





**Please mark on the pictures (above) where your pain is.**

**Please make a slash mark on the lines (below) to indicate how you feel:**

- What is the average level of pain you have everyday?

No Pain |-----| Pain as bad as it could be

- What is the least severe pain you have had in the last two weeks?

No Pain |-----| Pain as bad as it could be

- What is the greatest amount of pain you have had in the last two weeks?

No Pain |-----| Pain as bad as it could be

- How much is pain interfering with your activities?

Not at all |-----| Completely

- What is your mood like now?

Worst ever felt |-----| Best ever felt

- How well do you sleep?

Not at all |-----| Good night's sleep

What is the worst consequence of your pain? (i.e. Withdraw from people, lose my temper, overeat, etc.)

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- Since your present pain began, have you gained or lost any weight?  
If yes, how many pounds? \_\_\_\_\_

Please answer each question:

- Please write (in one sentence) the reason you scheduled an appointment:

\_\_\_\_\_

- As best as you can remember, what day did your pain begin:

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

- How did your pain begin? (check one)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Accident at work     | <input type="checkbox"/> Accident at home | <input type="checkbox"/> Following surgery   |
| <input type="checkbox"/> Following an illness | <input type="checkbox"/> Pain just began  | <input type="checkbox"/> Automobile accident |

Describe: \_\_\_\_\_

- Area of the body that your pain is the worst (check only one):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Head, face, mouth                    | <input type="checkbox"/> Stomach (abdomen) | <input type="checkbox"/> Anal, genital |
| <input type="checkbox"/> Neck                                 | <input type="checkbox"/> Lower back        | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Shoulders, arms                      | <input type="checkbox"/> Legs              |  |
| <input type="checkbox"/> Upper back (between shoulder blades) | <input type="checkbox"/> Pelvic, hips      |  |

- Please describe how the pain feels: ( i.e. burning, throbbing, stabbing, shooting, sharp, dull, ache, soreness)

\_\_\_\_\_

- Do you feel that your pain is radiating (moving) to any other areas? (check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Head, face, mouth                    | <input type="checkbox"/> Stomach (abdomen) | <input type="checkbox"/> Anal, genital |
| <input type="checkbox"/> Neck                                 | <input type="checkbox"/> Lower back        | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Shoulders, arms                      | <input type="checkbox"/> Legs              |  |
| <input type="checkbox"/> Upper back (between shoulder blades) | <input type="checkbox"/> Pelvic, hips      |  |

- How often do you have pain? (check one)

- |  |  |
|--|--|
| <input type="checkbox"/> Only at night       | <input type="checkbox"/> Intermittent throughout day |
| <input type="checkbox"/> Only in the morning | <input type="checkbox"/> Continuous, all day         |

- Which of the following activities makes your pain worse? (check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Lying down      | <input type="checkbox"/> Standing          | <input type="checkbox"/> Bending Twisting    |
| <input type="checkbox"/> Walking         | <input type="checkbox"/> Lifting           | <input type="checkbox"/> Reaching/stretching |
| <input type="checkbox"/> Sitting         | <input type="checkbox"/> Coughing/Sneezing |  |
| <input type="checkbox"/> Other, describe | _____                                      |  |

- Which of the following activities makes you pain better? (check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Lying down      | <input type="checkbox"/> Standing          | <input type="checkbox"/> Bending Twisting    |
| <input type="checkbox"/> Walking         | <input type="checkbox"/> Lifting           | <input type="checkbox"/> Reaching/stretching |
| <input type="checkbox"/> Sitting         | <input type="checkbox"/> Coughing/Sneezing |  |
| <input type="checkbox"/> Other, describe | _____                                      |  |

**Previous Medications** Check (✓) appropriate boxes below if you have used these types of medications for your current pain problem and indicate amount of relief. You may circle the medications you have tried.

Medications	No Relief	Some Relief	Great relief
<input type="checkbox"/> NARCOTICS i.e. Demerol, Morphine, Dilaudid, MS Contin, Methadone, Darvon, Percocet, Percodan, Talwin, Vicodin, Codeine, Tylenol #3, Tylox, Fentanyl Patch.			
<input type="checkbox"/> NSAIDS i.e. Aspirin, Motrin, Ibuprophen, Dolobid, Toradol, Advil, Naproxyn, Relafen, Orudis, Celebrex, Vioxx			
<input type="checkbox"/> SEDATIVES/RELAXANTS i.e. Ativan, Xanax, Valium, Librium, Fexeril, Parafon Forte, Orudis			
<input type="checkbox"/> SLEEP MEDICINES i.e. Halcion, Ambien, Restoril, Benadryl			
<input type="checkbox"/> ANTIDEPRESSANTS i.e. Elavil, Pamelor, Desipramine, Effexor, Desyrel, Prozac, Zoloft, Paxil, Serzone, Remeron			
<input type="checkbox"/> ANTICONVULSANTS i.e. Neurontin, Klonopin, Tegretol, Dilantin			
<input type="checkbox"/> NEUROPATHIC PAIN MEDICATIONS i.e. Baclofen, Mexitil, Hytrin, Phenoybenzamine, Ultram, Prazocin			

