Patient Pain Assessment Form*

Please complete the information below and return to your healthcare professional. ____/____/____ Date

1. Age: _____ Sex: ☐ Female ☐ Male

2. Has your pain lasted longer than 3 months? ☐ Yes ☐ No
If no, please stop here and return this questionnaire. If yes, complete this form in its entirety.

3. What is the cause of your pain? _____

4. Please rate your pain by circling one number.

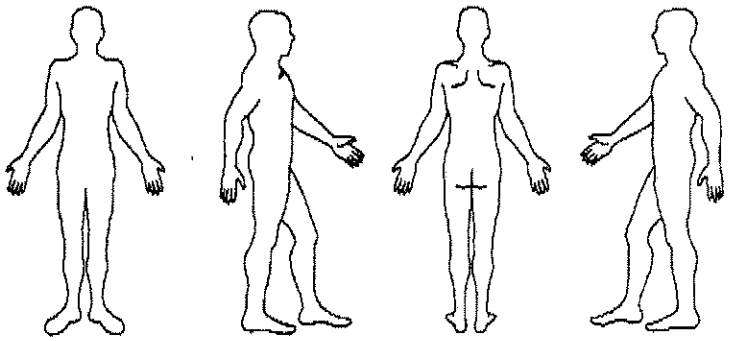
No pain	Mild			Moderate			Moderately severe		Severe	
0	1	2	3	4	5	6	7	8	9	10

5. OTHER MEDICAL CONDITIONS

Have you ever been diagnosed with any of the following conditions?

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Stroke
- ☐ Stomach or ulcerative problems
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Overweight / obesity
- ☐ Depression/ mood disorder
- ☐ Alcohol/ drug abuse
- ☐ Other

6. LOCATION (Mark an 'X' where you usually feel significant pain)



Front Right side Back Left Side

7. EFFECTS OF PAIN

	Always	More than half of the time	Half of the time	Less than half of the time	Never
Trouble falling asleep	☐	☐	☐	☐	☐
Need sleep medication	☐	☐	☐	☐	☐
Awakened from sleep during the night	☐	☐	☐	☐	☐
Awakened from sleep in the morning	☐	☐	☐	☐	☐
Trouble with activities of daily living	☐	☐	☐	☐	☐
Daytime fatigue/lack of concentration	☐	☐	☐	☐	☐

8. MEDICATIONS

What pain medications have you taken in the past (both over-the-counter and prescription)? _____

_____

List ALL pain medications and dose you are currently taking:

		Frequency
_____	Dose _____	☐ Less than once daily ☐ Once daily ☐ 2–3 times daily ☐ 4 times or more daily
_____	Dose _____	☐ Less than once daily ☐ Once daily ☐ 2–3 times daily ☐ 4 times or more daily
_____	Dose _____	☐ Less than once daily ☐ Once daily ☐ 2–3 times daily ☐ 4 times or more daily

PriCara™
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*Adapted from McCaffery M, Pasero C. *Pain: Clinical Manual*, 2nd Edition. St. Louis, MO: 1999, Page 60. Copyright by Mosby, Inc.

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Name _____

Date _____

SHOULDER RIGHT____ LEFT____

When did problem begin? _____

How did problem begin? _____

Are you still working? Yes___ No___

If no, how long have you been off? _____

Did you have previous problems with your shoulder? _____

Do you have pain every day? Yes___ No___

Do you have pain all day? Yes___ No___

Does you shoulder wake you from sleep? Yes___ No___

Do you have neck pain? Yes___ No___

Do you have pain with pushing, pulling, carrying, or lifting? _____

What makes you pain worse? _____

What makes you pain better? _____

Does the pain travel or radiate? Yes___ No___

If yes, where? _____

Can you work with your arm at shoulder level? _____

Can you work with your arm above shoulder level? _____

How does your shoulder interfere with your work? _____

What other activities are you unable to do (Sports, housework, grooming, etc.)? _____

Have you had surgery? _____

Have you had an arthrogram? _____

Have you had a CT scan? _____

Have you had a magnetic resonance scan? _____

Have you had a tomogram? _____

Have you had a somogram? _____

Name _____

SHOULDER

Date _____

P.E.

