BETTER LIVING Rx
Compounding Pharmacy and Wellness Center

Patient Name:___________________________

Pain Assessment

Male/Female Age: _____ years Height: ______ ft _____ in Weight: _____ lbs

Please List Any/All Allergies ____

What is the main problem for which you are seeking treatment? ______________________

____

When your current pain started, was there a precipitating event? (circle one):

Automobile accident Work Injury Surgery Sports Other ______________

How long have you had your current pain problem? ______ years, ______ months

Describe what the pain feels like: ____

How do the following affect your pain? (Please check one for each item.)

Lying down:	_____ Decrease	______ No Effect	_____ Increase
Standing	_____ Decrease	______ No Effect	_____ Increase
Sitting	_____ Decrease	______ No Effect	_____ Increase
Walking	_____ Decrease	______ No Effect	_____ Increase
Exercise (if applicable)	_____ Decrease	______ No Effect	_____ Increase
Medication	_____ Decrease	______ No Effect	_____ Increase

Are there other factors that make your pain…

Better? (please list) ____

Worse? (please list) ____

Please rate your pain intensity on a scale from 0 = no pain to 10 = excruciating, incapacitating worst pain possible. Write the number (from 0-10) in the spaces below:

- Your pain at its worst in the past month or since your injury ______
- Your pain at its least in the past month or since your injury ______
- Your current pain ______

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How often do you have your pain? (please check one below)

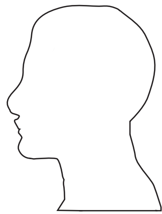
_____ Constantly (100% of the time)

_____ Nearly constantly (60% to 95% of the time)

_____ Intermittently (30% to 60% of the time)

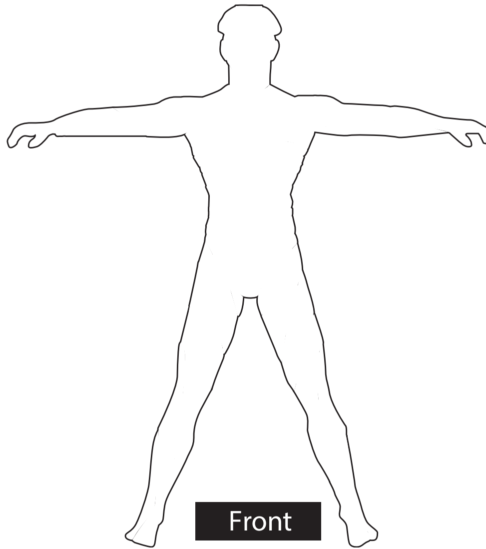
_____ Occasionally (less than 30% of the time)

Below - please indicate the location of pain.

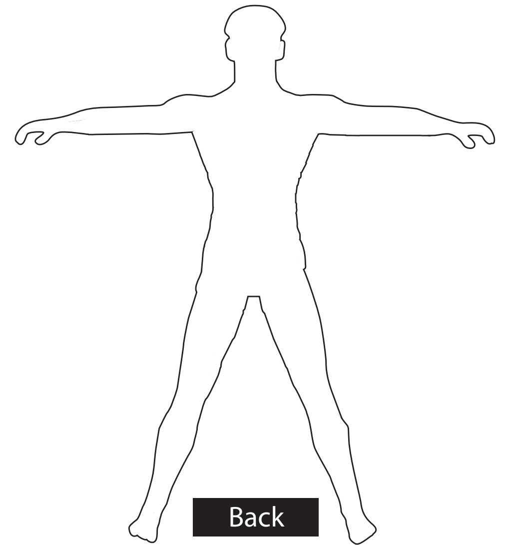


Left side

Right side



Front



Back

Circle the number that best describes your pain now.
0 = No Pain; 10 = Worst Imaginable Pain

0	1	2	3	4	5	6	7	8	9	10

C O N F I D E N T I A L
for evaluation and treatment purposes ONLY!

