Mark Bouffard, M.D.
Board Certified, Fellowship Trained

INITIAL EVALUATION

Referring Physician: ____

Patient ID #____________________ Your appointment is with Dr. Bouffard

PATIENT INFORMATION

____ Sex: ☐Male ☐Female
Last Name First M.I.

Appointment Date_____________ Date of Birth (mm/dd/yyyy): _______________ Age _____

Primary Care Physician (if not the same): ____

ABOUT YOUR PAIN

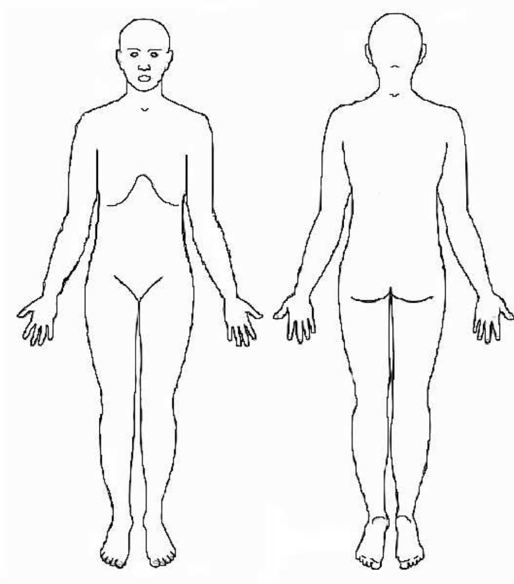
What is the main problem for which you are seeking treatment with Dr. Bouffard?

____

____

____

Please mark the area(s) in which your pain is located:



ONSET OF PAIN AND DURATION

Briefly describe when and how your current pain started?

____

____

____

____

PAIN QUALITY

How would you describe the pain (choose as many adjectives as are applicable)?

☐ Burning	☐ Sharp	☐ Cutting
☐ Throbbing	☐ Cramping	☐ Numbness
☐ Dull, aching	☐ Pressure	☐ Pins and needles
☐ Shooting	☐ Electric-like	☐ Other

TIMING OF PAIN

How often do you have your pain (please check one)?

☐ Constant	(100% of the time)
☐ Frequent	(75% of the time)
☐ Intermittent	(50% of the time)
☐ Occasional	(25% of the time)

INTERFERENCE OF PAIN

Does your pain interfere with work/activities of daily living? ☐ No ☐ Yes

Does your pain interfere with sleep? ☐ No ☐ Yes

Does your pain cause you to feel down or depressed? ☐ No ☐ Yes

PAIN INTENSITY

Circle or mark with an X your current pain intensity with "0" representing no pain and "10" representing the most severe pain imaginable:

0 1 2 3 4 5 6 7 8 9 10

Circle your average pain the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

Circle your best pain score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

Circle your worst pain score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

RELIEVING AND AGGRAVATING FACTORS

How do the following affect your pain (please check one for each item)?

	Increase	Decrease	No Change
Lying down			
Standing			
Sitting			
Walking			
Exercise (if applicable)			
Medications			
Relaxation			
Thinking about something else			
Coughing/Sneezing			
Urination			
Bowel movements			

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

Treatment	Date (approx.)	Relief	No Relief
Hospital bed rest			
Traction			
Surgery			
Hypnosis			
Acupuncture			
Nerve block/injections			
TENS			
Physical therapy			
Exercise			
Heat treatment			
Biofeedback			
Psychotherapy			
Chiropractic			
Other			

FUNCTIONAL LIMITATIONS

During the past month, place a check mark next to the activities that you avoided because of pain:

- ☐ Going to work
- ☐ Performing household chores
- ☐ Doing yard work or shopping
- ☐Socializing with friends
- ☐ Participating in recreation
- ☐ Having sexual relations
- ☐ Physically exercising
- ☐ Driving
- ☐ Caring for self

How many blocks can you walk before having to stop due to pain? __________

How many minutes or hours can you sit before having to get up and move about?
_________ minutes _________ hours

How many minutes or hours can you stand before you have to sit down?
_________ minutes _________ hours

How often during the day do you lie down because of pain?
☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Constantly

REVIEW OF SYSTEMS

Please check if you have any of the following:

General
- ☐ Fever/Chills
- ☐ Night sweats
- ☐ Unplanned weight loss
- ☐ Fatigue

Skin
- ☐ Rash
- ☐ Itching (Pruritus)
- ☐ Dryness

Lungs
- ☐ Shortness of breath (Dyspnea)
- ☐ Cough
- ☐ Wheezing

Heart
- ☐ Chest pain (Angina)
- ☐ Palpitations
- ☐ Murmur
- ☐ Swelling (Edema)

Hematological
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Sickle cell/thalasemia
- ☐ Blood transfusion reactions

GI
- ☐ Nausea/vomiting
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Incontinence of stool

GU
- ☐ Blood in urine (Hematuria)
- ☐ Decreased libido
- ☐ Incontinence of urine

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Decreased range of motion
- ☐ Atrophy

Neurological
- ☐ Headaches
- ☐ Seizures
- ☐ Fainting spells (Syncope)
- ☐ Memory loss

Endocrine
- ☐ Heat/Cold Intolerance
- ☐ Frequent urination (Polyuria)
- ☐ Increased thirst (Polydipsia)
- ☐ Increased appetite (Polyphagia)

Psychiatric
- ☐ Hallucinations
- ☐ Anxiety
- ☐ Depression

PAST MEDICAL HISTORY

Have you had any of the following health problems (please check all that apply)?

