



COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

9834 Genesee Avenue, Suite 411, La Jolla CA 92037
15725 Pomerado Road Suite 107 Poway CA 92064
Phone (858) 453-7700 Fax (858) 798-1225

INITIAL EVALUATION

(1) Referring Physician: _____

(2) Patient ID # _____ (3) Your appointment is with Dr. Chris Chisholm

PATIENT INFORMATION

(4) _____ (5) Sex: Male Female
Last Name First M.I.

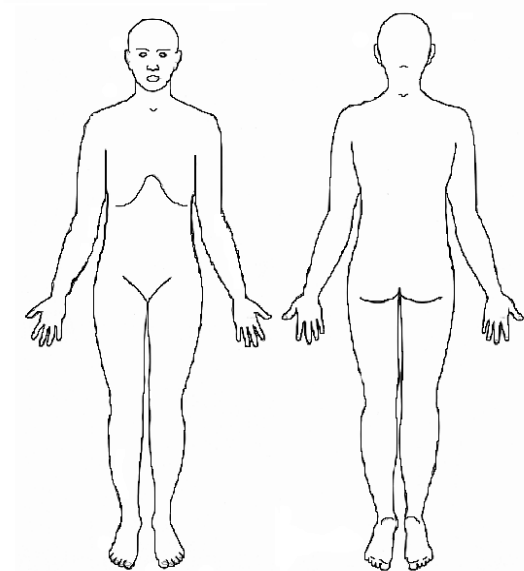
(6) Appointment Date _____ (7) Date of Birth (mm/dd/yyyy): _____ (8) Age _____

(9) Primary Care Physician (if not the same): _____

ABOUT YOUR PAIN

(10) What is the main problem for which you are seeking treatment with Comprehensive Pain Management Specialists?

Please mark the area(s) in which your pain is located:



For office use only: C: _____ C/PT: _____ C/TDD: _____

Patient Name _____



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ONSET OF PAIN AND DURATION

(11) Briefly describe when and how your current pain started?

TIMING OF PAIN

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

- Constantly (100% of the time)
- Frequently (75% of the time)
- Intermittently (50% of the time)
- Occasionally (25% of the time)

PAIN QUALITY

(13) How would you describe the pain (choose as many adjectives as are applicable)?

- Burning Sharp Cutting
- Throbbing Cramping Numbness
- Dull, aching Pressure Pins and needles
- Shooting Electric-like Other

PAIN INTENSITY

(14) Circle your current pain intensity with “0” representing no pain and “10” representing the most severe pain imaginable:

0 1 2 3 4 5 6 7 8 9 10

(15) Circle your average pain the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

(16) Circle your best pain score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

(17) Circle your worst pain score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

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RELIEVING AND AGGRAVATING FACTORS

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

	(18) Decrease	(19) Increase	(20) No Change
Lying down			
Standing			
Sitting			
Walking			
Exercise (if applicable)			
Medications			
Relaxation			
Thinking about something else			
Coughing/Sneezing			
Urination			
Bowel movements			

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

Treatment	Date (approx.)	(21)	(22)	(23)
		Excellent Relief	Moderate Relief	No Relief
Hospital bed rest				
Traction				
Surgery				
Hypnosis				
Acupuncture				
Nerve block/injections				
TENS				
Physical therapy				
Exercise				
Heat treatment				
Biofeedback				
Psychotherapy				
Chiropractic				
Other				

FUNCTIONAL LIMITATIONS

(24) During the past month, place a check mark next to the activities that you avoided because of pain:

- Going to work
- Performing household chores
- Doing yard work or shopping
- Socializing with friends
- Participating in recreation
- Having sexual relations
- Physically exercising
- Driving
- Caring for self

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(25) How many blocks can you walk before having to stop due to pain? _____

(26) How many minutes or hours can you sit before having to get up and move about?

_____ minutes _____ hours

(27) How many minutes or hours can you stand before you have to sit down?

_____ minutes _____ hours

(28) How often during the day do you lie down because of pain?

Never Seldom Sometimes Often Constantly

Allergies

(29) Do you have symptoms like red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following?

- Dye
- Iodine
- Medications: _____

Describe: _____

- Shellfish
- Foods: _____

- Latex**
- Rubber (Band-aids, tape, spandex, balloons) ***
- Kiwis, chestnuts, bananas, avocado ***
- No Known Allergy**

After doctor/dental visits *

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ALL PAST SURGERIES

(33) Please list, with approximate date and type of operation:

Have you had any previous back surgeries (please specify)?

PSYCHOSOCIAL HISTORY

(34) Your highest educational level achieved:

- Graduate or professional training (obtained degree)
- College graduate (obtained degree)
- Partial college training
- High school graduate
- GED or trade-technical school graduate
- Partial high school (10th grade through partial 12th)

LEGAL ISSUES

(35) Have you filed any legal claims related to your pain problem?

