



# PARK AVENUE WELLNESS

DONNA R. KESSELMAN, M.D., P.C.

74 EAST 79TH STREET @ PARK AVENUE • SUITE 1C • NEW YORK, NY 10075 • 212-988-1700

WWW.PARKAVENUEWELLNESS.COM

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Telephone Numbers: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Home Address: \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## ***Initial Pain Assessment***

By answering the following questions, you will help your physician better understand and treat your pain.

When and how did your pain problem start? \_\_\_\_\_

\_\_\_\_\_

As far as you know, what is the cause of your pain (ie, the diagnosis)? \_\_\_\_\_

\_\_\_\_\_

What doctors have you seen? When did you see them? What did they do?

Doctor's Name

Month/Year Seen

What was done?  
(for example: Doctor did  
physical exam, ordered  
tests, prescribed  
medication)

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

What tests and studies have been done?

Tests & Studies  
(for example: MRI,  
CT-Scan, X-Rays)

Month/Year Done

Results

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



List the body sites where you experience pain and circle the words that best describe the pain at that site. Also, indicate the intensity of the pain and those things that make your pain better or worse. Use a separate sheet for each body site.

Body Site \_\_\_\_\_

Circle the words that describe your pain.

- |              |            |             |
|--------------|------------|-------------|
| Aching       | Sharp      | Penetrating |
| Throbbing    | Tender     | Nagging     |
| Shooting     | Burning    | Numb        |
| Stabbing     | Exhausting | Miserable   |
| Gnawing      | Tiring     | Unbearable  |
| Intermittent | Continuous |             |

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 pain  
imaginable

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 pain  
imaginable

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 pain  
imaginable

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 pain  
imaginable

What sorts of things make this pain feel better (for example: heat, rest, medicine)?

---

---

---

---

---

What sorts of things make this pain feel worse (for example: walking, standing, lifting)?

---

---

---

---

---

Circle the numbers below that best describe how pain has interfered 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

Does not interfere

Completely interferes

**Walking Ability**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

**Normal Work Routine**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

**Relations With Other People**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

**Sleep**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

**Enjoyment of Life**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

**Ability to Concentrate**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

**Appetite**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

What levels 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 pain imaginable