Coping Information

Have you ever experienced any physical, emotional or sexual abuse? Yes No

If yes, explain: ______________________________

Have you ever had psychiatric, psychological, or social work evaluations for any problem, including your current pain? Yes No

If yes, what and when? ______________________________

Have you ever been in treatment for misuse of alcohol, illicit drugs or prescribed medications? Yes No

If yes, where and when? Location: ______________ Date: ______________

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Medication List

Name of Medication and Dosage	Date first prescribed	Daily amount taken	Reason for medication	Physician Name	Did this help with your pain? (Put an "x" by all that helped)

Please circle all of the treatments you have tried (or are currently using) for your pain.

Physical Therapy
Acupuncture
Massage Therapy
TENS Unit
(Transcutaneous Electrical Nerve Stimulation)
Chiropractor
Surgery
Spinal Cord Stimulator
Cognitive Behavior Therapy

Biofeedback
Hypnosis
Nerve Block
Trigger Point Injections
Rehabilitation
Radio Frequency Lesioning
Nutritional Supplements
Dietary Changes

Other: ______________________________

____

____

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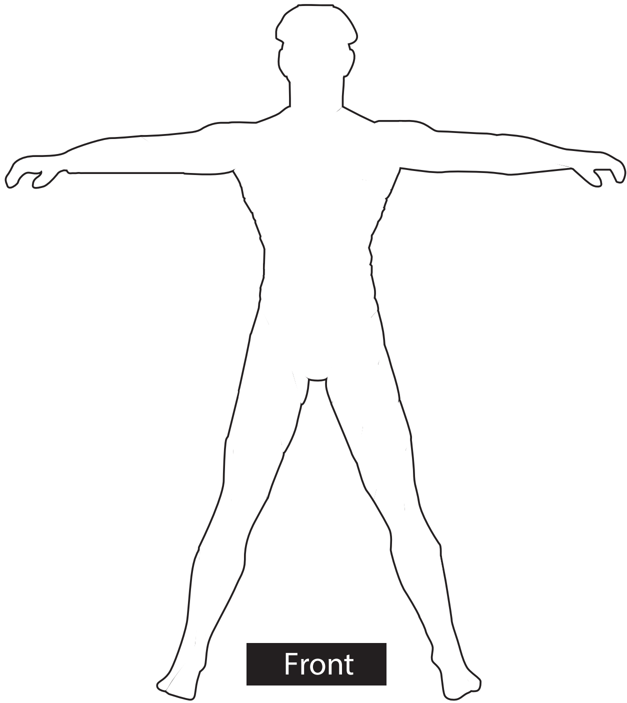
Initial Consultation Form

Date ____________________

Patient Name ____

Below - please shade in the areas of pain.



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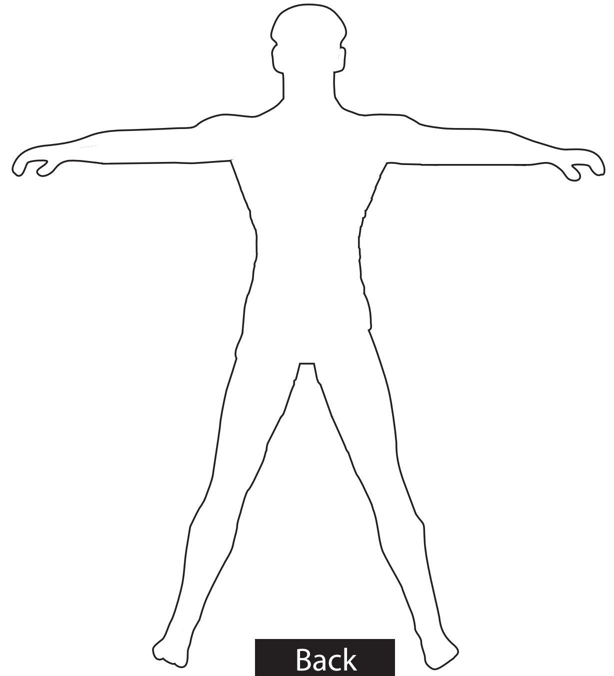
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Back

