PAIN ASSESSMENT INVENTORY

Patient Name: _____

Age/DOB: _____ / _____ Primary Phone Number: _____

MEDICAL/PAIN HISTORY

Pain Complaint (be brief and specific): _____

_____

When did you first notice your pain? Month _____ Day _____ Year _____

How did your pain begin?

___ Accident at work ___ Motor vehicle accident ___ Following an illness

___ At work, but not an accident ___ Accident at home ___ Following a surgery

___ Pain just began, no reason ___ Other (Please Describe): _____

Is your pain: ___ Constant ___ Intermittent

How often do you go to an Emergency Room for treatment of your pain?

Last ER Visit: Date: _____ Location: _____

What helps your pain to feel better?

_____

_____

List any therapies that you've tried for your pain condition

Please note location of treatment:

Injections	Chiropractic Care	Physical Therapy
Acupuncture	Aqua Therapy	Massage

Other: _____

Please list any physicians you have seen for this pain complaint, including address and approximate date seen:

_____

_____

_____

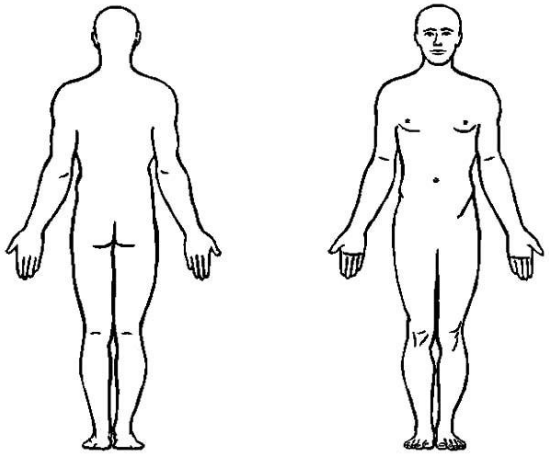
Please draw your pain using the symbols below:

XX = Burning Pain

II = Shooting Pain

AA = Aching Pain

OO = Pins and Needles



WORK HISTORY

Occupation: _____

___ Working full time ___ Student ___ Unemployed

___ Working part time ___ Retired ___ Applying for disability

___ Disabled (If disabled, last day worked) _____

SOCIAL HISTORY

Marital Status: _____ Number of Children: _____

Please list any "street drugs" you currently use (e.g. marijuana, cocaine, heroin, pills, etc.):

_____

Do you use medical marijuana: ___ Yes ___ No

Have you ever been treated for substance or alcohol abuse? ___ Yes ___ No

MENTAL STATUS

___ Stressful situation ___ Nervous breakdown ___ Phobias/excessive fears

___ Thoughts of suicide ___ Depression ___ Hallucinations

___ Schizophrenia ___ Manic depressive disorder (Bipolar) ___ Eating disorder

Have you ever been hospitalized for a nervous or mental condition? ___ Yes ___ No

If yes, date _____ location _____ duration _____

Who is your Primary Care Physician? _____ Phone: _____

Name of person completing form: _____ Date: _____