- No
- Yes (please explain):

PSYCHOLOGICAL TREATMENT

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

If yes, when? _____

(37) Have you ever considered suicide? Yes No

SUBSTANCE USE

- (38) Y (39) N Are you suffering from or do you have a history of alcoholism? Yes No
- Any illicit drug use? Yes No
- Have you ever been in a detoxification program for drug abuse? Yes No
- Alcoholics Anonymous? Yes No
- Narcotics Anonymous? Yes No

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(40) Do you or did you ever smoke cigarettes or use tobacco? Yes No
How many years have you smoked/did you smoke? _____
How many packs per day do you/did you smoke? _____
Have you quit using tobacco, and if so how long ago? _____

(41) How many drinks of each of the following do you consume in one week?
Beer _____
Wine _____
Liquor _____

FAMILY LIFE

(42) "I currently am":
 Living alone
 Living with friends
 Living with children
 Living with spouse/partner
 Living with spouse/partner and children

(43) N (44) Y
Do you have members of your family who have committed suicide?
 Yes No

Do you have members of your family who have had psychiatric illnesses?
 Yes No

Have any of your blood relatives had substance abuse problems, including alcohol?
 Yes No

PREVIOUS DIAGNOSTIC STUDIES

(45) Please indicate approximate date and results, if known:
MRI _____
CT _____
X-rays _____
EMG _____



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REVIEW OF SYSTEMS

Fill out and/or check all that apply to your health:

Respiratory		Heart		Elimination					
<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> at rest <input type="checkbox"/> with activity <input type="checkbox"/> Home oxygen (Supplier: _____) <input type="checkbox"/> Breathing medications <input type="checkbox"/> BIPAP/CPAP <input type="checkbox"/> Sleep Apnea/Disorder <input type="checkbox"/> TB <input type="checkbox"/> Lung Problem: _____ <input type="checkbox"/> No Problem		<input type="checkbox"/> Bruising/Bleeding <input type="checkbox"/> Heart Attack <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart Problem: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Problem		<table border="1"> <tr> <td>Urinary</td> <td>Bowel</td> </tr> <tr> <td> <input type="checkbox"/> Catheter <input type="checkbox"/> Burning <input type="checkbox"/> Bleeding <input type="checkbox"/> Ostomy <input type="checkbox"/> Unusual Frequency <input type="checkbox"/> Discomfort <input type="checkbox"/> Up at night to urinate? # Times: _____ <input type="checkbox"/> Loss of control <input type="checkbox"/> No Problem </td> <td> Last BM _____ Freq of BM _____ <input type="checkbox"/> Ostomy <input type="checkbox"/> Loss of control <input type="checkbox"/> Diarrhea/Colitis <input type="checkbox"/> Constipation <input type="checkbox"/> Use laxatives <input type="checkbox"/> Ulcers/Hiatal Hernia <input type="checkbox"/> No Problem </td> </tr> </table>		Urinary	Bowel	<input type="checkbox"/> Catheter <input type="checkbox"/> Burning <input type="checkbox"/> Bleeding <input type="checkbox"/> Ostomy <input type="checkbox"/> Unusual Frequency <input type="checkbox"/> Discomfort <input type="checkbox"/> Up at night to urinate? # Times: _____ <input type="checkbox"/> Loss of control <input type="checkbox"/> No Problem	Last BM _____ Freq of BM _____ <input type="checkbox"/> Ostomy <input type="checkbox"/> Loss of control <input type="checkbox"/> Diarrhea/Colitis <input type="checkbox"/> Constipation <input type="checkbox"/> Use laxatives <input type="checkbox"/> Ulcers/Hiatal Hernia <input type="checkbox"/> No Problem
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Neurological		Skeletal/Muscle		Nutrition					
<input type="checkbox"/> Memory loss/ Forgetfulness <input type="checkbox"/> Stroke <input type="checkbox"/> Fainting spells/ Dizziness <input type="checkbox"/> Epilepsy, seizures, convulsions <input type="checkbox"/> Mental illness <input type="checkbox"/> Headaches <input type="checkbox"/> No problem		<input type="checkbox"/> Arthritis <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Back pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Blood clots in legs <input type="checkbox"/> Pain in legs with activity <input type="checkbox"/> Skin disorder <input type="checkbox"/> Neck pain <input type="checkbox"/> No problem		<input type="checkbox"/> Weight Loss > 10 lbs/last 6 months _____ <input type="checkbox"/> Nausea Appetite <input type="checkbox"/> good <input type="checkbox"/> fair <input type="checkbox"/> poor <input type="checkbox"/> Vomiting <input type="checkbox"/> Dentures Fit properly? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Heartburn/ Reflux <input type="checkbox"/> Chewing problems <input type="checkbox"/> Indigestion <input type="checkbox"/> Swallowing problems <input type="checkbox"/> Sores in mouth <input type="checkbox"/> Foods you CANNOT eat. Explain: _____ _____					
Endocrine									
<input type="checkbox"/> Thyroid problems <input type="checkbox"/> Other: _____ _____ <input type="checkbox"/> No problem		Do you have any implanted devices? <input type="checkbox"/> Screws, pins, plates <input type="checkbox"/> AICD <input type="checkbox"/> Aneurysm Clip <input type="checkbox"/> Venous Access Device <input type="checkbox"/> None Where? _____ <input type="checkbox"/> IUD <input type="checkbox"/> Pacemaker <input type="checkbox"/> Type _____							

Do you have a history of "passing out" with needles, medical procedures etc.? If yes, please explain.

Positives (46) Negatives (47)

Patient Name _____