Ayman Basali, MD., Msc

Pain Management Institute Interdisciplinary Initial Evaluation

Name_____ DOB:_____ Date:_____

Age:_____ Gender:_____ Primary Care Physician:_____ Referred by:_____

Chief Complaint/ Reason for Visit/Pain history (See Pain Picture):_____

_____

_____

History of Present Illness:
Date of Onset:_____
☐Following illness, surgery
☐Pain "just began"
☐Accident at _____
☐Was Bureau of Worker's Compensation
Claim filed? No Yes
Last day worked_____

Past Diagnostic Tests:
☐MRI/CAT Scan_____
☐X-rays_____
☐EMG _____
☐Labs_____
☐Other _____
☐Current Infection _____Yes ____No

Past Treatments:
☐Blocks_____
☐Physical Therapy/Massage
☐Manipulation
☐Trigger Pointe Injection
☐Acupuncture
☐Medications
☐Physicians who treated my pain

☐Recent Fracture _____Yes ____No If yes, location_____ ☐Litigation related to Back Injury _____Yes_____No

Primary Pain/Intensity:
Location:_____
Radiates to:_____
_____/10 present
_____/10 worst
_____/10 best

Quality:
☐aching
☐dull
☐sharp
☐burning
☐throbbing
☐stabbing
☐ Electric Sensation

Duration: Exacerbation Factors:
☐continuous ☐unknown
☐intermittent ☐bending
☐occasional ☐standing
☐ Brief/momentary ☐sitting
☐ Night ☐Day Time ☐walking
☐lifting
☐weather

Alleviating Factors:
☐unknown
☐medication
☐rest
☐heat
☐ice
☐other_____

Other pain/Intensity:
Location:_____ _____/10 present_____/10 worst_____/10 best
Patient Pain Goal:_____/10 ☐radiates to _____

Accompanying Symptoms:
☐Not applicable (N/A)
☐Nausea
☐Headache
☐Dizziness
☐Tripping/Falling
☐Dropping Objects
☐Tingling
☐Numbness_____
☐Weakness
☐Muscle pains
☐Spasms
☐Stiffness
☐Decreased sphincter control
☐Other_____

Joint Swelling of: ☐N/A
☐hand: right left
☐back: neck thoracic lower
☐knee: right left
☐ankle: right left
☐other_____
☐ N/A

Joint Pains of: ☐N/A
☐hand right left
☐back: neck thoracic lower
☐hips: right left
☐knee: right left
☐ankle: right left
☐ N/A

Psychological:
☐Alert and oriented x 3
☐Mood, affect appropriate
☐Anxious, upset

Sleep Patterns:
☐No problems
☐For most part is adequate
☐Not sleeping well secondary to pain
☐ Awakes due to ☐Pain ☐Urination ☐Other:_____

Past Medical History:
☐Arthritis ☐Raynauds
☐Heart Disease ☐Asthma
☐Hypertension ☐Migraines
☐Stroke ☐Crohns
☐Diabetes ☐Cancer
☐ Unexplained Wt. Loss ☐Hx of back pain

Surgery:
☐Tonsillectomy ☐Hysterectomy
☐Hernia Repair ☐Gall Bladder
☐Appendectomy ☐Laminectomy: Cervical, Thoracic, Lumbar
☐Other:_____
☐ Spine Surgery:_____
☐ Other:_____

Over

Ayman Basali, MD., Msc

Interdisciplinary Initial Evaluation

Name:_____ DOB:_____ Date:_____

Allergies/Reactions: ☐None Known ☐Allergic to: _____

Present: Medications ☐See Medication Summary ☐N/A

Last Dose Pain Medications:_____

Past Pain Medications:_____

_____

Family History:

☐Arthritis ☐Cardiovascular ☐Hypertension ☐Stroke ☐Diabetes

☐Raynauds ☐Asthma ☐Migranies ☐Crohns ☐Cancer

☐Other_____

Review of Systems:

General:
☐Not Applicable (N/A)
☐Fatigue
☐Fever/Chills
☐Night Sweats
☐Adenopathy
☐Weakness
☐Anorexia
☐Weight Loss
☐Weight Gain

Skin:
☐N/A
☐Rash
☐Major Rash
☐Dry Mucosa
☐Mucosal Ulcers
☐Alopecia
☐Photosensitivity

Heart/Lung
☐N/A
☐Cough
☐Wheeze/Phlegm
☐Dyspnea
☐SOB on Exertion
☐Chest Pains
☐Palpitations
☐Chest Pressure
☐Pleuritic Pains
☐Orthopneic
☐Pulmonary Embolism

GI:
☐N/A
☐Nausea
☐Vomiting
☐Diarrhea
☐Constipation
☐Dysphagia
☐Gastric Reflux
☐Gastritis
☐Peptic Ulcer
☐Colitis
☐Abdominal Pains
☐Hematemesis/Melena

GU
☐N/A
☐Frequency
☐Urgency
☐Dysuria
☐Nocturia
☐Hematuria

Heme:
☐N/A
☐Anemia
☐Bleeding
☐Bruising
☐Leukopenia
☐Phlebitis

Endo:
☐N/A
☐Thyroid
☐Goiter

Neuro:
☐N/A
☐Sleep Disturbance
☐Seizures
☐Memory Loss
☐Cognition
☐Balance
☐Decreased Range of Motion
☐Psychosis

HEENT:
☐N/A
☐Headaches
☐Vertigo
☐Neuropathy

Skeletal:
☐N/A
☐Muscle Weakness
☐Muscle Pains

Psychosocial History:

Marital Status:
☐Single
☐Married
☐Widowed
☐Divorced

Occupation:_____ Education:_____
☐Employed or Houseperson
☐Unemployed
☐Disabled – Do you have any other workers compensation claims? ☐No ☐Yes_____
☐Retired

Do you feel safe at home? ☐No ☐Yes

Do you have any special cultural or religious practices that will effect medical treatment? ☐No ☐Yes

_____

Have you smoked within the last 12 months? ☐No ☐Yes How to Quit Smoking pamphlet given? ☐No ☐Yes

Date:_____ Time:_____ Nurse Signature:_____

PLEASE LIST ANY ADDITIONAL INFORMATION OR COMMENTS ABOUT YOUR PAIN PROBLEMS