☐ High blood pressure ☐ Diabetes ☐ Kidney disease

☐ Angina ☐ Stroke ☐ Liver disease

☐ Heart attack ☐ Cancer ☐ Arthritis

☐ Chronic cough ☐ Psychological or psychiatric problems

☐ HIV ☐ Hepatitis

☐ Other (please specify): ______________________________

PAST SURGICAL HISTORY

Please list, with approximate date and type of operation:

____

____

____

Have you had any previous back surgeries (please specify)?

____

____

SMOKING HISTORY

Do you or did you ever smoke cigarettes or use tobacco? ☐ Yes ☐ No

How many years have you smoked/did you smoke? ____________

How many packs per day do you/did you smoke? ____________

Have you quit using tobacco, and if so how long ago? ____________

SOCIAL HISTORY

Your highest educational level achieved:

- ☐ Graduate or professional training (obtained degree)
- ☐ College graduate
- ☐ Partial college training
- ☐ High school graduate
- ☐ GED or trade-technical school graduate
- ☐ Partial high school (10th grade through partial 12th)

Current employment status:

- ☐ Occupation(current or former): ______________________________
- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Disabled
- ☐ Unemployed
- ☐ Homemaker
- ☐ Student
- ☐ Retired: ____________________

PSYCHOLOGICAL TREATMENT

Have you ever had psychiatric or psychological evaluations or treatments for any problem, including your current pain? ☐ Yes ☐ No

If yes, when? ____

Have you ever considered suicide? ☐ Yes ☐ No

SUBSTANCE USE

How many drinks of each of the following do you consume in one week?

Beer _____________
Wine _____________
Liquor _____________

Question	Yes	No	Code	
Are you between the ages of 16 to 45 years old?	☐ Yes	☐ No	(F1/M1)	______
Are you suffering from or do you have a history of alcoholism?	☐ Yes	☐ No	(F3/M3)	______
Any personal history of illicit drug use?	☐ Yes	☐ No	(F4/M4)	______
Any personal history of prescription drug abuse?	☐ Yes	☐ No	(F5/M5)	______
Are you suffering from ADD, OCD, bipolar or schizophrenia?	☐ Yes	☐ No	(F2/M2)	______
Are you suffering from depression?	☐ Yes	☐ No	(F1/M1)	______
Have you ever been in a detoxification program for drug abuse?	☐ Yes	☐ No		
Any family history of alcohol abuse?	☐ Yes	☐ No	(F1/M3)	______
Any family history of illicit drug use?	☐ Yes	☐ No	(F2/M3)	______
Any family history of prescription drug abuse?	☐ Yes	☐ No	(F4/M4)	______
Any history of preadolescent sexual abuse?	☐ Yes	☐ No	(F3/M0)	______

FAMILY LIFE

"I currently am":

- ☐ Living alone
- ☐ Living with friends
- ☐ Living with children
- ☐ Living with spouse/partner
- ☐ Living with spouse/partner and children

FAMILY MEDICAL HISTORY

Have any of your blood relatives had any of the following health problems (F = Father, M = Mother, S = Sister, B = Brother, C = Child, GP = Grandparent)? Please circle or mark with an X all that apply.

High BP F M S B C GP	**Cancer** F M S B C GP	**Arthritis** F M S B C GP
Angina F M S B C GP	**Hepatitis** F M S B C GP	**Diabetes** F M S B C GP
Heart Attack F M S B C GP	**Liver disease** F M S B C GP	**Asthma** F M S B C GP
Heart disease F M S B C GP	**Stroke** F M S B C GP	**HIV** F M S B C GP
Kidney disease F M S B C GP	**Thyroid disease** F M S B C GP	**Psychological or psychiatric problems** F M S B C GP

☐ Other (please specify): ____

____

ALLERGIES

Do you have symptoms like red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following?

❑ X-ray dye/contrast
❑ Iodine
❑ Medications: ____________________
Describe: ________________________
❑ Medications: ____________________
Describe: ________________________
❑ Medications: ____________________
Describe: ________________________

❑ Shellfish
❑ Foods: ______________________
____
❑ Latex
❑ Rubber (Band-aids, tape, spandex, balloons)
❑ **No Known Allergy**

MEDICATIONS

Please list your current medications with dosages:

____

____

____

____

____

____

____

____

____

____

____

Please list any previously taken pain medications that you stopped taking and the reason for stopping:

____

____

____

____

____

____

PREVIOUS DIAGNOSTIC STUDIES

Have you had any of the following exams: (If so, when and where?)

- ☐ MRI
- ☐ CT Scan
- ☐ X-rays
- ☐ EMG

PAIN MANAGEMENT GOALS

What are your **realistic goals** from the pain management clinic?

☐ Decrease pain to tolerable level	☐ Participate in religious activities
☐ Decrease side effects from medications	☐ Perform hobbies
☐ Drive	☐ Play sports
☐ Exercise	☐ Play with children/grandchildren
☐ Garden	☐ Socialize (go out to eat, go to movies, etc.)
☐ Housework/Yardwork	☐ Volunteer
☐ Improve relationships with others	☐ Work
☐ Improve sexual relations	☐ Other:
☐ Improve sleep	☐ Other: