CONSULTANTS IN PAIN MANAGEMENT
INITIAL EVALUATION

Date of Appointment: ____________________

Patient Name: ________________________________ DOB: _______________ Age: _______ Sex: M__ F__

Location of your pain: ____

When did your pain start? ____

What caused your pain? ____

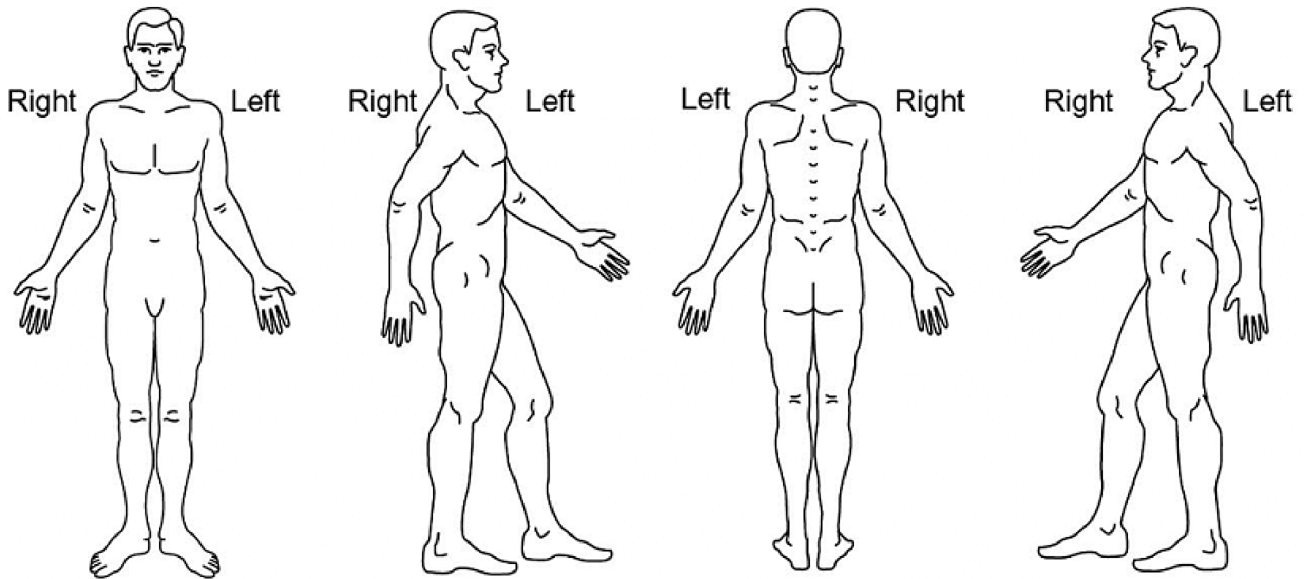
Are you ***currently*** in Physical Therapy? ___YES ___NO   Do you use a TENS Unit or Stimulator? ___YES ___NO

How intense is your pain? Circle

1	2	3	4	5	6	7	8	9	10

No Pain   Excruciating Pain

Using the diagrams below, shade all the areas of pain completely. Indicate more intense pain areas with darker markings. If applicable, indicate areas of spinal cord stimulation or TENS unit stimulation.



ALLERGIES: ____

CURRENT MEDICATION(S)

PILL COUNT OBTAINED BY: _____________ **(INITIALS)**

PHARMACY: ____ **PHONE**___________________________

VITALS:

WT:		**HT:**		**BP:**	/	**P:**		**R:**		**T:**		**O2 SAT:**	

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DESCRIPTION OF PAIN

CHOOSE THE WORDS THAT BEST DESCRIBE YOUR PAIN: ___ **CONSTANT** ___**INTERMITTENT**

___ GNAWING ___TINGLING ___NUMB ___SHARP ___DULL ___STABBING ___SHOOTING
___BURNING ___ ACHING ___ THROBBING

EPISODES OF PAIN BEST DESCRIBED AS: ***(CHOOSE ONLY ONE)***

___HORRIBLE ___MISERABLE ___UNCOMFORTABLE ___ UNBEARABLE ___ EXCRUCIATING

WHAT MAKES YOUR PAIN WORSE?

