CALIFORNIA PAIN CENTER

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Please take your time in answering the following questions. The information you provide is strictly confidential. Thank you.

Patient Name: _____Sex: _____Age: _____

Date: _____Referring Physician: _____

What do you expect to accomplish through this pain management consultation and treatment?

Complete Relief _____ Return to work _____ Increased Function _____ Partial Relief _____ Nothing _____

If total relief cannot be achieved, which of the following improvement are most important to you?

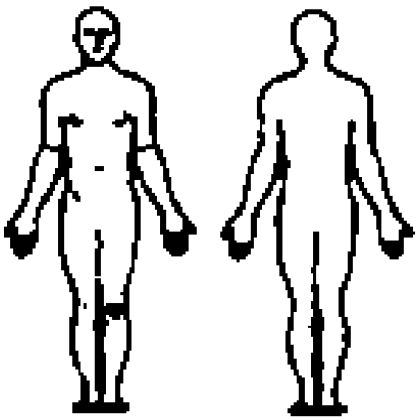
Please list in order of "1" being the most important, and "4" being the least important.

Decreased Medication Use _____ Increase in Activity _____ Pain Relief _____ Better moods _____

How do you rate your ability to tolerate pain. Please circle one.

High Pain Tolerance Better Than Average Very low No Tolerance

*Where is your pain?*_____ *Please shade in the area(s) you have pain.*



Please circle the following works that describe your pain.

Throbbing Aching Sharp Dull Shooting Tingling Burning Numb Electrical Sensation Hot

Cold Tender Tiring Penetrating Nagging Miserable Unbearable Gnawing Exhausting

Stabbing Constant or Intermittent- *how long do the episodes last?* _____

*How long have you had this pain?*_____

Circle the number below, that reflects your pain when you are resting and when you are moving about.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

*What makes your pain worse?*_____

*What makes your pain better?*_____

Does your pain limit your activities? _____ *How?* _____

_____

*Does your pain affect your sleeping habits?*_____ *How?*_____