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COMPREHENSIVE INITIAL EVALUATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Eval. Date: \_\_\_\_\_

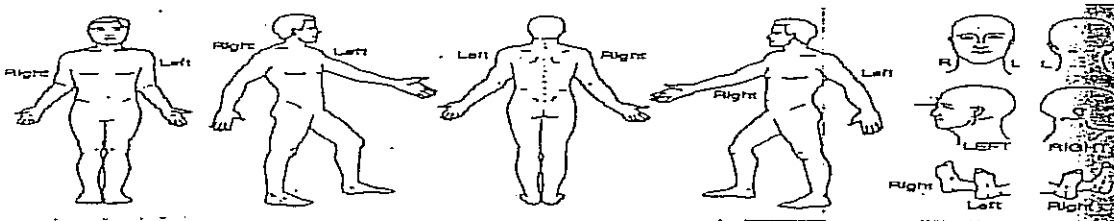
Describe your Chief Complaint:

HISTORY OF PRESENT ILLNESS:

Where is your pain located? Check all that apply. Circle side Left ( L ), Right ( R ), or Middle ( M ).

- |                                     |       |                                  |       |                                   |       |
|-------------------------------------|-------|----------------------------------|-------|-----------------------------------|-------|
| <input type="checkbox"/> Low Back   | L M R | <input type="checkbox"/> Buttock | L M R | <input type="checkbox"/> Head     | L M R |
| <input type="checkbox"/> Mid Back   | L M R | <input type="checkbox"/> Thigh   | L M R | <input type="checkbox"/> Face     | L M R |
| <input type="checkbox"/> Upper Back | L M R | <input type="checkbox"/> Calf    | L M R | <input type="checkbox"/> Shoulder | L M R |
| <input type="checkbox"/> Neck       | L M R | <input type="checkbox"/> Ankle   | L M R | <input type="checkbox"/> Arm      | L M R |
| <input type="checkbox"/> Chest      | L M R | <input type="checkbox"/> Foot    | L M R | <input type="checkbox"/> Hand     | L M R |
| <input type="checkbox"/> Abdomen    | L M R | <input type="checkbox"/> Other   |       |                                   |       |

Please indicate on the diagram where your pain occurs by shading the painful areas.



Circle the number that best describes your pain at its worst during the last month.											
0	1	2	3	4	5	6	7	8	9	10	
No pain										Worst possible pain	
Circle the number that best describes your pain at its least during the last month.											
0	1	2	3	4	5	6	7	8	9	10	
No pain										Worst possible pain	
Circle the number that best describes your pain on average during the last month.											
0	1	2	3	4	5	6	7	8	9	10	
No pain										Worst possible pain	
Circle the number that best describes your pain as it is right now.											
0	1	2	3	4	5	6	7	8	9	10	
No pain										Worst possible pain	

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Pt. Name \_\_\_\_\_

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Circle the words that describe your pain

Aching	Sharp	Penetrating	Throbbing	Tender
Nagging	Shooting	Burning	Numb	Stabbing
Exhausting	Miserable	Gnawing	Tiring	Unbearable

Does your pain travel anywhere? ( ) Yes ( ) No If Yes, Where? \_\_\_\_\_

Which statement best describes your pain frequency?

- ( ) Always present, always same intensity
- ( ) Always present, intensity varies
- ( ) Usually present, but have short period without pain
- ( ) Often present, but have pain free periods lasting for one to several hours
- ( ) Often present, but am pain free for most of the day
- ( ) Occasionally present, have once to several times per day, lasting minutes to an hour
- ( ) Occasionally present for brief periods, a few seconds to a few minutes
- ( ) Rarely present, have pain every few days or weeks

What time of day is your pain worst?

- ( ) Morning upon arising ( ) Later in the morning ( ) Afternoon
- ( ) Evening ( ) Bedtime ( ) Night
- ( ) Pain is always the same ( ) Pain varies, but is not worse at any particular time

Do you have associated:

- ( ) Numbness ( ) Tingling, pins and needles ( ) Increased sweating
- ( ) Coldness ( ) Muscle spasm, tightness ( ) Skin discoloration
- ( ) Weakness ( ) Bladder Problems ( ) Bowel Problems

What makes your pain feel worse?

- ( ) Sitting ( ) Coughing, sneezing ( ) Lying down
- ( ) Standing ( ) Physical activity ( ) Sexual activity
- ( ) Walking ( ) Other \_\_\_\_\_

What makes your pain feel better?

