Interventional Pain Management
Clinic Walter Reed National Military
Medical Center

Initial Pain Assessment Tool

Name: _____ Date:_____

Sponsor SSN#_____ Age: _____
DOD #_____
Referring Physician: _____ Primary Physician: _____

Have you fallen in the last 6 months? Y/N Were you injured in the fall? Y/N

Please mark the location of your current pain on the diagram below.

Vitals

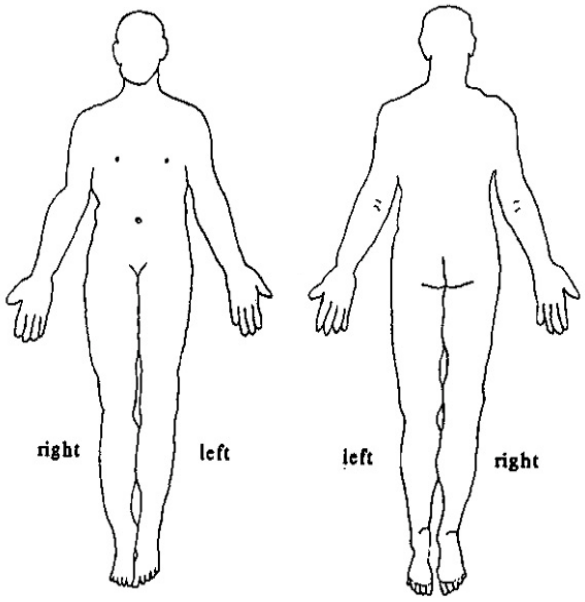
Temp _____
Pulse _____
Blood Pressure_____
SpO_2 _____
Respirations _____

Height _____

Weight _____

Alcohol use Y/N _____

Tobacco use Y/N _____



Have you been deployed since September 11th 2001?
Y/N _____

Could the reason for your visit today in some way be related to your deployment?
Y/N _____

Pain began: _____

Onset:	Sudden	Were you in an accident?	Y/N
	Gradual	Were you injured at work?	Y/N
Pain is:	Stable	Is legal action pending?	Y/N
	Worsen	Is a medical board pending?	Y/N
	Improving	Are you currently working?	Y/N

Pain Severity

Today:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Average Day:
0 1 2 3 4 5 6 7 8 9 10

Worst in the last 2 weeks:
0 1 2 3 4 5 6 7 8 9 10

Best in the last 2 weeks:
0 1 2 3 4 5 6 7 8 9 10

My pain affects my:

(Mark all that apply)

___ Ability to work
Hrs. you work per day: _____
___ Ability to Sleep
Hrs. of sleep per night:_____
___Interrupted
___Uninterrupted
___Use sleep medication
____Recreational activities
____Relationship with family
____Relationship with friends
____Concentration
____**Emotions:**
I am frequently:
____Angry
____Tearful
____Sad
____ Suicidal

Do you have an active plan if suicidal? Y/N
Do you have an active plan to hurt or kill others? Y/N

Please indicate if you are taking any of the following medications.

Coumadin / warfarin
Ticlid / Ticlopidine
Ginkgo or ginkgo balboa
Any other "blood thinner"

Are you allergic to any medications, contrast dye, iodine, or shellfish?

____No, I have no allergies
____Yes, I am allergic to: _____
_____
_____

Please indicate all treatments you have tried to help your pain.

	Did it help? Yes	No
___Physical Therapy	___	___
___TENS unit	___	___
___Ultrasound	___	___
___Chiropractic	___	___
___Acupuncture	___	___
___Massage	___	___
___Biofeedback	___	___
___Psychology / counseling	___	___
___Steroid injections	___	___
___Nerve blocks	___	___

Please list all medications, herbs, and supplements that you are *currently* taking. <u>Include all medications</u>, not just pain medications.

Name of Drug, herb or supplement.	Strength or dosage	How many tablets at a time	How often	Total number of tablets per day	How long you have been taking it	Does it help?

Please list all medications you have taken *in the past* to treat your pain.

Name of Drug, herb or supplement.	How long did you take it?	When did you stop taking it?	Did it help your pain?

Please list all doctors that you have seen for your pain.			
Doctor's Name	Hospital	Phone number	Date you were last seen

Please list all operations or surgery that you have had.

Operation	Date

Please indicate if you have any of the following medical conditions:

___Stroke
___Dizziness
___Blurry vision
___Hearing loss
___Tremors
___Seizures
___Headaches
___Altered taste
___Memory loss
___Numbness of hands or feet

___Heart attack
___Heart failure
___Palpitations
___Irregular heart beat
___High blood pressure
___Chest pain
___Shortness of breath
___Murmurs
___Cancer

___Muscle disease
___Broken bones
___Fibromyalgia
___Myopathy

___Adrenal gland disease
___Diabetes
___Thyroid disease
___Heat intolerance
___Cold intolerance
___Pituitary disease

___COPD
___Tuberculosis
___Coughing blood
___Smoking
___Asthma
___Bronchitis
___Wheezing
___Emphysema

___Ulcer
___Blood in stool
___Hiatal hernia
___Pancreatitis
___Hepatitis
___Liver disease
___Diarrhea

___Blood in urine
___Kidney stones
___Kidney disease
___Loss of bladder control

___Depression
___Bipolar disease
___Schizophrenia

___Easy bruising
___Anemia
___Sickle cell disease
___HIV / AIDS

Interventional Pain Management Clinic
Pain History Matrix and Comfort Goal

Pain Complaint	**Primary Source of Pain**	**Secondary source if applicable**
Location of Pain Example: back, leg, neck, arm, hip, etc.		
Character: (sharp, dull, continuous, radiating, tingling, intermittent, aching, etc.)		
Aggravating factors: (It hurts when I run, bend over, sit, stand, weather, etc.)		
Mitigating factors: (It feels better when I stand, sit, lay down, etc.)		
Alleviating factors: (heating pad, meds, stretching, exercise, swimming, physical therapy, etc.		
Patient Pain Comfort Goal: What pain intensity level that would allow you maximum pain relief while preserving your daily activities.		

Setting Comfort Goals: It is important that you and your medical team help establish a comfort goal. This may be a pain intensity scale from 0-10 or it may be an activity that you are working towards to make your activities of daily living bearable.

Tips on setting comfort goal

* **Be specific**: state what you want to achieve
* Goal should be measurable: example: I want to decrease my pain level from a 7 to 3 in 2 months.
* Attainable: Ask yourself if the goal is reasonable, within reach.
* **Realistic:** Is the goal realistic for you (unfortunately, depending on the underlying cause, 0/10 may not realistic.
* **Trackable:** tracking your progress will encourage you to keep going and reach your goal.