TEXAS PAIN CENTERS
3519 TOWN CENTER BLVD, SUITE B
SUGAR LAND, TX 77479
PHONE: 832-730-PAIN (7246)
FAX: 844-302-5696

Initial Assessment

Name:

_____

Date of Birth: _____ Daytime Phone _____

Cell Phone_____ E-mail_____

Insurance Company Name _____ Effective Date_____

Address of Insurance Company

_____

Phone Number of Insurance Company _____

Group #_____ SSN:_____

Policyholder's Name _____

Policy #_____

Policyholder's
address_____

Relationship to Participant _____

Referring Physician: _____

Primary Care Physician: _____

Person(s) to be contacted in case of Emergency:

Name _____ Relationship_____

Address _____

Daytime Phone _____ Cell Phone_____

Name _____ Relationship_____

Address _____

Daytime Phone _____ Cell Phone_____

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PAIN HISTORY

(Please answer all questions)

What do you think caused the pain?

_____

_____

_____

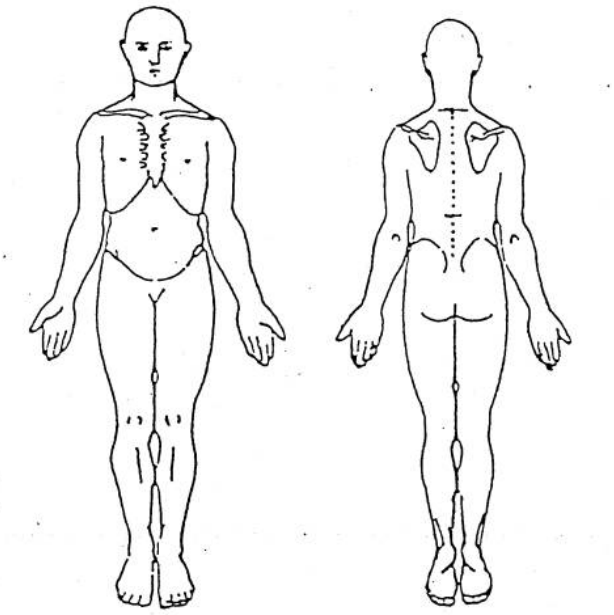
How long have you had the pain?

_____

Is your pain associated with: (1) an auto accident? Yes ☐ No ☐ (2) Workers comp? Yes ☐ No ☐

Are you involved in any litigation? Yes ☐ No ☐

Shade the areas where you feel pain. Put an **X** on the area that hurts the most or list details:



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Note the terms that describe your pain:				
Quality	**None**	**Mild**	**Moderate**	**Severe**
Ache	☐	☐	☐	☐
Pressure	☐	☐	☐	☐
Sharp	☐	☐	☐	☐
Dull	☐	☐	☐	☐
Stabbing	☐	☐	☐	☐
Pulling	☐	☐	☐	☐
Squeezing	☐	☐	☐	☐
Twisting	☐	☐	☐	☐
Throbbing	☐	☐	☐	☐
Burning	☐	☐	☐	☐
Cold	☐	☐	☐	☐
Numb	☐	☐	☐	☐
Tingling	☐	☐	☐	☐
Electric	☐	☐	☐	☐
Tiring	☐	☐	☐	☐

Please Answer the following:

Do you feel pain all the time? Yes ☐ No ☐

Does the pain come and go? Yes ☐ No ☐

Do you have: -

- Weakness Yes ☐ No ☐
- Skin color changes Yes ☐ No ☐
- Unusual swelling Yes ☐ No ☐
- Feelings of hot or cold Yes ☐ No ☐
- Unusual sweating /dry skin Yes ☐ No ☐

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Your pain **increases** with: (i.e. bending, walking, lifting, coughing) Yes ☐ No ☐

_____

_____

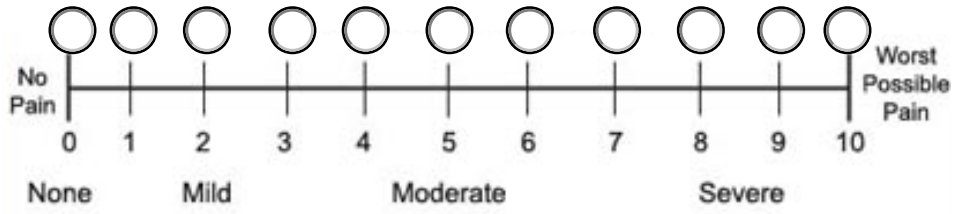
Your pain **decreases** with: (i.e. rest, heat, medications) Yes ☐ No ☐

_____

_____

Pain ratings. Please circle the number that best describes your pain: 0= No pain at all; 10= Worst pain you can imagine.

