AdventHealth Shawnee Mission

Patient Assessment Form

Name_____ Date of Birth: _____ Today's Date: _____

Age_____ Sex: M _____ F _____ Height: _____ft. _____ in. Weight _____ lbs.

Primary Physician Referring Physician (if different)

In detail, please explain where your primary pain is located on your body:

Pain Rating Today

No Pain **Worst Pain**

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

What is your pain goal ____/10

When did the pain begin? _____

Did it begin gradually or suddenly? If suddenly, is it the result of an injury? ☐ Yes ☐ No

What do you think caused your pain? _____

Since your pain started is it (check one) ☐ **Worse** ☐ **Unchanged** ☐ **Intermittent** ☐ **Better** ☐ **N/A**

Pain Descriptors

- ☐ Aching
- ☐ Dull
- ☐ Nagging
- ☐ Discomfort
- ☐ Sore
- ☐ Tightness
- ☐ Radiating
- ☐ Shooting
- ☐ Burning
- ☐ Sharp
- ☐ Stabbing
- ☐ Deep
- ☐ Cramping
- ☐ Spasms
- ☐ Tender
- ☐ Pressure
- ☐ Throbbing
- ☐ Penetrating
- ☐ Numbness
- ☐ Tingling
- ☐ Pins/Needles
- ☐ Heaviness
- ☐ Weakness
- ☐ Other

What makes your pain worse?

- ☐ Exercise
- ☐ Bending
- ☐ Twisting
- ☐ Kneeling
- ☐ Stairs
- ☐ Standing
- ☐ Walking
- ☐ Laying down
- ☐ Sitting
- ☐ Housework
- ☐ Bathing/Self Care
- ☐ Yard Work
- ☐ Job Duties
- ☐ Yard Work
- ☐ Car Rides
- ☐ Shopping

HISTORY OF TREATMENTS

Please indicate whether or not you have had any of these tests for your present problem:

	YES	NO
X-RAYS	☐	☐
CT SCAN	☐	☐
MRI	☐	☐
EMG (nerve test)	☐	☐

Please indicate the following treatments you have tried in the past.

TREATMENTS			Additional Comments
	YES	NO	
Physician prescribed home exercise program			
Physical Therapy			
Occupational Therapy			
Chiropractic care			
Counseling			
Massage			
Injections/Nerve Block			
TENS Unit			
History of spinal surgery			
Dry Needling			

MEDICATIONS FOR PAIN

(Please circle any you have tried for your pain)

☐ **PRESCRIPTIONS: Gabapentin, lyrica, duloxetine, tizanidine, Flexeril, Robaxin, Soma, baclofen, Celebrex, naproxen, meloxicam, oral diclofenac, hydrocodone, oxycodone, tramadol, Other:**

☐ **OVER THE COUNTER: ibuprofen, Advil, Aleve, Motrin, aspirin, Tylenol, lidocaine, Voltaren gel, Salonpas, Biofreeze, icy hot, Aspercreme, CBD, Other:**

HISTORY OF PAST PROVIDERS FOR YOUR PAIN

Please list the names of all previous providers you have seen for your pain including Neurosurgeons, neurologist, rheumatologist, orthopedic specialist, and pain management specialist.

NAME OF PHYSICIAN	SPECIALTY	DATE FIRST SEEN	DATE LAST SEEN

REVIEW OF SYSTEMS

Do you have any of the following symptoms? Please check all that apply.

- ☐ ***GENERAL***: Weight loss, rashes, itching, color changes, dizziness, fever or chills, night sweats
- ☐ ***EYES***: Blurred vision, light sensitivity, deficits in your vision, changes in your vision.
- ☐ ***EAR,NOSE,THROAT***: Sinus problems, trouble swallowing, ringing in your ears, dental problems.
- ☐ ***CARDIAC***: Chest pain, palpitations, poor circulations, swelling in extremities, poor exercise tolerance
- ☐ ***RESPIRATORY***: Shortness of breath, difficulty breathing, wheezing, coughing, sputum production.
- ☐ ***URINARY***: Painful urination, difficulty urinating, bladder control problems, frequent urinary infections.
- ☐ ***GASTROINTESTINAL***: Heartburn, nausea, vomiting, diarrhea, bloody stools, constipation.
- ☐ ***MUSCULOSKELETAL***: Achy swollen joints, stiff joints, muscle spasms, sore/ tender muscles.
- ☐ ***SKIN***: Rashes, skin irritations, skin ulcers.
- ☐ ***NEUROLOGICAL***: Poor memory, headaches, poor balance, loss of consciousness, fainting, muscle weakness, numbness, or changes in sensation.
- ☐ ***PSYCHOLOGICAL***: Anxiety, depression, increased emotional stress, hallucinations, paranoia, suicidal ideations (thoughts of harming yourself), difficultly with concentration.
- ☐ ***ENDOCRINE***: Always thirsty, always hot, always cold, hair and nail changes.
- ☐ ***HEMATOLOGY***: Easy bruising, cuts take a long time to stop bleeding, painful lymph nodes, frequent leg swelling, fatigue.
- ☐ ***ALLERGIC/IMMUNE***: Prone to infections, sensitivity to food, sensitivity to medications.