Inspection

Active: _____

IR _____ NECK _____

ER _____ FF _____

FF _____ ABD _____ ROTATION _____

ABD-FF-IR _____ PASSIVE ABD _____ BEND _____

EXT _____ EXT _____

PAINFUL ARC _____

MOBILITY _____ RHYTHM _____

CREPITATION _____

Resistive

IR _____

ER _____

ABD _____

ADD _____

FORCED ADDUCTION _____

FLEXION _____

EXTENSION _____

SUPINATION _____

PRONATION _____

JAMAR _____ R _____ L _____

	R	L
FOREARM CIRCUMFERENCE		
ARM CIRCUMFERENCE		
ELBOW ROOM		

X-RAY _____ | PLAN _____

Name_____

Date_____

KNEE Right___ Left___

How did the problem occur?_____

How long ago?_____

Are you still working? yes___ No___ If no, when did you stop?_____

Do you have pain every day? Yes___ No___ Sometimes___

Do you have pain all day? Yes___ No___ Sometimes___

Do you have swelling? Yes___ No___ Sometimes___

Do you have locking? Yes___ No___ Sometimes___

Do you have giving away? Yes___ No___ Sometimes___

Do you have pain going upstairs? Yes___ No___ Sometimes___

Do you have pain going downstairs? Yes___ No___ Sometimes___

Do you have pain sitting? Yes___ No___ Sometimes___

Do you have pain walking? Yes___ No___ Sometimes___

Do you have pain standing? Yes___ No___ Sometimes___

Does you knee snap or pop? Yes___ No___ Sometimes___

Are you able to run? Yes___ No___ Sometimes___

Are you able to jump? Yes___ No___ Sometimes___

Are you able to kneel? Yes___ No___ Sometimes___

Are you able to climb ladders? Yes___ No___ Sometimes___

Do you have pain walking on hard surfaces? Yes___ No___ Sometimes___

Do you have pain walking on uneven surfaces? Yes___ No___ Sometimes___

Do you wear a brace? Yes___ No___ Sometimes___

Have you had any problems before this with your knee? Yes__ No__If yes, when did it occur?_

Have you had surgery on your knee? Yes___No___ If yes, when?_____

KNEE

P.E.

Name _____

Date _____

Inspection: _____

Effusion _____ R L

Instability _____ R L

Varus Stress _____ R L

Valgus Stress _____ R L

Lachman _____ R L

A C _____ R L

P C _____ R L

Rotatory _____ R L

Thigh Circ _____ R L

Knee Circ _____ R L

Calf Circ _____ R L

P F Crepitation _____ R L

Pre-Patella Tenderness _____ R L

Sub-Patella Tenderness _____ R L

Dynamic-Patella Compression _____ R L

Supra-Patella Tenderness _____ R L

Para-Patella Tenderness _____ R L

Patella Ligament Tenderness _____ R L

Joint Line Tenderness R MED LAT

Joint Line Tenderness L MED LAT

Range of Motion _____ EXT FLEX

X-rays _____

Plan _____

Name _____

Date _____

NECK

How did problem occur? _____

How long ago? _____

Does pain radiate or travel? _____ Where? _____

Is pain present everyday? Yes_____ No_____ Sometimes_____

Is pain present all day? Yes_____ No_____ Sometimes_____

What makes pain worse? _____

What makes pain better? _____

Do you have headaches? _____

How do you get relief? _____

Are you still working? Yes____ No____ If no, how long have you been off? _____

Have you ever had any other problems before this with your neck? _____

P.E.

