



Are you able to take care of yourself?      **YES**    **NO**    How does your pain affect your care?

How does your pain affect your social functions, appetite, relationships, emotions and sleep?

<b>SUBSTANCE ABUSE HISTORY: C for current; P for past; For Amount: O-Occasionally, F-Frequently, C-Constantly</b>								
Substance	C/P	Amount: O/F/C	Illicit Drugs	C/P	Amount: O/F/C	Withdrawal Symptoms	C/P	Amount: C/F/C
Caffeine			Hallucinogens			Blackouts		
Tobacco			Hash			Seizures		
Alcohol			Heroin			Delirium Tremens		
Tranquilizers			Inhalants					
Cocaine			LDS					
Crystal Meth			Marijuana					
Downers			PCP					
Ecstasy			Prescriptions					
GHB			Stimulants					
<b>Comments:</b>								

**Alcohol Use:** Rare      Socially      Daily      Never

**Tobacco Use:** Cigarettes      Cigars      Pipes    Other: \_\_\_\_\_ PPD \_\_\_\_\_ Yrs: \_\_\_\_\_ Quit date: \_\_\_\_\_

**Assistive Devices Used:** Hearing Aid    Cane    Wheelchair    Walker    Other: \_\_\_\_\_

**WORK STATUS:** \_\_\_\_\_ Regular Duty    \_\_\_\_\_ Light Duty, Restrictions: \_\_\_\_\_  
\_\_\_\_\_ Off Work: Last worked: \_\_\_\_\_  
\_\_\_\_\_ Disabled: Since: \_\_\_\_\_ By what Doctor: \_\_\_\_\_  
\_\_\_\_\_ Retired: Since what year: \_\_\_\_\_

**Location of pain:** \_\_\_\_\_

**What treatments have you had for your pain? Check all that apply:**

\_\_\_\_\_ Physical Therapy      \_\_\_\_\_ Favorable Results      \_\_\_\_\_ Poor Results

\_\_\_\_\_ Acupuncture      \_\_\_\_\_ Favorable Results      \_\_\_\_\_ Poor Results

\_\_\_\_\_ Chiropractor      \_\_\_\_\_ Favorable Results      \_\_\_\_\_ Poor Results

\_\_\_\_\_ Trigger Point Injection      \_\_\_\_\_ Favorable Results      \_\_\_\_\_ Poor Results

\_\_\_\_\_ TENS Unit      \_\_\_\_\_ Favorable Results      \_\_\_\_\_ Poor Results

\_\_\_\_\_ Nerve Blocks      \_\_\_\_\_ Favorable Results      \_\_\_\_\_ Poor Results

\_\_\_\_\_ Type of Nerve Block \_\_\_\_\_

\_\_\_\_\_ Back or Neck Surgery    Type: \_\_\_\_\_      When: \_\_\_\_\_

\_\_\_\_\_ Spinal Cord Stimulator    Type: \_\_\_\_\_      Date Implanted: \_\_\_\_\_

\_\_\_\_\_ Morphine Pump      Type: \_\_\_\_\_      Date Implanted: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

**PATIENT SIGNATURE:**

**DATE:**