PAST MEDICAL HISTORY

Do you have, or have you had any of the following conditions? (Please Check All That Apply)

ENDOCRINE
- ☐ Diabetes
- ☐ Hypo/Hyperthyroid

HEMATOLOGY
- ☐ Bleeding disorder
- ☐ Anemia

RHEUMATOLOGY
- ☐ Arthritis, Type_____
- ☐ Fibromyalgia

CARDIAC
- ☐ Heart Attack
- ☐ Congestive Heart failure
- ☐ Coronary Artery Disease
- ☐ Valvular heart Disease
- ☐ High Blood Pressure

GENITOURINARY
- ☐ Incontinence
- ☐ Bladder control problems
- ☐ Kidney disease
- ☐ Kidney infections

GASTROINTESTINAL
- ☐ Ulcers
- ☐ Gallstones
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Pancreatitis
- ☐ GERD/reflux disease

OTHER

Cancer, Type _____
_____
_____
_____

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema/COPD

NEUROLOGICAL
- ☐ Stroke/TIA
- ☐ Migraines

PSYCHIATRIC
- ☐ Bipolar disease
- ☐ Depression
- ☐ History of Drug/Alcohol problems
- ☐ Other mental illness_____
- ☐ Anxiety

Please provide any additional information about the above conditions below, or list other conditions not covered on the above list:

_____

PAST SURGICAL HISTORY

Please list any surgeries you have had including procedure and date:

Surgery	Year	Facility/Physician

CURRENT MEDICATIONS

***ARE YOU TAKING ANY BLOOD-THINNING MEDICATIONS*? (e.g. ASPIRIN, COUMADIN, HEPARIN, TICLID, PLAVIX (CLOPEDIGREL) PLETAL, LOVENOX, ARISTA, JANTOVEN, WARFARIN, OTHER**

YES☐ NO☐

Please list any medications you are currently taking. Include vitamins, over-the-counter medications, herbal preparations, laxatives, or inhalers.

Medication & Dose	How often	Medication & Dose	How often

ALLERGIES

DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO If yes, please list the medication and the reaction:

This includes: medications, food, latex, iodine

Item/Drug	Reaction	Item/Drug	Reaction

SOCIAL HISTORY

Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widowed
Tobacco Use	☐ Never	☐ Former	☐ Every Day	☐ Some Days
Current: Packs/Day _____ # of Years _____			Former: Quit Date _____ # of Years: _____	
Other Tobacco (check one)		☐ Pipe	☐ Vape	☐ Chew
Alcohol use	☐ Never	☐ Occasional	☐ Daily	How many drinks per week?
Do you use marijuana			☐ Yes	☐ No
Have you ever had, or do you have a substance abuse problem			☐ Yes	☐ No

EXERCISE: Type of exercise: _____ Days/Week:_____

Are you currently employed? ☐ YES ☐ NO ☐ RETIRED

Your current occupation:_____ Your usual duties include: _____

Are you involved with Workman's compensation? _____Yes _____No If yes, name and phone number of your case worker?

Primary Language	☐ English	☐ Spanish	☐ Other _____	
Do you need an interpreter?	❑ Yes	☐ No		
Do you use a walking and/or balancing aide?	☐ None	☐ Cane	☐ Walker	☐ Wheelchair
Are there any religious or cultural factors which may impact your care while in the clinic?			☐ Yes	☐ No
☐ If yes, please explain:				
Do you have someone who loves and cares for you?			☐ Yes	☐ No
Do you have a source of joy in your life?			☐ Yes	☐ No
Do you, or anyone you know, need information regarding problems of abuse and/or neglect?			☐ Yes	☐ No

What are your realistic goals for treatment of your pain? (check all that apply)

To be pain free _____ Help living with pain _____ Other _____

Reduced pain _____ Increased activity _____

Thank you for your time in completing this form

Patient Signature: _____ Date: _____