Patient Name: _____

Pinellas Pain and Palliative Care

Date of Birth: _____

What caused initial injury? _____
Previous Pain management Doctor: _____
Primary Care Provider: _____
Orthopedic surgeon/Neurosurgeon: _____
Other specialists: _____

Failed pain treatments/surgery: _____
Drug Allergies/Sensitivities: _____
Emergency Phone #: _____ Contact Person/Relationship: _____

Date	Chronic Medical Problem List		Past Surgical History	Date

Effective?	Medications attempted for pain	Effective?	**Alternative pain treatments**	**Date**
Yes No	NSAIDS- Ibuprofen, alleve, Advil, etc	Yes No	_Physical Therapy	
Yes No	Tylenol	Yes No	_Chiropractor	
Yes No	Tramadol	Yes No	_Acupuncture	
Yes No	Lidocaine gel/cream	Yes No	_Massage	
Yes No	Voltaren/anti-inflammatory gel/cream	Yes No	_Injections	
Yes No	Muscle relaxers	Yes No	_Radiofrequency Ablation	
Yes No	Gabapentin/Lyrica	Yes No	_Occupational Therapy	
Yes No	Cymbalta	Yes No	_Water therapy	
Yes No	Antidepressants	Yes No	_TENS Unit	
Other-		Other-	(Please list)	

Family History of

Y	N		Family Member
☐	☐	Back pain	_____
☐	☐	Back surgery	_____
☐	☐	Neck surgery	_____
☐	☐	Degen Disk Dz	_____
☐	☐	Joint replacement	_____
☐	☐	Substance abuse	_____
☐	☐	Depression	_____
☐	☐	Alcoholism	_____
☐	☐	RA	_____
☐	☐	Diabetes	_____
☐	☐	HTN	_____

Please list any other _____
_____

Initial Risk Assessment

	Date
☐ Illegal Drug Use	_____
☐ alcohol abuse	_____
☐ Domestic Violence	_____
☐ Depression	_____
☐ Mood disorder	_____
☐ Anxiety	_____
☐ Arrests	_____
☐ Family Hx Substance Abuse	_____

Social History

☐ Married ☐ Single ☐ Lives Alone
☐ Divorced ☐ Widow(er)

☐ Disability (start date _____)

Occupation: _____

Alcohol Use: ☐ Yes ☐ No
drinks per week _____

Smoker? ☐ Yes ☐ No
packs per day _____

Educ.: ☐ JHS ☐ HS ☐ College
Other:

Signature: _____ Date: _____