The Office of Leila Rhodes M.D.

Pain / Injury Evaluation

Visit Date	Last Name	First Name	MI	Date of Birth	Height	Weight

Visit Information:

1.	What is the reason for this visit? (Chief Complaint)					
2.	Have you had this before?				○ Yes	○ No
	If so, when?					
3.	When did you first notice the pain?					
4.	Where is the location of your pain?					
5.	Does the pain radiate out?				○ Yes	○ No
	If so, where?					
6.	Is your pain always present or does it come and go?	○ always present		○ come and go		
7.	On a scale of 1-10, rate the severity of your pain;1 being mild and 10 being severe.					
8.	Are you currently taking any of the following types of medications for pain?					
	☐ Opioid or Narcotic Pain Prescriptions		☐ Sedating Medications			
9.	In the past, how much relief has pain medication provided? Select one	○ 0%	○ 25%	○ 50%	○ 75%	○ 100%
10.	Describe your pain and discomfort.					
11.	What medications have you tried and what were the results?					
12.	Is there anything that makes your pain better?				○ Yes	○ No
	If yes, what have you tried and what were the results?					
13.	Is there anything that makes your pain worse?				○ Yes	○ No
	If yes, what happened and what were the results?					
14.	Since the onset of your chief complaint, please select the status of your symptoms?					
	○ symptoms are getting better	○ symptoms are getting worse		○ symptoms are staying the same		
15	Select the following if affected by pain:	☐ Bathing / Dressing	☐ Mood	☐ Walking Ability		
	☐ Employment	☐ Housework	☐ Sleep	☐ Enjoyment of life		
	☐ Transportation	☐ Relationship with others	☐ Toileting	☐ Food Preparation		

Depression Screening: Important Notice: The information gathered on this questionnaire will remain confidential.

	Over the last 2 weeks, how often have you been bothered by any of the following problems? Please select the option that applies to each feeling.	Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	○	○	○	○
2.	Feeling down, depressed, or hopeless	○	○	○	○
3.	Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4.	Feeling tired or having little energy	○	○	○	○
5.	Poor appetite or overeating	○	○	○	○
6.	Feeling bad about yourself or that you are a failure or have let yourself or family down	○	○	○	○
7.	Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9.	Thoughts you would be better off dead, or of hurting yourself in some way	○	○	○	○
				[For Office Use Only:	0]
10.	If you checked off any problems, how difficult have these problems made it for you to do our work, take care of things at home, or get along with other people?				
	○ Not difficult at all	○ Somewhat difficult	○ Very difficult	○ Extremely difficult	

The Office of Leila Rhodes M.D. / 6525 La Jolla Blvd, La Jolla, CA 92037 / 858-454-5557

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