

# PAIN MANAGEMENT INTAKE SHEET

Patient Name: \_\_\_\_\_ Chart #: \_\_\_\_\_

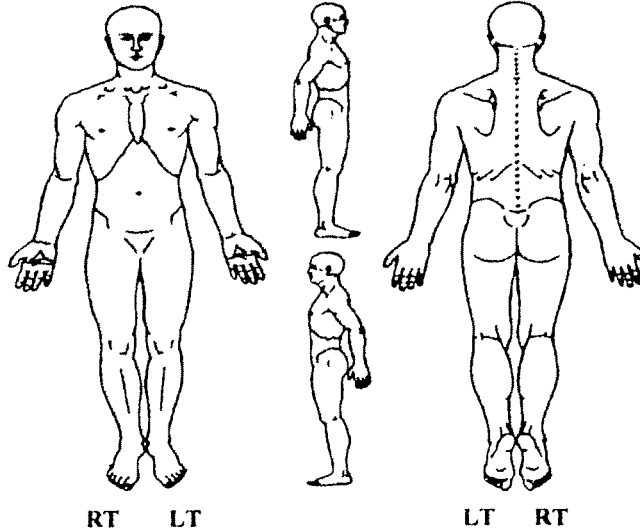
Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

When did the problem begin? \_\_\_\_\_

What activity triggered it? \_\_\_\_\_

### Mark problem areas of pain

XXX = Aching	- - - = Burning	* * * * = Pins & Needles
> > = Shooting	/// = Stabbing	0 0 0 0 = Throbbing



### PAIN SCALE

Rate your pain on the scale from 1-10 with an X  
 NO PAIN    MINIMAL    MODERATE    INTENSE    EMERGENCY  
 0            1-3            4-6            7-9            10

1    2    3    4    5    6    7    8    9    10

**My pain today compared to onset of problem is:**

- The same     Better     Worse

**My pain is improved by:**

- Sitting     Standing     Walking     Laying     Bending forward     Bending back

Describe in detail: \_\_\_\_\_

**My pain is worsened by:**

- Sitting     Standing     Walking     Laying     Bending forward     Bending back  
 Sneeze/cough     Bowel movement

Describe in detail: \_\_\_\_\_

**My pain is described as:**

- Constant     Intermittent     Sharp     Dull     Achy     Burning     Stabbing  
 Searing     Throbbing     Shooting     Cramping     Numbness/Tingling

Describe in detail: \_\_\_\_\_

If you have low back and leg pain please select the statement that best fits:

\_\_\_\_\_ My back pain is greater than my leg pain.

\_\_\_\_\_ My leg pain is greater than my back pain.

\_\_\_\_\_ My back pain is equal to my leg pain.

If you have neck and arm pain select the statement that best fits:

\_\_\_\_\_ My neck pain is greater than my arm pain.

\_\_\_\_\_ My arm pain is greater than my neck pain.

\_\_\_\_\_ My neck pain is equal to my arm pain.

**Previous pain injections:**

Trigger Points     Epidurals     Facet injections     Discogram

Other: \_\_\_\_\_

**Other Therapies:**

Physical Therapy     Chiropractic     Massage Therapy     Acupuncture     Biofeedback

Surgery (list type & date) \_\_\_\_\_

Other: \_\_\_\_\_

**Previous Pain Medications Tried and Effect:**

Medications	Dosage	Effect
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Do you now or have you in the past had any of the following?**

- |                                       |  |                          |   |
|---------------------------------------|--|--------------------------|---|
| <b>Yes</b>                            | <b>No</b>  | <b>Yes</b>               | <b>No</b>   |
| <input type="checkbox"/>              | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> | <input type="checkbox"/> Bleeding Disorders/Clotting Problems |
| <input type="checkbox"/>              | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> | <input type="checkbox"/> High Cholesterol                     |
| <input type="checkbox"/>              | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> | <input type="checkbox"/> Urinary Disorders                    |
| <input type="checkbox"/>              | <input type="checkbox"/> Thyroid                   | <input type="checkbox"/> | <input type="checkbox"/> Arthritis                            |
| <input type="checkbox"/>              | <input type="checkbox"/> Stomach Ulcer             | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy                             |
| <input type="checkbox"/>              | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> | <input type="checkbox"/> Lung/Breathing Problems              |
| <input type="checkbox"/>              | <input type="checkbox"/> Rashes/non-healing lesion | <input type="checkbox"/> | <input type="checkbox"/> Could you possibly be pregnant?      |
| <input type="checkbox"/> Other: _____ |  |                          |   |

**Have you had any surgery in the past? If yes, list type and date of surgery:** \_\_\_\_\_

**Have you been hospitalized for a problem other than listed above? If yes, please specify condition:** \_\_\_\_\_

**Have you had any complications with anesthesia? If yes, please explain:** \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

**Current Medications:**

Medications	Dosage	Doctor Prescribing

Do you take any blood thinners? (Coumadin, Plavix, Lovenox, etc.)  YES  NO

**Allergies:**

None  Penicillin  Sulfa  Iodine  IVP dye / contrast  Latex  Eggs  
 Other: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced  Separated

Do you smoke?  Yes  No \_\_\_\_\_ packs per day for \_\_\_\_\_ years

Do you drink alcohol?  Yes  No Amount per week \_\_\_\_\_

Recreational drug use?  Yes  No

If yes, please list what and when last used \_\_\_\_\_

Are you currently employed?  Yes  No If yes, what is your occupation? \_\_\_\_\_

If no, how long have you been unemployed? \_\_\_\_\_

Family Member	Alive/Deceased	Age	If deceased, what was the cause?
Father	A / D	_____	_____
Mother	A / D	_____	_____

**Review of Systems:**

		Yes	No
Constitutional	Unintended Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
	Fever/Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	Change in vision	<input type="checkbox"/>	<input type="checkbox"/>
ENT	Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>
	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	Swelling of legs/ankles	<input type="checkbox"/>	<input type="checkbox"/>
	Calf cramps while walking	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal		<input type="checkbox"/>	<input type="checkbox"/>
Integumentary	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Heme/Lymphatic	Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	Numbness of arms/legs	<input type="checkbox"/>	<input type="checkbox"/>
	Bladder/Bowel Incontinence	<input type="checkbox"/>	<input type="checkbox"/>