Name: DOB:

Age: Date:

WEST TENNESSEE BONE & JOINT

PAIN MANAGEMENT GLOBAL PAIN SCALE

Please answer ALL questions.

INSTRUCTIONS: For each question, please indicate your response by circling a number from 0 to 10.

YOUR PAIN:	0 = No Pain										10 = Extreme Pain
During the **past week**, the **best** my pain has been is:	0	1	2	3	4	5	6	7	8	9	10
During the **past week**, the **worst** my pain has been is:	0	1	2	3	4	5	6	7	8	9	10
During the **past week**, my **average** pain has been:	0	1	2	3	4	5	6	7	8	9	10
During the **past 3 months**, my **average** pain has been:	0	1	2	3	4	5	6	7	8	9	10
YOUR FEELINGS:											
During the past week, I have felt **AFRAID**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, I have felt **DEPRESSED**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, I have felt **TIRED**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, I have felt **ANXIOUS**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, I have felt **STRESSED**:	0	1	2	3	4	5	6	7	8	9	10
YOUR CLINICAL OUTCOMES:											
During the past week, **I had trouble sleeping**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, **I had trouble feeling comfortable**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, **I was less independent**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, **I was unable to work (or perform normal tasks)**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, **I needed to take more medication**:	0	1	2	3	4	5	6	7	8	9	10
YOUR ACTIVITIES:											
During the past week, I was **NOT** able to **go to the store**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, I was **NOT** able to **do chores in my home**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, I was **NOT** able to **enjoy my friends and family**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, I was **NOT** able to **exercise (including walking)**:	0	1	2	3	4	5	6	7	8	9	10
During the past week, I was **NOT** able to **participate in my favorite hobbies**:	0	1	2	3	4	5	6	7	8	9	10

Staff initials: _____ Score: _____

Complete this section for New Pain Management Patients only:

Opioid Risk Tool		
Mark each box that applies	Female	Male
Family History of Substance Abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal History of Substance Abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring Totals		

WEST TENNESSEE BONE & JOINT

PAIN MANAGEMENT FOLLOW UP FORM

GENERAL REASONS FOR VISIT: (Check all that apply)

_____ Follow up on Existing pain. Location: _____
_____ Evaluation of New pain. Location: _____
_____ Refill Medications. List needed medications: _____
_____ Discuss medication effectiveness or side effects
_____ Test results. Tests: _____
_____ Post procedure evaluation
_____ Post physical therapy evaluation
_____ Other issues you wish to discuss: _____
_____
_____

Review of Systems - Mark all of the following that you **CURRENTLY** suffer from**:**

Constitutional:
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Insomnia

Eyes:
- ☐ Change in vision/acuity
- ☐ Eye Pain
- ☐ Glaucoma

Ears/Nose:
- ☐ Recurrent Nose Bleeds
- ☐ Difficulty Hearing

Skin:
- ☐ Skin infections
- ☐ Changes in skin color

Respiratory:
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chronic cough
- ☐ Sleep apnea
- ☐ Home oxygen/Cpap

Cardiovascular:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Pacemaker/defibrillator
- ☐ Swelling in feet/edema

Gastrointestinal:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Gastritis
- ☐ Reflux/GERD/hiatal hernia
- ☐ Diverticulitis/colitis
- ☐ Blood in stools

Genitourinary:
- ☐ Loss of bladder control
- ☐ Difficulty urinating
- ☐ Recurrent infections/UTIs
- ☐ Blood in urine

Musculoskeletal
- ☐ Neck Pain
- ☐ Mid scapular/upper back pain
- ☐ Low back pain
- ☐ Shoulder pain
- ☐ Arm/elbow pain
- ☐ Wrist/hand pain
- ☐ SI joint pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot pain

Neurological:
- ☐ Vertigo
- ☐ Dizziness
- ☐ Instability when walking
- ☐ Leg weakness
- ☐ Arm/hand weakness
- ☐ Arm/hand numbness
- ☐ Leg/foot numbness
- ☐ Headaches

Psychiatric:
- ☐ Depression
- ☐ Suicidal thoughts/planning
- ☐ Bipolar disorder
- ☐ Anxiety/increased worrying

Patient Signature: _____ Date: _____