How has your pain been in the past week?



Please circle the number that describes how much pain interferes with the following areas.
0=Pain does not interfere at all 10=Pain completely limits the item.

Activity |---|---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

Sleep |---|---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

Good mood |---|---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

Appetite |---|---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

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Prior Pain Treatment	Yes	No	When? (Year)	Did it help? Yes	Did it help? No	Where was the procedure done and who did it?
Physical Therapy	☐	☐		☐	☐	
Steroid Injections	☐	☐		☐	☐	
Nerve Blocks	☐	☐		☐	☐	
Relaxation or Biofeedback	☐	☐		☐	☐	
Anti-inflammatories (which ones)	☐	☐		☐	☐	
Narcotics (which ones)	☐	☐		☐	☐	
Other medications (Which ones)	☐	☐		☐	☐	
Other (please specify)	☐	☐		☐	☐	

Diagnostic Tests	Yes	No	Date	Where was it done?
X-rays	☐	☐		
Cat Scans	☐	☐		
MRI Scan	☐	☐		
Nerve Conduction	☐	☐		
Other	☐	☐		

(**Note**: Please bring **ALL** Results/Reports with you to the appointment)

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Health History

Height: - _____ Weight: - _____

Allergies: - (**Please List All**)

_____

_____

_____

List ALL medications taken routinely in the past month:

Medications	Dose & time	Medications	Dose & time

Previous Surgeries	Date	Procedure	Where was it done?

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Are you on Blood Thinners? Yes ◯ No ◯

If you circled **Yes**, then please provide the reason: -

_____

_____

Do you:	**Yes**	**No**	**Comments**
Smoke?	☐	☐	If yes, how much?
Drink Alcohol?	☐	☐	If yes, how much?
Do you have a history of drug abuse?	☐	☐	
Have you experienced any recent changes in			
• Weight	☐	☐	
• Appetite	☐	☐	
• Sleep patterns	☐	☐	
Do you have any problems with:			
Heart			
• High blood pressure	☐	☐	
• Chest pain (angina)	☐	☐	
• Heart attack	☐	☐	
• Abnormal Heart Rhythm	☐	☐	
• Other	☐	☐	
Lungs			
• Cold or flu in the past 2 weeks	☐	☐	
• Asthma/wheezing in the past year	☐	☐	
• Shortness of breath	☐	☐	
• Other	☐	☐	

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	Yes	No	Comments
Urinary • Kidney or bladder disease • Urinary tract infection in the past month • Other	☐ ☐ ☐	☐ ☐ ☐	
Do you need assistance walking? (e.g. cane)	☐	☐	
Digestive • An ulcer or frequent heart burn • Other	☐ ☐	☐ ☐	
Muscle or bone • Arthritis **Neurological** • Stroke • Convulsions/epilepsy/seizures • Other	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Do you have diabetes?	☐	☐	If yes, how long?
Do you have endocrine (hormone) disease?	☐	☐	
Blood • Excessive bleeding problems • Other (Deep vein thrombosis, pulmonary embolism etc.)	☐ ☐ ☐	☐ ☐ ☐	
Do you have an immune disorder?	☐	☐	

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	Yes	No	Comments
Did you ever have • Cancer? • Chemotherapy/radiation therapy?	☐ ☐	☐ ☐	If yes, specify type: -
Do you have any other medical problems?	☐	☐	
Do you have any psychiatric problems? • Do you have depression? • Do you have anxiety?	☐ ☐	☐ ☐	If yes the date of onset: If yes the date of onset: Are you being treated for depression? Yes ☐ No ☐ Are you being treated for anxiety? Yes ☐ No ☐

Family Medical History

	Status **A**live / **D**eceased	Any medical problems?
Mother		
Father		
Siblings		
Children		
Husband		
Wife		

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Work and Social Survey

Occupation: -

_____

Currently working: _____hours/week

Do you have any work restrictions? Yes ☐ No ☐

_____

_____

What is the highest level of education you have completed?

_____

Do you live alone? Yes ☐ No ☐ If no, with whom?_____

Do you have people nearby who support you emotionally? Yes ☐ No ☐

Have you experienced violence in your life or relationships? Yes ☐ No ☐

If so, when and what type? _____

_____

Have you received mental health care? Yes ☐ No ☐ If yes, when & from whom?

_____

_____

Have you ever abused drugs / medications? Yes ☐ No ☐ If yes, when & what?

_____

_____

Have you enrolled in a detoxifications / addiction treatment program? Yes ☐ No ☐ If yes, give details:_____

_____