Forward Flexion _____

R & L Lat Rotation _____

R & L Lat Bend _____

Extension _____

Mobility _____

Paracervical Spasm _____ ANT _____ POST _____

Ligamentum Nuchae _____

Rhomboids _____

Trapezius _____

Levator _____

DTR'S _____

Sensation _____

Thenar Eminence _____

Hypothenar Eminence _____

Compression _____

Distraction _____

Jamar Grip _____

X-ray: Impression: Plan:

BACK

Name_____
Date_____

When did problem with back begin?_____
Are you working? Yes___ No___ If no, how long have you been off?_____
Have you had any problems before this with your back? Yes___ No___
Do you have pain everyday? Yes___ No___ Sometimes___
Do you have pain all day? Yes___ No___ Sometimes___
What makes pain worse?
Reaching? Yes___ No___
Twisting? Yes___ No___
Bending? Yes___ No___
Leaning? Yes___ No___
Lifting? Yes___ No___
How many pounds can you lift without making pain worse? _____lbs.
Standing? Yes___ No___
How many hours or minutes are you able to stand?_____hours _____minutes
Walking? Yes___ No___
How many miles or blocks or hours or minutes can you walk?____hours ____minutes
____miles ____blocks
Sitting? Yes___ No___
How many hours or minutes are you able to sit?_____hours _____Minutes
Does pain travel or radiate? Yes___ No___
If yes, where?_____
What effect does cold or rainy weather have?_____
What makes pain better?_____
What medications do you take now?_____
Have you had injections for back pain?_____
Do you have bladder problems?_____
Do you have bowel problems?_____
Do you have pain with coughing?_____
Do you have pain with sneezing?_____
Does pain wake you from sleep?_____
How many times have you been hospitalized for your back?_____
When?_____ Hospital?_____
Did you have back surgery? Yes_____ No_____
Have you had myelograms? Yes_____ No_____
Have you had cat scans? Yes_____ No_____
Have you had EMG's? Yes_____ No_____
Have you had an MRI of the back? Yes_____ No_____
Are you seeing a psychologist? Yes_____ No_____
Are you seeing a psychiatrist? Yes_____ No_____
Are you seeing a chiropractor? Yes_____ No_____

Name _____ Date _____

PHYSICAL

Scoliosis _____

Scars _____

Extension _____

Right Lateral Bend _____

Left Lateral Bend _____

Flexion _____

Heel and Toe Lift _____

Mobility _____

Deep Tendon Reflexes _____

Motor Function _____

Sensation Deficit _____

Calf Circumference _____

Thigh Circumference _____

Leg Length Decrepency _____

Sitting Straight Leg Raise _____

Recumbent Straight Leg Raise _____

A. Cervical Flexion _____
B. Dorsi-Flexion _____

Femoral Stretch _____

Palpation _____

A. Muscle _____ Spasm _____ Tenderness _____
   1. Thoracic _____
   2. Lumbar _____
B. Ligaments _____
C. Sciatic Notch _____

Percussion _____

Recovery _____

X-rays Impression Plan

Name _____

ANKLE Right____ Left____

Date _____

When did problem begin? _____

How did problem begin? _____

_____

How many times have you injured your ankle? _____

Do you have pain everyday? Yes____ No____ Sometimes____

Do you have pain all day? Yes____ No____ Sometimes____

How do you get relief? _____

Do you have pain with standing? Yes____ No____ Sometimes____

Do you have pain with walking? Yes____ No____ Sometimes____

Do you have pain with sitting? Yes____ No____ Sometimes____

Do you have swelling? Yes____ No____ Sometimes____

Can you run? Yes____ No____ Sometimes____

Can you jump? Yes____ No____ Sometimes____

Can you climb? Yes____ No____ Sometimes____

Do you have pain walking on uneven surfaces? _____

_____

Do you have pain walking on hard surfaces? _____

_____

Have you had injections of the ankle or foot? _____ How many? _____

Have you had ankle or foot surgery? Yes____ No____ If yes, when? _____

_____

Do you wear a brace, splint, or bandage? _____

Do you use a cane? Yes____ No____ sometimes____

Have you had x-rays of the ankle? Yes____ No____

Have you had a CT scan of the ankle? Yes____ No____

Have you had an MRI of the ankle? Yes____ No____

Have you had an arthrogam of the ankle? Yes____ No____

Have you had a bone scan of the ankle? Yes____ No____

In what way does your ankle interfere with your work? _____

_____

Are you still working? Yes____ No____ If no, how long have you been off?

