

**PAIN EVALUATION
HEAD AND NECK**

PATIENT I.D. _____

Date: _____ Arrival Time: _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Daytime Phone # _____ Alternate Phone # _____

Primary language: _____ Height: ____ Weight: ____ Dominant Hand: Right Left

OTHER / REFERRING DOCTORS: please list the Doctors you would like records sent to

Name of Doctor	Specialty	Phone Number	Fax	Address

UNDERSTANDING YOUR CURRENT PAIN: *(Reason for visit)*

Describe in ***your own words*** the pain problem(s) you would like help with:

- Is nausea associated with your pain? Yes No
- Is vomiting associated with your pain? Yes No
- Does your pain increase with bright lights? Yes No
- Does your pain increase with loud noises? Yes No
- Does physical activity make your pain: (check one) better worse no change
- Do you get an aura (flashing lights, zigzags, blindness, smells)? Yes No
- *If Yes, (describe): _____
- Does your pain wake you from sleep? Yes No
- Does your pain keep you from falling asleep? Yes No
- Do any of your family members have the same or similar pain problem? Yes No
- Do any of these occur with your pain? (check all that apply)
- Redness of the eye(s) Eyelid drooping
- Tearing of the eye(s) Nasal stuffiness Facial sweating
- Do you have difficulty opening or closing your mouth? Yes No
- Do you hear clicking or popping in your jaw joints? Yes No

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UNDERSTANDING YOUR CURRENT PAIN: (Cont'd)

Is your pain: Continuous or Intermittent*?

*If your pain is **intermittent** how often does it occur?

- Several times a day Several times per week Less than once per week
 Once per day Once per week Never
 Other _____

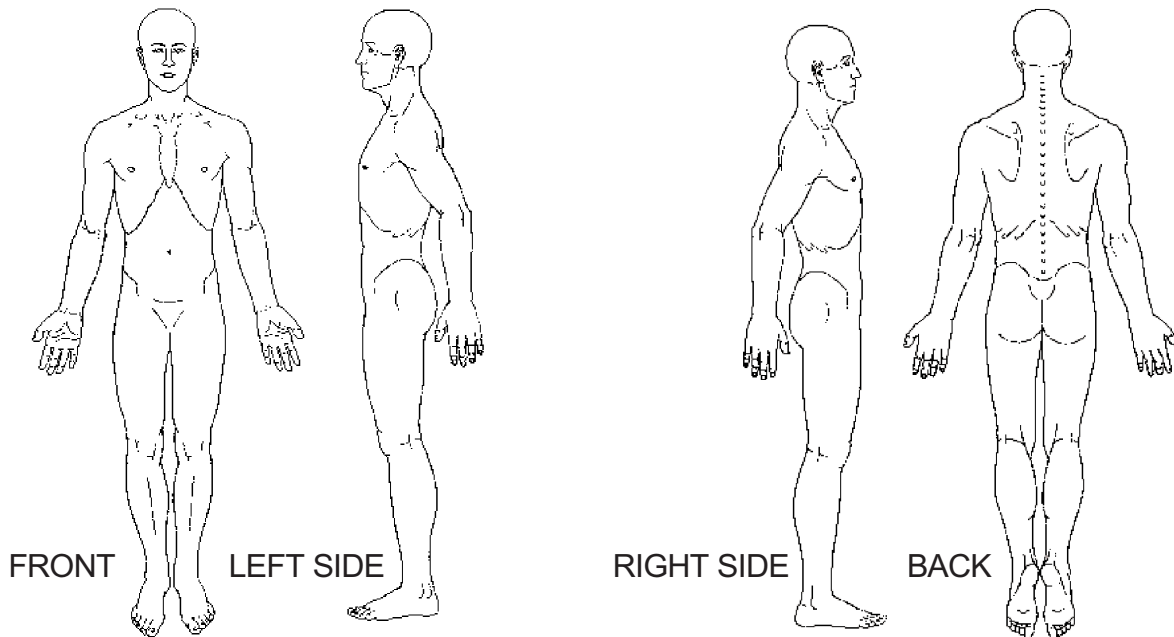
How long does your pain last? None Seconds Minutes Hours Days Weeks

Circle a number below to indicate your **usual** pain intensity over the past week:

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

No pain Mild pain Moderate pain Severe pain Most intense pain imaginable

Please mark area(s) of pain with an (X):



What makes the pain **WORSE**? Be Specific.

What makes the pain **BETTER**? Be Specific.

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CURRENT MEDICATIONS:

List all medications you are currently taking for medical and pain problems including prescribed, over-the-counter, herbs, vitamins. Do not bring your medicines to the clinic unless you have a question to discuss with the physicians.

Name started	Pill Strength	# of times taken per day	Doctor who prescribed	Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

History of your pain: ~~History of your pain:~~ Pharmacy name, phone, and FAX: _____

When did your pain start? _____
 When did your pain become a problem? _____
 What event(s) led to your present pain?
 Accident Other injury Other disease No obvious cause
 Cancer Following an operation Other: _____
 What do **YOU** think is the cause of your pain?

EFFECTS OF PAIN:

Circle the number to indicate how much your pain has interfered with your activities this **past week**.