___LYING DOWN ___SITTING ___STANDING ___WALKING ___WEATHER ___EXERCISE
OTHER: ______________

WHAT MAKES YOUR PAIN BETTER?

___LYING DOWN ___SITTING ___STANDING ___WALKING ___MEDICATIONS ___EXERICSE
___ ELEVATION ___RELAXATION OTHER: _______________________________________

MY MEDICATION WORKS: ___Well ___Fair ___Poor

ADVERSE EFFECT:

Are you experiencing any side effects from your current pain reliever? ___ Yes ___ No

Mark overall severity of any side effects you are experiencing	None	Mild	Moderate	Severe
Nausea/Vomiting				
Constipation				
Drowsiness				
Itching				
Sweating				
Other:				

ACTIVITY:Functional Assessment

TODAY you are able to**:**	**NO DIFFICULTY**	**SOME DIFFICULTY**	**MUCH DIFFICULTY**	**UNABLE TO DO**
Stand upright				
Walk normally				
Sit comfortably				
Bend over				
Concentrate				
Bathe/groom yourself				
Shop				
Housekeeping/Chores				
Drive and get out of car				
Lift a cup/glass to mouth				
Open a jar				

AFFECT:

Is pain affecting your sleep? ____ Yes ____ No
On average how many hours per night are you sleeping? _______________
Which, if any, of the following has your pain affected? ***Please circle all that apply:***

Mood Daily Activities Relationships Weight Work (your job) Other:

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REVIEW OF SYSTEMS: ***please check all that apply***	
GENERAL	___ Fatigue ___ Fever ___ Weight Gain ___ Weight Loss
GASTROINTESTINAL	___ Blood in Stools ___ Change in Bowel Movements ___ Constipation ___Heartburn ___ Loss of Appetite ___ Nausea ___ Vomiting
ENDOCRINE	___ Excessive Thirst ___ Excessive Urination ___ Gland or Hormone Problems ___ Heat Intolerance ___ Cold Intolerance
SKIN	___ Itching ___ Rash ___ Skin Color Changes
HEMATOLOGIC	___ Anemia ___ Bleeding Tendencies ___ Bruising Tendencies ___ Past Blood Transfusions ___ Slow Healing
HEENT **(Head, Eyes, Ears, Nose, Throat)**	___ Bleeding Gums ___ Blurred Vision ___ Double Vision ___Earache/Drainage ___ Eye Pain ___ Headache ___Mouth Sores ___ Sinus Problems ___ Swollen Neck Glands ___ Hearing Loss/Ringing
GENITOURINARY	___ Birth Control ___ Frequent Urination ___ Irregular Menstrual Cycle ___ Painful Urination ___ Prostate Problems ___ Sexual Dysfunction
PSYCHIATRIC	___ Depression ___ Nervousness ___ Poor Sleep
CARDIOVASCULAR	___ Chest Pain ___ Irregular Heartbeat ___ Swelling of Feet ___ Swelling of Hands
RESPIRATORY	___ Chronic Cough ___ Shortness of Breath ___ Spitting up Blood
MUSCULOSKELETAL	___ Back Pain ___ Difficulty Walking ___ Joint Pain ___ Joint Stiffness ___ Joint Swelling ___ Muscle Cramps ___ Muscle Pain ___ Neck Pain
NEUROLOGICAL	___ Dizziness ___ Frequent Headaches ___ Lightheadedness ___ Numbness ___ Tremors ___Tingling

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Patient name: ____________________________ DOB: ____________ Today's Date: ____________

PAST MEDICATION HISTORY

Which, if any, of these medications have you taken for pain? Did it help? Yes/No

If you are able, please list the dates (approximate) you used the medication and reason for discontinue. For example: not helping, side effect, insurance issue.