- ( ) Sitting ( ) Standing ( ) Walking ( ) Lying down
- ( ) Heat ( ) Relaxation ( ) Sexual activity ( ) Alcoholic drinks
- ( ) Medicines- List \_\_\_\_\_
- ( ) Other \_\_\_\_\_

Nothing makes me feel better ( ) True ( ) False

Before your pain began, did you consider yourself to be:

Extremely ill 0 1 2 3 4 5 6 7 8 9 10 Perfect Health  
Very Tired 0 1 2 3 4 5 6 7 8 9 10 Very energetic

Do you feel you are helpless to change your present pain condition?

Always helpless 0 1 2 3 4 5 6 7 8 9 10 Never helpless

Do you feel that your present pain condition is hopeless?

Very hopeless 0 1 2 3 4 5 6 7 8 9 10 Never hopeless

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When did you first notice your pain? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 Date of injury or accident if different. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 When did you first see a doctor for this pain? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Under what circumstances did your pain begin?

- Accident at work
- Accident at home
- Motor vehicle accident
- At work, not an accident
- Pain just began, no reason
- Following surgery
- Following illness

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

Describe the accident, injury, or circumstances:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If pain began at work, please list:

Place of employment when pain began

\_\_\_\_\_

How long were you employed there \_\_\_\_\_ Months \_\_\_\_\_ Years

If injured in motor vehicle accident, please list or circle:

Driver/Passenger/Pedestrian/Rider      Location: \_\_\_\_\_  
 Automobile/Truck/Motorcycle      Type: \_\_\_\_\_

Details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you been hospitalized or had surgery for your pain?

Date	Hospital	Physician	Surgery/Reason for admission
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you seen other physicians for your pain?

Date	Physician	Specialty	Diagnosis/Treatment
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Approximately how many physician visits have you had for pain in the last year? \_\_\_\_\_

How many visits to other health care professionals (circle all that apply)?

Physical Therapist, Occupational Therapist, Chiropractor, Acupuncturist,  
 Other: \_\_\_\_\_

What tests have you had done to diagnose your pain (Circle all that apply)? X-Ray CT Scan

MRI Scan Bone Scan Myelogram EMG Other Tests \_\_\_\_\_

Please make sure we have the results of all tests done.

Have you had nerve blocks (injections) for pain relief? ( ) Yes ( ) No

If yes, how long of relief? ( ) None ( ) Few hours ( ) Few days ( ) Few Weeks ( ) A month or more

Have you had any of the following for relief or pain? If yes did it relieve your pain?

- Hypnosis ( ) Yes ( ) No ( ) Relief Comment: \_\_\_\_\_
- Biofeedback ( ) Yes ( ) No ( ) Relief Comment: \_\_\_\_\_
- TENS ( ) Yes ( ) No ( ) Relief Comment: \_\_\_\_\_
- Acupuncture ( ) Yes ( ) No ( ) Relief Comment: \_\_\_\_\_
- Chiropractic ( ) Yes ( ) No ( ) Relief Comment: \_\_\_\_\_
- Heat Therapy ( ) Yes ( ) No ( ) Relief Comment: \_\_\_\_\_
- Bed Rest ( ) Yes ( ) No ( ) Relief Comment: \_\_\_\_\_
- Osteopathic ( ) Yes ( ) No ( ) Relief Comment: \_\_\_\_\_
- Psychotherapy ( ) Yes ( ) No ( ) Relief Comment: \_\_\_\_\_
- Other: \_\_\_\_\_ ( ) Relief

Comment: \_\_\_\_\_

Since your pain began, overall has it ( ) Increased ( ) Decreased ( ) Stayed the same

Circle the number that best describes how your pain interferes with your daily functioning.

General Activity

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere Completely Interferes

Mood

0 1 2 3 4 5 6 7 8 9 10

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Normal Work Routine

0 1 2 3 4 5 6 7 8 9 10

Social Activity

0 1 2 3 4 5 6 7 8 9 10

Sleep

0 1 2 3 4 5 6 7 8 9 10

Enjoyment of Life

0 1 2 3 4 5 6 7 8 9 10

Ability to Concentrate

0 1 2 3 4 5 6 7 8 9 10

Appetite

0 1 2 3 4 5 6 7 8 9 10

What level of pain do you think you could function with on a daily basis?