0	1	2	3	4	5	6	7	8	9	10
No Interference	Mild Interference		Moderate Interference			Severe Interference			Complete Interference	

Previous Doctors

List ALL of the doctors you have seen for your pain problem

Date	Name	Specialty	Address / Phone / Fax
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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PREVIOUS MEDICATIONS: List all previous medications you have taken for pain:

Name of Medicine	Dose	Dates of Use	Helpful	Reason for stopping
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

PREVIOUS TREATMENTS:

Indicate which of the following treatments you have tried for your pain problem:

- Nerve Blocks
 Chiropractor
 Psychotherapy
 Relaxation Training
 Acupuncture
 Physical Therapy
 Biofeedback
 Exercise Program
 Other (list): _____

DIAGNOSTIC TESTS:

Please list, in chronological order, all tests and x-rays performed to evaluate your pain:

Date	Test	Results

PAST MEDICAL PROBLEMS, SURGERIES, HOSPITALIZATIONS OR INJURIES:

Year	Describe	Hospital	Doctor

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ALLERGIES: No Known Allergies

Medicine	Reaction	Medicine	Reaction

REVIEW OF SYSTEMS:

Please check if you have or had any of the following:

General

- Weight loss
- Poor appetite
- Severe fatigue / low energy
- Cancer

Hematological

- Anemia
- Easy bruising
- Bleeding disorder
- Taking blood thinners
- Blood Transfusion:
 - Yes No

Reaction: _____

Skin

- Rash
- Nail changes
- Bumps / nodules

Head and Neck

- Headaches
- Visual changes
- Mouth problems
- Neck pain
- TMJ problems

Cardiac

- Exercise limitations
- Chest pain
- Irregular heartbeat
- Heart murmurs
- High or low blood pressure
- Circulation problems
- Ankle swelling

Pulmonary

- Shortness of breath
- Cough
- Asthma or bronchitis
- Lung disease
- Sleep apnea
- Snoring

Endocrine

- Diabetes
- Thyroid problems

Gastrointestinal

- Abdominal Pain
- Nausea or vomiting
- Constipation
- Diarrhea
- History of ulcers or heartburn

Genitourinary

- Frequent or hesitant urination
- Pain with urination
- Blood in urine
- Incontinence
- Sexual dysfunction

Musculoskeletal

- Arthritis -Type: _____
- Osteoporosis
- Muscle pain
- Muscle wasting
- Fractures

Neurologic

- Numbness
- Weakness
- Falling
- Stroke
- Seizures
- Memory Loss
- Loss of balance

Infectious Diseases
(check all that apply)

- Measles Mumps
- Chicken Pox
- Rheumatic fever
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Other: _____
- HIV AIDS
- Herpes (Oral)
- Herpes (Genital)
- Shingles
- Post-herpetic neuralgia

In the last 5 years:

Received:

- Pneumovax: Yes No
- Flu shot: Yes No

Gynecologic

- Pregnant
- Post-menopausal:
- Last Menstrual Period: _____

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HABITS:

Smoking: Yes No Quit Packs per day: _____ Number of years smoked: _____
 Alcohol use: None Occasional Daily How much per week? _____
 Are you currently using recreational drugs? No Yes: Amphetamines Cocaine
 Heroin Marijuana Other: _____
 Do you drink caffeine (coffee, tea, etc.)? How many cups per day? _____
 Do you clench your teeth? Yes No
 Do you grind your teeth? Yes No
 Do you wear a night guard over your teeth? Yes No

EXERCISE:

Do you exercise? No Yes, what type? _____
 How many days per week do you exercise? _____
 How long do you exercise each time (on average)? _____

FAMILY HISTORY: Are you adopted? Yes No

Member	Deceased or Living		Age	Medical Problems
Father	<input type="checkbox"/>	<input type="checkbox"/>		
Mother	<input type="checkbox"/>	<input type="checkbox"/>		
Siblings	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
Spouse	<input type="checkbox"/>	<input type="checkbox"/>		

SOCIAL HISTORY:

Relationship Status: Single Separated Married Widowed
 Domestic Partner: Female Male
 With whom do you live? Name: _____ Relationship: _____
 Highest level of education completed: Less than High School High School Vocational
 Graduate College Other: _____
 Current or most recent occupation: _____
 Status: Full Time Part time Self-employed Homemaker Retired _____ years
 Unemployed _____ years due to pain Unemployed _____ years due to _____
 Are you happy with your job? Yes No
 Are you on Disability? No Yes, Date Started: _____
 Reason for disability: _____

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PSYCHOLOGICAL HISTORY:

Describe your mood: _____

Do you have problems with any of the following:

- Concentration Motivation Sleep Appetite Anxiety
 Depression Self-worth Homicidal thoughts Suicidal thoughts

Do you have a history of physical or mental abuse? Yes No

Are you currently in therapy? No Yes, who do you see? _____ Phone # _____

FINANCIAL INFORMATION:

Do you have any legal action pending related to this pain or any other health problem?

No Yes, Attorney's name: _____ Phone # _____

Address: _____

HEALTHCARE DECISIONS: (Check boxes that apply)

- Patient prefers to make own medical decisions.
 Medical decisions are made jointly between patient and family.
 Patient prefers family members to make the major medical decisions.
 Patient has Advance Directives: Yes* No

* If Yes, Copy of Directives given to CSMC: Yes No

Source of information if other than patient: _____

Signature of person acquiring this information: _____

Signature of patient: _____ Date: _____

Evaluation reviewed by Physician:

Name of Physician (*please print*) Signature of Physician ID# Date Signed

For Clinical Use Only:

Blood Pressure: _____ / _____ Heart Rate: _____ Respiration Rate: _____