Medication	Y/N	Dates/Reason Discontinued	Medication	Y/N	Dates/Reason Discontinued
ANTIDEPRESSANTS			**NERVE PAIN**		
Celexa (citalopram)			Cymbalta (duloxetine)		
Paxil (paroxetine)			Effexor (venlafaxine)		
Prozac (fluoxetine)			Elavil (amitriptyline)		
Wellbutrin (bupropion)			Lyrica (pregabalin)		
Zoloft (sertraline)			Neurontin (gabapentin)		
ANTI-INFLAMMATORY			Gralise (gabapentin)		
Flector Patch			Savella		
Lidoderm			**SEDATIVES**		
Pennsaid			Ambien (zolpidem)		
Voltaren Gel			Ativan (lorazepam)		
Celebrex			Belsomra (suvorexant)		
Diclofenac			Klonopin(clonazepam)		
Etodolac			Lunesta (eszopiclone)		
Ibuprofen			Restoril (temazepam)		
MOBIC (meloxicam)			Valium (diazepam)		
Naproxen			Xanax (alprazolam)		
RELAFEN (nabumetome)			Rozerem (ramelteon)		
MIGRAINE			Trazodone		
Amerge (naratriptan)			**SHORT-ACTING**		
Frova (frovatriptan)			Demerol (meperidine)		
Imitrex (sumatriptan)			Dilaudid (hydromorphone)		
Maxalt (rizatriptan)			Hydrocodone		
Relpax (eletriptan)			Morphine IR		
Zomig (zolmitriptan)			Nucynta IR (tapentadol)		
Fioricet (APAP/butalbital/caffeine)			Oxycodone IR		
Fiorinol(aspirin/butalbital/caffeine)			Opana IR (oxymorphone)		
Tegretol (carbamazepine)			**LONG-ACTING**		
Topamax (topiramate)			Butrans Patch		
MUSCLE RELAXERS			Duragesic (fentanyl)		
Baclofen			Exalgo (hydromorphone)		
Flexeril (cyclobenzaprine)			Methadone		
Norflex (orphenadrine)			Nucynta ER (tapentadol)		
Robaxin (methocarbamol)			Opana ER (oxymorphone)		
Skelaxin (metaxalone)			Oxycontin (oxycodone ER)		
Soma (carisoprodol)			Ultram (tramadol HCl ER)		
Zanaflex (tizanidine)			Hydrocodone: Hysingla Er, Zohydro		
Parafon Forte (chlorzoxazone)			Morphine: Embeda, Kadian, Ms Contin		

If you have taken other medications not listed, please list here: ____

____

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PAST TREATMENT HISTORY

What diagnostic tests have you had for your pain? Indicate where and when.

X-Rays		CT Scan	
Ultrasound		Bone Scan	
Arteriogram		MRI Scan	
EMG/NCS		Myelogram	

Which, if any, of the following Pain Treatments have you had? Did it help? Yes/No

Bed Rest		TENS Unit		Exercise Program	
Traction		Biofeedback		Physical Therapy	
Heat Therapy		Acupuncture		Work Hardening	
Ultrasound		Chiropractor		Psychotherapy	

Which, if any, of the following Pain Procedures have you had? Did it help? Yes/No

Joint Injections		Spinal Cord Stimulator	
Trigger Point Injections		Internal Narcotic Pump	
Nerve Block Injections		Surgery	
Spinal Injections			

Past Medial History: Which of the following do your currently have or have you had in the past?

Arthritis (Rheumatoid/Osteoarthritis)		Gout		Osteoporosis	
Asthma		Heart Disease		Reflux/Ulcers	
Cancer		Hepatitis		Seizure	
Congestive Heart Failure		High Blood Pressure		Stroke	
Diabetes (type I or II)		Kidney Disease		Other:	
Diverticulitis		Liver Disease			
Emphysema		Migraines			

Past Surgical History: Which of the following have you had and when? Circle L/R					
Appendectomy		Lung Surgery		Eye Surgery	L/R
Bladder Surgery		Oral Surgery		Foot Surgery	L/R
Blood Vessel Surgery		Spine Surgery (Back)		Hand/Wrist Surgery	L/R
Bowel Surgery		Spine Surgery (Neck)		Hip Surgery	L/R
Brain Surgery		Stomach Surgery		Knee Surgery	L/R
Facial Surgery		Thyroid Surgery		Shoulder Surgery	L/R
Gallbladder Surgery		Tonsillectomy			
Hernia Repair					

