The PAIN RELIEF Center
Your pain stops here.

New Patient Pain Form

PATIENT NAME:_____ DATE:_____

Which doctor are you here to see? _____

Patient Race: ☐White ☐Black ☐Asian or Pacific Islander ☐American Indian or Alaskan Native ☐Multiracial ☐Hispanic

Patient Ethnicity: ☐ Hispanic ☐Non-Hispanic

Chief Pain Complaint:_____

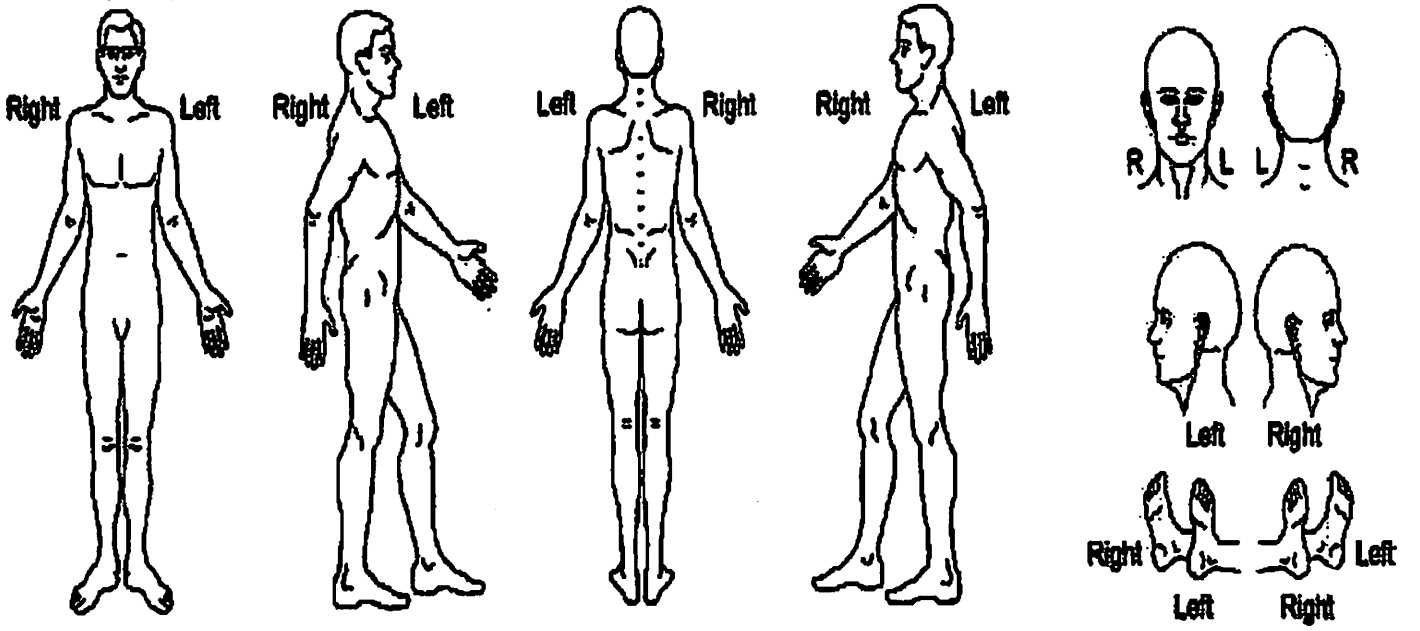
Physicians and Specialty seen for this pain including pain management_____

How long have you had this pain? _____

Has the pain recently changed in intensity and/or character? ☐ YES or NO☐If Yes, please describe:_____

_____

Where is your pain located? (Please mark location of pain with an X)



PAIN SCALE

Over the last week, rate: (Circle Answer)

	None									Worst
Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
Least Pain:	0	1	2	3	4	5	6	7	8	9	10
Usually:	0	1	2	3	4	5	6	7	8	9	10
Right Now:	0	1	2	3	4	5	6	7	8	9	10
Acceptable Level:	0	1	2	3	4	5	6	7	8	9	10

Office use only:

Vital Signs

Temp:_____ BP:_____ SP:_____

Weight:_____ Height:_____

Pulse:_____ Resp:_____

Taken by:_____

What makes the pain better? (Check all that apply)

☐Heat ☐Cold ☐Walking ☐Sitting ☐Standing ☐Massage ☐Resting in bed ☐Medications ☐Other:_____

What makes the pain worse? (Check all that apply)

☐Heat ☐Cold ☐Walking ☐Sitting ☐Standing ☐Activity ☐Bending down ☐Stretching ☐Running

☐Coughing ☐Being still ☐Lying down ☐Other:_____

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How would you describe your pain? (Check all that apply)

☐Aching ☐Penetrating ☐Stabbing ☐Tender ☐Miserable ☐Twisting ☐Tiring

☐Shooting ☐Numb ☐Sharp ☐Burning ☐Pressure ☐Throbbing ☐Nagging ☐Gnawing ☐Unbearable ☐Dull

☐Tingling ☐Shocking ☐Other:_____

Pharmacy Name:_____ Phone:_____

CURRENT MEDICATIONS: **List below or please attach a list**

Medications	Dose	Frequency

ALLERGY: _____

Reaction: _____

Other Pain Treatments: (Check all that apply)

☐Physical Therapy ☐Nerve Blocks ☐Back Brace

☐Other: _____

How much pain relief have pain treatments and medicines (in total) provided for you in this past week?

10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% ☐

Are you currently taking any blood thinners or anti-coagulants? ☐YES ☐NO

Does your pain interfere with (Check all that apply)

☐General Activity ☐Normal Work ☐Relationships ☐Mood ☐Sleep, How many hrs a night are you sleeping?_____

☐Life Enjoyment

What other symptoms do you have? (Check all that apply)

☐Fatigue ☐Nausea ☐Depression ☐Anxiety ☐Drowsiness ☐Difficulty Thinking ☐Shortness of Breath

Bowel Patterns: Usual Frequency: _____ Last BM:_____ Bowel Regimen: ☐YES ☐NO

Last Menstrual Cycle: _____ Are you on Birth Control? ☐YES ☐NO

Sexual Dysfunction: ☐YES ☐NO

Past Medical History: (Check all that apply) ☐Diabetes ☐High Blood Pressure ☐Seizure ☐Stroke ☐Heart Attacks

☐Kidney Problems ☐Liver Problems ☐Bleeding Problems ☐Cancer ☐Infections

☐Other:_____

Past Surgery History: (Past surgeries with date) _____

_____

Family History of Cancer or Painful Conditions:_____

_____

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Social History

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced

Children (#):_____ Occupation: _____

Smoking: ☐YES ☐NO or ☐Quit, when?_____ Pack per day:_____ How long have you smoked?_____

Alcohol Use: ☐Never ☐Occasionally ☐Frequently Drinks per day: _____

History of Drug Abuse: ☐YES ☐NO If yes, please elaborate: _____

Anything else we can help you with today? _____

_____

SOAPP® Version 1.0 – SF

Name: _____ Date:_____

The following questionnaire will allow us to determine the plan of care for chronic pain. This questionnaire is given to all patients at The Pain Relief Center who are on or being considered for opioid treatment.

Please answer each question honestly and to the best of your ability. This information will remain confidential. These answers alone will not determine your complete plan of care.

Please answer the questions below using the following scale:
0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, ect.) in the past 5 years? 0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

_____

_____

_____

_____

_____

Print Submit