Pain Management Intake Form

Name: _______________________________    DOB:____________

Date: _______________

Work related? [  ] Yes   [  ] No
Legal Actions pending? [  ] Yes [  ] No
Workers Compensation? [  ] Yes [  ] No
Are you working now? [  ] Yes [  ] No

Name of the doctor that referred you to this clinic: ________________________________

[  ] I referred myself.

Legal Actions pending? [  ] Yes   [  ] No

Workers Compensation? [  ] Yes [  ] No

Are you working now? [  ] Yes [  ] No

How long have you had this pain? _____Days    _____Weeks

_____Months   _____Years

Was there any injury/event that caused your pain? [  ] No   [  ] Yes
If yes briefly explain:_________________________________________________________

Any prior back injury or pain before the event above? [  ] No   [  ] Yes
What type?_________________________________________________________________

Have you had surgery on your back / neck? [  ] No   [  ] Yes
What type?_________________________________________________________________

WHERE IS THE PAIN?
Using any or all of the symbols below, please mark the diagrams to indicate your typical areas of pain.
Ache  >>>>>>
Pins & Needles  ooooo
Numbness  --------
Stabbing  ///////////

Please rate your pain over the last TWO WEEKS:
Rate your WORST pain: NO PAIN  0 1 2 3 4 5 6 7 8 9 10 THE WORST PAIN IMAGINABLE
Rate your LEAST pain: NO PAIN  0 1 2 3 4 5 6 7 8 9 10 THE WORST PAIN IMAGINABLE
Rate your AVERAGE pain: NO PAIN  0 1 2 3 4 5 6 7 8 9 10 THE WORST PAIN IMAGINABLE

Is your pain: [  ] Constant   or   [  ] Intermittent

Adjectives to describe your pain:

Please see reverse for page 2
Sharp | Radiating | Cruel | Punishing
---|---|---|---
Burning | Achy | Dull | Shooting
Tingling | Numb | Pressure | Pins/Needles

What makes your pain better?
________________________________________________________

What makes your pain worse?
_________________________________________________________

What treatments have you tried up to this point?

<table>
<thead>
<tr>
<th>Currently Receiving</th>
<th>Helped</th>
<th>Made things worse</th>
<th>No difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot packs/ice/ultrasound</td>
<td>☐</td>
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<tr>
<td>Massage</td>
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<tr>
<td>Physical therapy</td>
<td>☐</td>
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<td>TENS Unit at home</td>
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<tr>
<td>Body mechanics training</td>
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<tr>
<td>Strengthening exercises</td>
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<tr>
<td>Aerobics (e.g. treadmill)</td>
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<tr>
<td>Gravity inversion/traction</td>
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<tr>
<td>Bedrest</td>
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<tr>
<td>Chiropractic treatment</td>
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<tr>
<td>Osteopathic manipulation</td>
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<tr>
<td>Biofeedback</td>
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<tr>
<td>Local (trigger point) injection</td>
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<td>Spinal injections</td>
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<tr>
<td>Soft back/neck brace</td>
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<tr>
<td>Rigid back/neck brace</td>
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<tr>
<td>Acupuncture</td>
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<tr>
<td>Pain Specialist</td>
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<tr>
<td>Other ______________</td>
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Have you ever lost control of your bowel or bladder? [ ] No [ ] Yes

Do you have any weakness in your arm(s) or leg(s)? [ ] No [ ] Yes

In the past 1 month have you experienced any of the following more frequently than half of the time?

- Trouble falling asleep? [ ] No [ ] Yes
- Waking at night and not being able to fall back asleep? [ ] No [ ] Yes
- Feeling not rested when you wake up in the morning? [ ] No [ ] Yes
- Feeling excessively sleepy during the day? [ ] No [ ] Yes

Do you feel you might be depressed or overly anxious? [ ] No [ ] Yes

Circle the appropriate number to indicate the extent of the problem you are having with each of the following:

- Anxiety:
  - None: 0 1 2 3 4 5 6 7 8 9 10 Severe
- Depression:
  - None: 0 1 2 3 4 5 6 7 8 9 10 Severe
- Irritability:
  - None: 0 1 2 3 4 5 6 7 8 9 10 Severe

Are you receiving care from a mental health professional? [ ] No [ ] Yes
If yes briefly explain:__________________________________________________________

Does your pain limit your function? [ ] No [ ] Yes
If yes briefly explain:___________________________________________________________