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Therapy Instructions/Adjustments____

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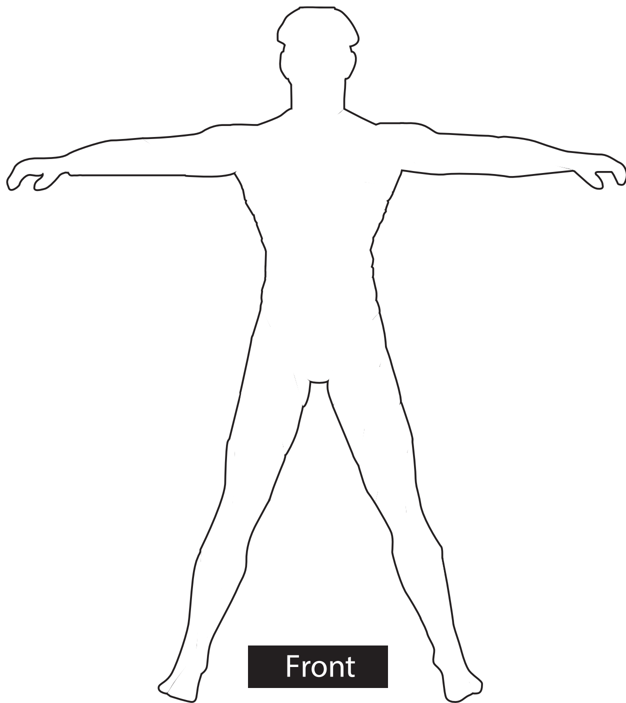
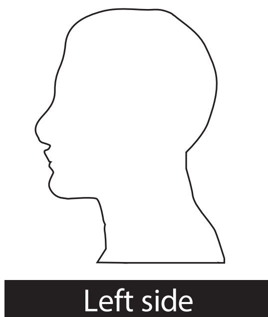
Patient Re-Evaluation Form

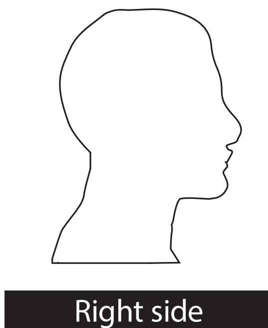
Date ____________

Patient Name ______________________________

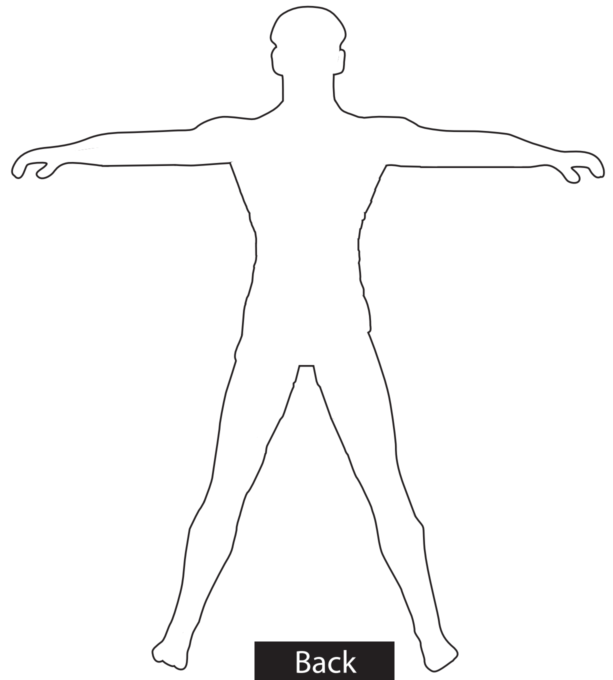
Below - please shade in the areas of pain.

Left side



Right side



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Therapy Instructions/Adjustments______________________________

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