):

__AICD	__Alcoholism	__Anemia
__Anorexia	__Anxiety	__Arthritis
__Asthma	__Atrial fibrillation	__autoimmune disorder
__bipolar disorder	__bleeding disorder	__bowel incontinence
__C difficile	__Coronary artery disease	__Cancer
__chest pain/angina	__kidney stones	__cirrhosis
__congestive heart failure	__COPD	__Depression
__diabetes type 1	__diabetes type 2	__diabetic neuropathy
__DVT/PE	__Diverticulitis	__Diverticulosis
__eating disorder	__fibromyalgia	__gastrointestinal bleeding
__GERD	__gestational diabetes	__headaches
__hearing impairment	__increased lipids	__Hepatitis B

__Hepatitis C	__HIV	__Hypertension
__Thyroid disorder	__implanted stimulator	__irritable bowel syndrome
__low back pain	__MRSA	__multiple sclerosis
__myocardial infarction	__neck pain	__obesity
__pacemaker	__Parkinson's disease	__peptic ulcer disease
__pneumonia	__prostate cancer	__restless leg syndrome
__rheumatoid arthritis	__schizoaffective disorder	__seizure disorder
__sexual abuse	__shingles	__sleep apnea
__stroke	__substance abuse	__syst. lupus erythematosus
__thrombophlebitis	__urinary stress incontinence	__visual impairment

Please list any additional diseases not listed above (if applicable):

_____

_____

_____

Surgical History:
Please list any surgical procedure that you have had in your lifetime:

Surgery	Year	Surgery	Year
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Family History:
Please list any significant diseases that members of your immediate family have or have had in the past:

_____

_____

_____

Social History:
Do you smoke cigarettes? YES NO If yes, how many packs per day? _____

Do you drink alcohol? YES NO If yes, how many drinks per day? _____

Do you ever use marijuana, cocaine, heroin or any other illicit drugs (including illicit prescription drugs)? YES NO

If yes, please list substances used?_____

If no, have you every used any of these substances in the past? YES NO

If yes, when did you last use?_____

Medications/ Allergies:

Are you allergic to latex? YES NO
Are you allergic to shellfish, iodine, or IV dye? YES NO

List all **allergies to medications** and the reaction (e.g., hives, rash, etc.):

_____
_____
_____
_____
_____
_____

Are you taking any anticoagulant (blood thinning) medications? YES NO

If you do not carry a **medication list** with you, please list all medications that you currently take (including over the counter medications and herbal supplements).

Name	Dose	Frequency	Name	Dose	Frequency

(The section below this line is to be completed by clinic staff and/or physicians)

Reviewed by:_____ Reviewed by:_____
Date:_____ Date:_____