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FAMILY HISTORY					
	Living	Deceased		Living	Deceased
Mother			Brother(s)		
Father			Sister(s)		

Which, if any, of the following do they have? (Parents, Grandparents, Brothers, Sisters)

Asthma		Gout		Osteoporosis	
Cancer		Heart Disease		Reflux/Ulcers	
Congestive Heart Failure		High Blood Pressure		Seizure	
Diabetes		Kidney Disease		Stroke	
Diverticulitis		Liver Disease			
Emphysema		Migraines			

MARITAL STATUS

Single	Married	Divorced	Divorced-Remarried	Separated	Significant Other	Widowed	Widowed-Remarried

LIVING SITUATION

Alone	With Spouse/Significant Other	With Family	With Friend	Other:

TOBACCO USE

Non-Smoker	Quit	Smokes, # packs per day _____

DRUG USE

Marijuana	Cocaine	Heroin	Methamphetamines	Other:

ALCOHOL USE

Drinks Socially	Drinks Rarely	# Drinks per day _______	Abstains at this time

OCCUPATION

What type of work do you do or have you done in the past?

Unemployed	Retired	Homemaker	Employed Full-Time	Employed Part Time

Disabled, Date Disability Awarded	Self- Employed	# Of Hours Worked Per Week _____

EDUCATION

Less than High School	Completed High School	Some College/2 year degree	4 or more years completed

WOMEN OF CHILDBEARING AGE

Date of Last Menstrual Cycle: __________	Are you pregnant ***or*** do you plan to become pregnant? ___YES___NO
Have you had a hysterectomy? ___ NO ___ YES Date: _______________	Have you had a tubal ligation? ___ NO ___ YES Date: _______________

Current form of birth control: ___Oral Contraceptive Pills ___IUD ___ Other:____________________________

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SOAPP VERSION 1.0- SF					
Please answer the questions below using the following scale: **0=NEVER, 1=SELDOM, 2= SOMETIMES, 3= OFTEN, 4= VERY OFTEN**					
How often do you have mood swings?	**0**	**1**	**2**	**3**	**4**
How often do you smoke a cigarette within an hour after you wake up?	**0**	**1**	**2**	**3**	**4**
How often have you taken medication other than the way it was prescribed?	**0**	**1**	**2**	**3**	**4**
How often have you used illegal drugs (i.e. marijuana, cocaine, etc.) in the past five years?	**0**	**1**	**2**	**3**	**4**
How often, in your lifetime, have you had legal problems or been arrested?	**0**	**1**	**2**	**3**	**4**

PROVIDERS ONLY

COMPLIANCE MONITORING

We reviewed and discussed the following:

- Pill Count
- TNCSMD reviewed
- Pain Management Agreement signed
- Urine Drug Test; the policy of routine scheduled and periodic urine drug screens also discussed
- Risks and benefits of the use of the opioids have been discussed with the patient, significant other, and/or family

ASSESSMENT

Is your overall impression that this patient is benefiting from opioid therapy? ___YES ___NO ___ NEW PATIENT

Is there concern about opioid use? ___NO ____ YES

___ Misuse/Abuse ___Side Effects ___Tolerance ___ Diversion ___ Dependence

Is the patient's pain relief clinically significant? ___ YES ___NO ___UNSURE

GOALS/TREATMENT PLAN

Discussed goals of opioid therapy to be decrease pain, increase functionality, improve quality of life.

Discussed current opioid guidelines and the MEDD with the patient.

Current MEDD: ______

___ Discussed opioid taper with patient. We will continue to monitor patient and consider opioid taper in the future if warranted.

___ Continue current treatment. Patient is on **lowest effective dose** of narcotic pain medication. We will continue to monitor patient and efforts will be made in the future to taper if warranted.

___ Begin Opioid Taper

___ Continue opioid therapy with the following changes:

Provider Comments: ____

____

Provider Signature **Date** **Patient Signature** **Date**