

COLORADO PAIN AND REHABILITATION, PLLC

Pain Self-Evaluation

NAME _____ Date _____
Height/Weight _____ Phone # _____
Birth date _____ Age _____ Occupation _____
Referred by _____ Handedness: LEFT / RIGHT
Social Security # _____ Insurance Name: _____
Email _____ Hobbies _____

Describe any injuries or pain conditions experienced **before current** injury. _____

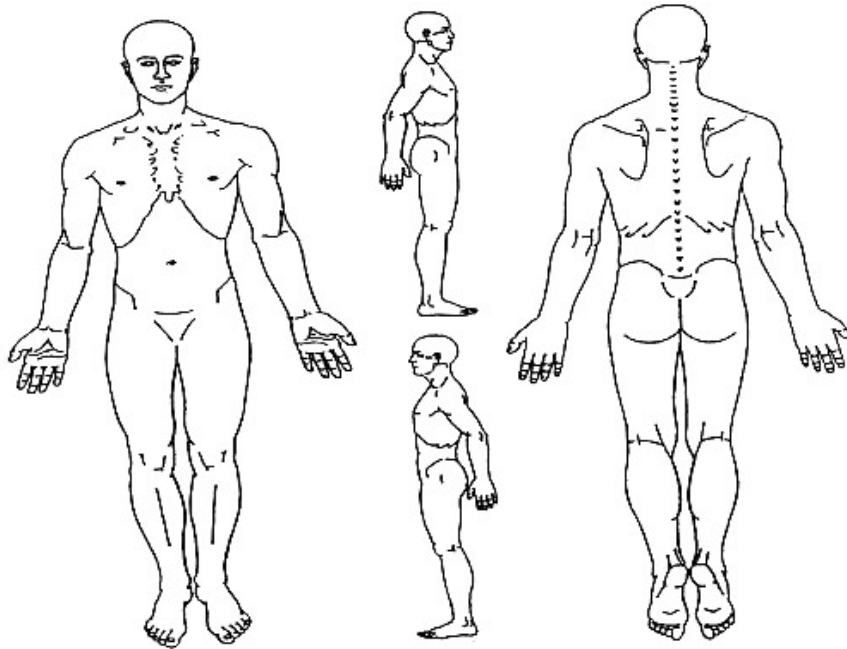
What actions have you taken to get better? _____

Date of injury _____
Where did injury occur? Slip ___ Fall ___ Hit ___ Other _____
Describe **in detail** how injury occurred: _____

Auto Accident describe **in detail**: _____

Pain Diagram: Mark the areas on the diagram where you feel your pain.
Use appropriate symbol to indicate the character of the pain:

- A = ACHE
- B = BURNING
- N = NUMBNESS
- P = PINS AND NEEDLES
- S = STABBING
- T = THROBBING



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How long does you pain last daily?

1-4 hrs/day _____ 4-8 hrs/day _____ 8-12 hrs/day _____ 12-24 hrs/day _____

When is your pain the worst?

Morning _____ Afternoon _____ Evening _____ Nighttime _____

What makes your pain better? (circle) Ice Heat Rest Medications

What makes your pain worse? _____

How long can you presently (in minutes)

Sit continuously _____ Stand continuously _____

Drive continuously _____ Walk continuously _____

What limitations do you have? _____

Have you ever seen a chiropractor before? If yes, when _____

Have you ever had acupuncture? If yes, when _____

Did your pain decrease or increase? _____

If increase, where and how long did your pain last? _____

On a scale of 0-10: (Over the last month)

0=No Pain 1=Pain which does not interfere with daily activities 10=Suicidal Pain

What is your pain today? 0 1 2 3 4 5 6 7 8 9 10

What is your least pain? 0 1 2 3 4 5 6 7 8 9 10

What is your most pain? 0 1 2 3 4 5 6 7 8 9 10

What is your activity level? 0 1 2 3 4 5 6 7 8 9 10

Current Medications:

Name

Dosage

Frequency

What non-prescription medicines and/or vitamins do you take?

Allergies:

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Surgical History

Date	Operation	Doctor
_____	_____	_____
_____	_____	_____

Past Medical History (Include past pregnancies)

Date	Illness
_____	_____
_____	_____

Past Psychological History

Have you ever been treated for a psychological condition?

Date	Name	Reason
_____	_____	_____

Do you currently have any of the following? (Circle all that apply)

- | | | |
|---------------------|------------------------|-------------------|
| High blood pressure | Tuberculosis | Glaucoma |
| Heart Attack | Cough up Blood | Cancer |
| Stroke | Seizures | Anxiety |
| Swollen Ankles | Alzheimer's | Depression |
| Frequent Fainting | TMJ Problems | Bleeding Problems |
| Hepatitis | Insomnia | Easy Bruising |
| Ulcers | Kidney Problems | Memory Problems |
| Thyroid Disease | Difficulty Urinating | Visual Problems |
| Diabetes | Bowel Problems | Headaches |
| Pancreatitis | Arthritis | Weight Loss |
| Emphysema | Stiff & Swollen Joints | Weight Gain |
| Asthma | Sexual Problems | Night Sweats |
| Knee Pain | Back Pain | Muscle Pain |

Occupational History:

Are you working?

Full Duty? _____ or WITH RESTRICTIONS? _____ or NOT WORKING? _____

When was the last date you worked full time? _____

Have you ever had a previous worker's comp injury? YES NO

If yes, what was your impairment rating? _____

Describe your current job: _____

How long have you held this job: _____

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List all occupations/jobs that you have held in the last 5 years:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Do you currently receive wage compensation or disability income? YES NO
If yes, how much? _____

Do you have an attorney involved in your case? YES NO
If yes, briefly explain: _____

Social History

Are you married? _____ Single? _____ Divorced? _____ Widowed? _____

Do you smoke or have you ever smoked? YES NO
If yes, how many years? _____ Packs per day? _____
When did you quit? _____

Do you use caffeine products (coffee, tea, colas)? YES NO
If yes, how much? _____

Do you drink alcohol? YES NO If yes, how much? _____
Have you ever been treated for alcohol or other substance abuse? YES NO
If yes, what treatment? _____

Level of Education (Circle One):

- | | |
|-----------------------|------------------------------|
| Less than High School | High School or GED |
| Some College | College Degree |
| Advanced Degree | Vocational Training in _____ |

Family History:

Has anyone in your family had any chronic pain or chronic illness: YES NO
If yes, please explain: _____

Patient Signature

Date

