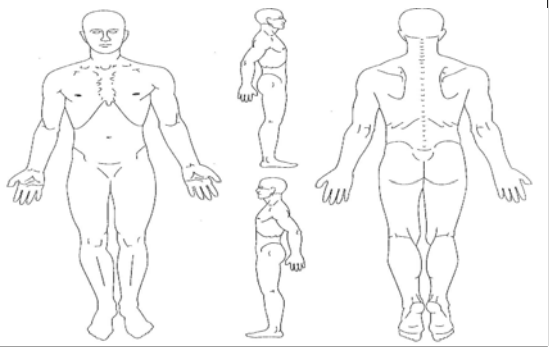
CPHCS Chronic Pain Intake Sheet

(Recommended questions to elicit accurate pain history)

Tell me about your pain – when did it start?	Mark the diagram below with the type of pain you have: ΔΔΔ Aching === Numbness ○○○ Pins & Needles XXX Burning /// Stabbing
How did it start? Were you injured?	
Where is it? Where does it go?	
What are your goals?	

What have other doctors told you was causing your pain?
What tests have you had in the past? (results)
Have you ever had surgery because of your pain? Yes No If yes, when? Did it help?
What medications have you tried in the past for your pain and were they helpful? Side effects? Name Effects Side Effects
What other treatments have you tried and when? Physical therapy Counseling TENS Other: Were they helpful?
History of mental health disorder in past? Anxiety Depression Schizophrenia Personality Disorder Currently seeing mental health? Yes No
During the last 2 weeks have you felt down, depressed or hopeless? Yes No
Have you had little interest in doing things? Yes No
History of substance abuse/illegal drugs? Yes No Which drugs? Last use? Route? Oral Nasal Injection
What do you believe is causing your pain?
What do you find makes your pain better (e.g. rest, medicine, etc.)?
What makes the pain worse (e.g. walking, lying, resting, etc.)?

For the following questions, use the *Pain Rating Scale*: 0 = No Pain 10 = Worst Pain

a. Please use the pain scale to describe your pain at its **worst in the last week:**	*No pain*	0	1	2	3	4	5	6	7	8	9	10	*Worst Pain*
b. Please use the pain scale to describe your pain at its **best in the last week:**	*No pain*	0	1	2	3	4	5	6	7	8	9	10	*Worst Pain*
c. Please use the pain scale to describe your pain **on average:**	*No pain*	0	1	2	3	4	5	6	7	8	9	10	*Worst Pain*
d. Please use the pain scale to describe your pain **right now:**	*No pain*	0	1	2	3	4	5	6	7	8	9	10	*Worst Pain*

CDCR Stamp:

Patient Name:

CDCR #

DOB:

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Can you do the following activities?				How much can you exercise? (minutes/days)
a. Getting in or out of bunk/shower:	Yes	No	Sometimes	
b. Transfer from/to floor:	Yes	No	Sometimes	Type of exercise?
c. Self-care (bathing, grooming, dressing, toileting, bed mobility)	Yes	No	Sometimes	Walking Jogging Other:

How does your pain affect your mood/relations with other people?	None	Some	Very Much
Is your pain worse when you are anxious, stressed, depressed or angry?	None	Some	Very Much
How does your pain affect your ability to work?	None	Some	Very Much
How does your pain affect your sleep?	None	Some	Very Much

Chart Review – significant past medical history, chronic conditions and medications:

Physical Exam

Ht:	Wt:	BMI:	BP:	P:

Exam of Area of Pain:

_____
_____
_____
_____
_____
_____
_____
_____

Include
- Inspection
- Palpation
- Range of Motion
- Soft tissue
- Neuro
- Sensory exam
  - Light touch
  - Pinprick
- Other
- Reflexes
- Gait

A/P chronic pain due to (location and etiology) :

Notes:_____
_____
_____
_____
_____
_____

Patient Education:_____
_____
_____
_____
_____

Ordered
- ☐ Referrals
- ☐ Diagnostics
- ☐ Mental Health Referral
- ☐ Physical Therapy
- ☐ Exercise Prescription/Diet
- ☐ Medications
- ☐ Patient Education
- ☐ Labs, UOT, Other

If Opioids Prescribed
- ☐ Pain Agreement Completed
- ☐ Referral to Medical Leadership via existing Committee structure
- ☐ Meets medical criteria with Objective

Follow up in:
Provider (print name):
Provider (signature):
Date:

CDCR Stamp:

Patient Name:

CDCR #

DOB:

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