_____

Name _____

ANKLE

Date _____

P.E. APPEARANCE: _____

Dorsiflexion		R	L
Plantar Flexion		R	L
Eversion		R	L
Inversion		R	L
Circumference			
ANKLE		R	L
CALF		R	L
FOREFOOT		R	L
Anterior Draw		R	L
Posterior Draw		R	L
Varus Stress		R	L
Valgus Stress		R	L
Palpation		R	L
Pulse	DP	R	L
Pulse	PT	R	L

X-ray: Impression: Plan:

Name: _____ Date: _____

WHAT OTHER MEDICAL PROBLEMS DO YOU HAVE AT THIS TIME?

1.	4.
2.	5.
3.	6.

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL DISEASES OR CONDITIONS?

- ☐ Memory Loss
- ☐ Seizures
- ☐ Loss of consciousness/blackouts
- ☐ Stroke or head injury
- ☐ Parkinsonism

- ☐ Major depression
- ☐ Thoughts of suicide
- ☐ Overwhelming life stress
- ☐ Nervous breakdown

- ☐ Difficulty Urinating
- ☐ Urinary tract infection/burning urination
- ☐ Kidney Stones
- ☐ Renal failure

- ☐ Osteoarthritis/Degenerative Arthritis
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Brittle or weak bones/osteoporosis
- ☐ History of bone or joint infections
- ☐ Broken bones or joint injuries
- ☐ Peripheral blood vessel disease
- ☐ Varicose veins
- ☐ Blood clots in your legs, veins or lungs
- ☐ Peripheral nerve injuries/disease

- ☐ Generalized weakness lethargy
- ☐ Undesired weight loss
- ☐ Cancer type _____

- ☐ Hearing Loss
- ☐ Dizzy or Spinning sensations
- ☐ Lightheadedness on standing
- ☐ Poor eyesight or blindness
- ☐ Cataracts or Glaucoma

- ☐ Thyroid disease/goiter
- ☐ Sugar Diabetes
- ☐ Hardening of the arteries
- ☐ Heart attack

- ☐ Irregular heart rhythm
- ☐ High blood pressure
- ☐ Bleeding abnormalities

- ☐ Difficulty breathing/Asthma
- ☐ Bronchitis or emphysema
- ☐ Pneumonia
- ☐ Tuberculosis-you or one you live with

- ☐ Ulcers or Gastritis
- ☐ Stones in gait bladder
- ☐ Jaundice Hepatitis Liver disease
- ☐ Pancreatitis
- ☐ Frequent Diarrhea or constipation
- ☐ Dark tarry stools
- ☐ Skin disease (psoriasis, lupus)
- ☐ Skin ulcers/sores/rash

WHAT MEDICINES DO YOU TAKE BESIDES THOSE FOR YOUR ORTHOPEDIC PROBLEM?

1.	4.
2.	5.
3.	6.

Name: _____ Date: _____

Past Medical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? No Yes
Have any problems with anesthesia? No Yes Describe _____

Family History

Member	Alive	Deceased	Age	Health or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Social History

Work in the home ☐ Employed (occupation _____) ☐ Student
Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Children No Yes #_____
Do you live alone? No Yes
Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
What type of exercise? _____
Are you on a special diet? No Yes What? _____
History of substance abuse? No Yes What? _____
Smoke currently? No Yes ____ packs per day for ____ years
Quit smoking? ☐ this year ☐ > 1 year ☐ > 5 years ☐ > 10 years
Previously smoked ..... _____ packs per day for _____ years.
Drink alcohol? ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ 1-2 x/year

Reviewed By: _____ M.D. Date: _____