0 1 2 3 4 5 6 7 8 9 10  
 No pain Worst possible pain

How many hours a day do you spend in the following activities now?

Sitting down	0	1	2	3	4	5	6	7	8	9	10 or more
Lying down	0	1	2	3	4	5	6	7	8	9	10 or more
Walking	0	1	2	3	4	5	6	7	8	9	10 or more
Working	0	1	2	3	4	5	6	7	8	9	10 or more
Sleeping	0	1	2	3	4	5	6	7	8	9	10 or more
Exercising	0	1	2	3	4	5	6	7	8	9	10 or more

How many hours per day do you spend in the following activities before your pain begins?

Sitting down	0	1	2	3	4	5	6	7	8	9	10 or more
Lying down	0	1	2	3	4	5	6	7	8	9	10 or more
Walking	0	1	2	3	4	5	6	7	8	9	10 or more
Working	0	1	2	3	4	5	6	7	8	9	10 or more
Sleeping	0	1	2	3	4	5	6	7	8	9	10 or more
Exercising	0	1	2	3	4	5	6	7	8	9	10 or more

Review of Systems:

Has your appetite  Increased  Decreased  No change  
 Has your weight  Increased  Decreased How much \_\_\_\_\_ lbs.  No change

Body System  
 1. Constitutional

Symptoms  
 Fever

Chills

Circle all that you have or have had  
 Malaise Fatigue

Other

2. Skin	Itching	Rash	Hives		Other
3. Allergy/Immune	Cancer	Seasonal Allergies			Other
4. Ear/Nose/Throat	Nosebleeds	Hearing Loss	ringing in Ears		Other
5. Eyes/Head	Headache	Dizziness	Nosebleeds	Vision changes	Other
6. Respiratory	Cough	Wheezing	Short of breath		Other
7. Cardiovascular	Chest Pain	Fainting	Swelling in feet		Other
8. Intestinal	Nausea	Indigestion	Bowel Changes	Abdominal pain	Other
9. Urinary	Frequency	Urgency	Pain	Blood in Urine	Nighttime Urination
10. Endocrine	Diabetes	Thyroid	Steroid use	Menstrual/Breast changes	
11. Muscular	Stiffness	Gout	Osteoporosis	Muscle aches	
	Weakness	Bursitis	Arthritis	Joint pain	Other
12. Neurologic	Epilepsy	Tremor	Stroke	Memory Loss	Other
	Paralysis	Weakness	Numbness	Tingling	
13. Mental Health	Anxiety	Depression	Stress		Other
14. Heme/Lymph	Anemia	Easy bruising	Swollen glands	Bleeding Disorder	Other

Are you allergic to any medications? ( if no allergies write "No") \_\_\_\_\_

List all medications you currently take for pain:

Medication Name	Dose	Doses per day	Time of Day	No Relief										Complete Relief											
				0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

List all Medications you have previously taken for pain:

Medication Name	Dose	Doses per day	Time of Day	No Relief										Complete Relief											
				0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
_____	_____	_____	_____	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

List all Medications you take other than pain medications:

Medication Name	Dose	Doses per day	Time of Day	Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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List any surgery you have had for pain:

Date	Procedure	Surgeon	Result/Outcome/Relief
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any other surgery you have had:

Date	Procedure	Surgeon	Result/Outcome/Relief
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all your current and past medical problems:

Onset Date	Medical Problem/Disorder	Current treating physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you having any Medication side effects?

	None	0	1	2	3	4	5	6	7	8	9	10 Extreme
Nausea/Vomiting												
Constipation												
Memory Loss												
Sedation												
Itching												
Insomnia												

Family History:

Describe your families health status- describe any chronic illness or pain problems in family members.

Father ( ) Alive ( ) Well ( ) Deceased Illnesses: \_\_\_\_\_

Mother ( ) Alive ( ) Well ( ) Deceased Illnesses: \_\_\_\_\_

Brother(s) # \_\_\_\_\_ Alive # \_\_\_\_\_ Deceased

Illnesses: \_\_\_\_\_

Sister(s) # \_\_\_\_\_ Alive # \_\_\_\_\_ Deceased

Illnesses: \_\_\_\_\_

Children # \_\_\_\_\_ Alive # \_\_\_\_\_ Deceased

Illnesses: \_\_\_\_\_

Any family member with chronic pain? \_\_\_\_\_

Any family member with psychiatric illness? \_\_\_\_\_