Previous Treatments	No Relief	Some Relief	Great relief
<input type="checkbox"/> Acupuncture			
<input type="checkbox"/> Chiropractor			
<input type="checkbox"/> Biofeedback			
<input type="checkbox"/> Traction			
<input type="checkbox"/> Warm Heat			
<input type="checkbox"/> Massage			
<input type="checkbox"/> TENS unit			
<input type="checkbox"/> Physical Therapy			
<input type="checkbox"/> Psychologist			
<input type="checkbox"/> Psychiatrist			
<input type="checkbox"/> Other			

**Symptoms:** Please check (✓) all that apply

- Fever, weight loss
- Changes in skin color or temperature
- Rash
- Enlargement or Pain of Lymph Nodes
- Weakness or paralysis of arms or legs.
- Goiter
- Intolerance to heat or cold
- Diabetes
- Excessive thirst or urination
- Environmental allergy
- Positive allergic skin test
- Positive TB test
- Headache
- Visual changes
- Dizziness
- Ringing in Ears
- Hoarseness
- Seizures
- Cough, wheezing or shortness of breath
- Palpitations, chest pain
- Changes in bladder habits or incontinence
- Changes in bowel habit
- History of easy bruising or blood thinners
- Possibility of Pregnancy

**PMH:** Please check (✓) if you have a history of:

- High blood pressure (hypertension)
  - Angina/Coronary Artery Disease
  - Heart Attack
  - Heart Failure
  - Emphysema or asthma
  - Stroke
  - Seizures
  - Liver Disease
  - Kidney Disease
  - Peptic Ulcer
  - Other GI Illness
  - Bleeding Disorder
  - Taking anticoagulants (blood thinners)
  - Thyroid Disease
  - Cancer
  - Rheumatologic Disease
  - Diabetes
  - Skin Condition
  - Depression
  - Migraine Headaches
  - Auto Immune Disease
  - Other \_\_\_\_\_
-

**Past Surgical History** (please indicate approximate date, type of surgery and physician's name)

Date	Surgery	Surgeon

**Medications** (Please fill out all medications that you are using at this time, including over the counter.)

Drug	Dose	How many times a day?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

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**Social History** (Please complete Information below)

Do you drink alcohol? Y / N If yes, specify quantity \_\_\_\_\_

Do you use any type of tobacco products Y / N If yes, specify type and quantity \_\_\_\_\_

Do you use any street drugs or illicit drugs? Y / N

Do you have:  Glasses  Dentures  Implanted Devices? (Circle one)  
 Contacts  Partial Pump Stimulator Pacemaker Other \_\_\_\_\_  
 Hearing Aid  Visiting Nurses or Home Health at home?

By what name do you like to be called – Do you have a nickname? \_\_\_\_\_

Have you ever been diagnosed with Sleep Apnea?  Yes  No

Are you allergic to latex?  Yes  No If yes, what type of reaction? \_\_\_\_\_

Do you use any Medical Equipment at home?  Yes  No  
If yes, describe \_\_\_\_\_

Are you:  Employed Full time  Employed Part Time  Self Employed  
 Unemployed due to other reasons  Unemployed due to pain  Retired

Present or most recent occupation:

Marital history:  Single  Married  Remarried  Divorced  Separated  Widowed

Litigation history: *Is there any litigation in progress in regard to your pain condition?*  Yes  No

With whom do you live?  Self  Spouse  Children  Parents  Friends  Other

Name of your significant other or contact? \_\_\_\_\_

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Females:

Are you pregnant or is there any chance of pregnancy?  Yes  No  N/A  Last cycle

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**Family History**

Mother: Living/Deceased Cause: \_\_\_\_\_

Father: Living/Deceased Cause: \_\_\_\_\_

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**PLEASE DO NOT WRITE BELOW THIS LINE**

I have reviewed this intake and assessed this patient. To the best of my knowledge, I find it true and accurate.

Signature \_\_\_\_\_ Date: \_\_\_\_\_