McLaren Flint
Flint, MI

SURGERY AND ENDOSCOPY CENTER
PAIN CLINIC

PATIENT ASSESSMENT

Name:_____ **Age:** _____**Date:** _____

Family Physician:_____ **Referring Physician: Dr.**_____

Current Pain Problem(s): _____

What issues or concerns would you like to focus today? ☐ Prescription refill ☐ Post procedure follow up

Other:_____

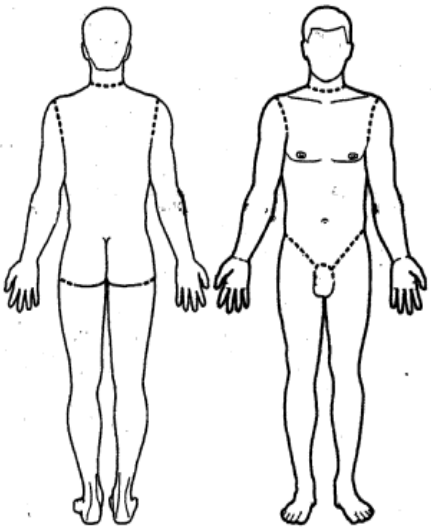
_____

Have you had any new medications / surgeries since last visit? ☐ No ☐ Yes_____

Are you taking your medication as prescribed? ☐ No ☐Yes

Are you getting any pain medication from others? ☐ No ☐ Yes

Mark the areas of PAIN below: **<u>In a scale of 0 to 10,</u>**



Pain level today:_____**Pain level usually at:**_____

Comparing with last visit, your pain level:

☐ Much Improved ☐ Improved ☐ No change ☐ Worse

Is your pain relief adequate? ☐ No ☐ Yes

Any additional/new stressors/factors that could influence your pain level? ☐ Yes ☐ No , explain: _____

Social history: Working: ☐ No ☐ Yes

Tobacco: ☐ No ☐ Yes, pack per day: **Alcohol:** ☐ No ☐ Yes

Illicit Drugs: ☐ No ☐ Yes ____☐ Marijuana ☐ Cocaine ☐ Heroin

☐ Other Drugs: _____ ☐ Last time used: _____

For patient with child-bearing age: Are you pregnant? ☐ No ☐ Yes

PATIENT SIGNATURE:_____ ***DATE/TIME:***_____

PT.

MR.#/P.M.

DR.