Patient Label

Marshall Pain Clinic

PATIENT INFORMATION

Name: _____ Date: _____

County you reside in: _____

Height: _____ Weight: _____

Check any of the following medical problems that apply to you:

❑ Arthritis	❑ Heart Disease	❑ Memory Problems	❑ _____
❑ Asthma	❑ Hepatitis	❑ Mental Illness	❑ _____
❑ Cancer	❑ High Blood Pressure	❑ Seizures	❑ _____
❑ Circulation Problems	❑ HIV	❑ Stroke / TIA	❑ _____
❑ COPD	❑ Kidney Problems	❑ Reflux / Ulcers	❑ _____
❑ Diabetes	❑ Liver Problems		

SURGERY: Check any of the surgeries you have had and add any that are not listed:

❑ Bowel	❑ Heart	❑ _____
❑ Colonoscopy	❑ Hysterectomy	❑ _____
❑ Exploratory Laparotomy	❑ Orthopedic	❑ _____
❑ Gallbladder	❑ Prostate	❑ _____
❑ Back Surgery	❑ Tubal	❑ _____
❑ Neck Surgery	❑ Appendectomy	

List all of your current medications you are taking on a regular or frequent basis (including herbs and vitamins)

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

List all of your *DRUG ALLERGIES* and reactions to each

MEDICATION	REACTION
1.	
2.	
3.	
4.	

Circle any of the following you have had recently: Fever / Chills / Night Sweats / Weight Loss

Do you smoke: _____ How much: _____

Do you drink alcohol: _____ How much: _____

Occupation: _____ Are you on disability: Y / N Are you on Workmen's Comp: Y / N

Circle if you have: Dentures / Partials / Retainers / Hearing Aids

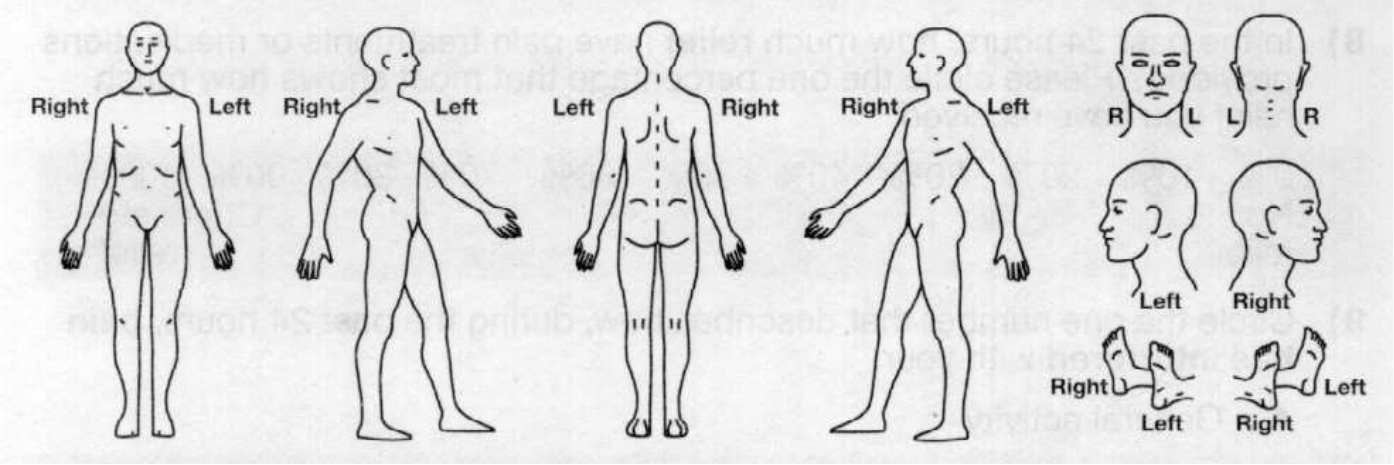
Do you need help with dressing, eating, driving, medications: _____

Please list any devices that you may use to perform activities of daily living: _____

Please answer the following questions:

1. How long have you had this pain? _____

2. On the diagram, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.



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

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 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

6. Please rate your pain by circling the one number that best describes 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

7. In the past 24 hours, how much **RELIEF** have pain treatments or medications provided? Please circle the percentage that most shows how much

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
no relief										complete relief

8. What treatments or medications are you receiving for your pain?

_____

_____

Check the words that describe your pain today:

❑ Constant	❑ Intermittant	❑ Burning	❑ Throbbing
❑ Dull	❑ Sharp	❑ Electric Shock	❑ Nagging
❑ Ache	❑ Shooting	❑ Pins and Needles	❑ Miserable
❑ Tender	❑ Stabbing	❑ Numb	❑ Unbearable

What makes your pain better: _____

What makes your pain worse: _____

Do you have weakness associated with this pain? _____ Bowel or Bladder Incontinence: YES / NO