GREENVILLE HEALTH SYSTEM

Today's Date_____ Patient Name _____ DOB_____

Referring Physician: _____ Who is your Primary Care Provider?_____
In your own words, why were you referred to our office?
_____

Pain Assessment
When did you first notice this pain? (mm/dd/yyyy): _____/_____/_____

Please describe how your pain first started: _____

Rate your pain level below using a scale of 0-10 (0 is no pain at all and 10 is the worst pain you can imagine):

Current Pain Level _____ Lowest Pain Level (good day)_____ Worst Pain Level (bad day) _____ Average Pain Level _____

Have you received treatment from another pain management specialist? € Yes € No
If Yes, from which physician or facility name? _____

Do you receive financial compensation because of your pain? € Yes € No
If yes, check all that apply: € Worker's Comp € Private insurance € Disability € Other:-
_____

Previous Pain Treatments: (Check all that apply)
€ Injections € Nerve Block € Acupuncture € TENS € Chiropractor € Surgery € Psychotherapy € Biofeedback € Exercise € Massage Therapy € Support (Splint, Brace, Cervical Collar, Sling, Prosthesis) € Other_____

Have you tried Physical Therapy? € Yes € No
If Yes, when and at what facility?_____

Symptoms (check all that apply):

My pain is:	**Pain is worse:**	**Does your pain make you:**
€ Constant	€ In the morning	€ Depressed
€ Frequent	€ In the evening	€ Angry
€ Intermittent	€ Same all day	€ Frustrated
€ Occasional	€ Varies day to day	€ Helpless/Hopeless

What does your pain feel like?
€ Throbbing € Shooting € Stabbing € Burning € Sharp € Tingling € Dull € Numb € Aching € Tender

What makes your pain increase?
€ Sitting € Standing € Lying Down € Sneezing € Lifting € Exercising € Walking € Coughing € Straining in restroom

What makes your pain decrease?
€ Sitting € Standing € Walking € Lying Down € Medications € Exercising € Alcoholic drinks € Heat € Cold € Nothing

What does your pain interfere with?
€ Sleep € Daily Activities € Work € Nothing

Which of these is related to your pain?
€ Numbness or loss of feeling € Weakness € Tingling (pins and needles) € Muscle spasms € Swelling
€ Change in skin color € Bowel or Bladder problems € Increased temperature or warmth € Decreased temperature or coolness

Psychosocial History:

Have you ever been physically abused? € Yes € No Have you ever been sexually abused? € Yes € No

Have you ever been treated for: € Anger € Depression € Anxiety € Suicidal Ideation

Do you use Recreational Drugs? € Yes € No If Yes, please list:_____

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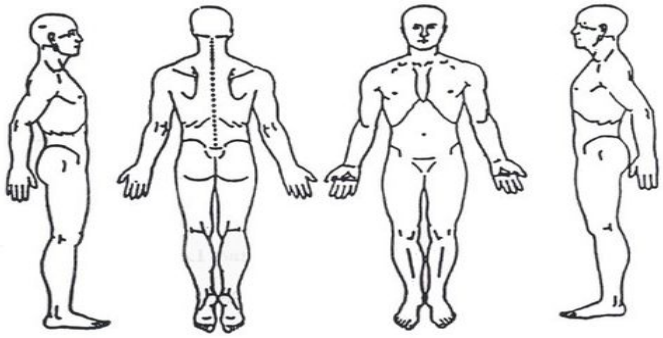
Social History:

Do you work? € Yes € No Occupation/Description:_____

Do you have children? € Yes € No If Yes, how many?_____

I live: € Alone € With Spouse € With Children € Other:_____

Please shade in on the diagram in the areas where you have pain. Mark the areas where pain begins with an 'X'.



Diagnostic Tests:	**Date**	**Facility**
MRI	_____	_____
CT Scan	_____	_____
X-Ray	_____	_____
EMG	_____	_____
Nerve Conduction Study	_____	_____
Other: _____	_____	_____

Review of Systems: In the last 6 weeks or since your last visit, have you experienced any of the following?

Constitution
- € Activity change
- € Appetite change
- € Chills
- € Excessive sweating
- € Fatigue
- € Fever
- € Unexpected weight change

Ear, Nose, Throat
- € Congestion
- € Dental Problems
- € Drooling
- € Ear discharge
- € Ear Pain
- € Facial Swelling
- € Hearing loss
- € Mouth Sores
- € Nosebleeds
- € Postnasal Drip
- € Runny nose
- € Sinus Pressure
- € Sneezing
- € Sore Throat
- € Ringing in ears
- € Trouble swallowing
- € Voice change

Eyes
- € Eye discharge
- € Eye itching
- € Eye pain
- € Eye redness
- € Light sensitivity
- € Visual disturbance

Respiratory
- € Apnea
- € Chest tightness
- € Choking
- € Cough
- € Short of Breath
- € Noisy breathing
- € Wheezing

Cardiovascular
- € Chest pain
- € Leg swelling
- € Palpitations

Gastrointestinal
- € Abdominal bloating
- € Abdominal Pain
- € Anal bleeding
- € Blood in stool
- € Constipation
- € Diarrhea
- € Nausea
- € Rectal Pain
- € Vomiting

Endocrine
- € Cold intolerance
- € Heat intolerance
- € Excessive thirst
- € Excessive hunger
- € Excessive urination

Genitourinary
- € Difficulty urinating
- € Painful urination
- € Urinary Incontinence
- € Flank pain
- € Frequent urination
- € Genital sores
- € Blood in urine
- € Penile discharge
- € Penile pain
- € Penile swelling
- € Scrotal swelling
- € Testicular pain
- € Urinary urgency
- € Urine decreased

Musculoskeletal
- € Joint pain
- € Back pain
- € Difficulty walking
- € Joint swelling
- € Muscle pain
- € Neck pain
- € Neck stiffness

Skin
- € Color change
- € Extreme Paleness
- € Rash

Allergy/Immunology
- € Environment allergies
- € Food allergies
- € Immunocompromised

Neurological
- € Dizziness
- € Facial asymmetry
- € Headaches
- € Light headedness
- € Numbness
- € Seizures
- € Speech difficulty

€ Fainting
€ Tremors

Hematologic

€ Swelling
€ Bruises easily

Psychiatric

€ Agitation
€ Behavior problems
€ Confusion
€ Decreased concentration