THE PAIN MANAGEMENT CENTERS OF SOUTH TEXAS

APPT DATE:_____APPT TIME: _____ ARRIVAL TIME: _____
PATIENT'S NAME:_____ ACCT #: _____

DOB: _____ INSURANCE: _____

Pain Scale

0-2 Short Term ex: sub a toe
3-4 Achy ex: always there
5-6 Sharp ex: constant pain
7-8 Pain that stops function ex: can't dress themselves
9 Intense ex: sweating
10 Torturing ex: in ER Hospital

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. YES 2. NO

2) Where do you feel your pain?

_____
_____
_____

3) Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10

No Pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10

No Pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10

No Pain — Pain as bad as you can imagine

6) Does your pain radiate from the area of maximum intensity, if so please describe from what area start to end. _____
_____

7) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0%	10	20	30	40	50	60	70	80	90	100%

No Relief — Complete Relief

8) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

D. Normal Work (both outside the home and Housework).

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

In addition to comparing the pain inventory to help your doctor better manage your pain please tell us:

What does the pain feel like? Circle those words that describe your pain.

aching	throbbing	shooting
stabbing	nagging	sharp
dull	tender	burning
numb	radiating	squeezing
cramping	deep	

How long have you had this pain?
Circle one.

Less than a week	1 to 2 weeks
2 to 4 weeks	more than a month

What kinds of things make you pain feel better (for example, heat, medicine, rest)?

_____

_____

What kinds of things make your pain worse (for example, walking, standing, lifting)?

_____

_____

LIST PAIN MEDICATION(S) AND HOW OFTEN TAKEN (CURRENT)

_____

_____

_____

_____

_____

ALLERGIES:_____

OTHER CURRENT PAIN TREATMENTS MODALITIES

_____

Do you have any other symptoms?

Circle any that apply:

nausea	vomiting
constipation	diarrhea
lack of appetite	indigestion
difficulty sleeping	feeling drowsy
nightmares	dizziness
tiredness	itching
urinary/bowel problems	sweating
weakness	headaches

COMMENTS: Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.

_____

_____

_____

_____

_____

_____

Does the patient have any of the following device.
Are they helpful or ineffective?

___Intrathecal Pump ___Medtronics SCS

___ANS SCS ___BMR – 2000 ___None

_____

_____

_____