COMPREHENSIVE PAIN MANAGEMENT INTAKE FORM

DATE: _______________

Last Name:	First Name:	Mi:

DOB:	Age:	Sex:

Address:	City:	State:	Zip:

Primary Phone: home/cell/work	Secondary Phone: home/cell/work

Email:	Insurance:

Name of Referring Physician:	Phone:	Fax:

Address:	City:	State:	Zip:

Name of Family Physician:	Phone:	Fax:

Address:	City:	State:	Zip:

Other Physicians currently involved in my care: ____

____

____

What is the main problem for which you are seeking treatment?

____

How long have you had your current pain problem? _____________ Years ____________ Months

Onset of Pain: How did your current pain problem start? (check one)

☐ Accident/Injury at work ☐ Accident/Injury not at work ☐ Motor Vehicle Accident

☐ Cancer ☐ Disease, non-injury ☐ Undetermined ☐ Other: ___________________________

☐ Treatment caused (e.g. radiation, surgery, etc.): ____

Severity of Pain: In general, over the past month, the intensity of my pain has been (check one):

☐ Mild ☐ Moderate ☐ Moderate-Severe ☐ Severe

Timing of Pain: How often do you have your pain (check one):

☐ Constantly (100% of the time) ☐ Nearly Constantly (60-95% of the time)

☐ Intermittently (30-60% of the time) ☐ Occasionally (less than 30% of the time)

Pain/Symptom Quality: How would you describe your pain? (please check all that apply)

☐ Burning ☐ Sharp ☐ Cutting ☐ Throbbing ☐ Cramping ☐ Dull/Aching

☐ Pressure-like ☐ Shooting ☐ Other (describe) _______________________________________

Associated with pain, I feel the following: ☐ Numbness ☐ Pins and needles

I have weakness in my: ☐ Upper extremities ☐ Lower extremities ☐ Dropping objects ☐ Falls

☐ Loss of bladder/bowel control, if so explain ______________________________ Other: ______________

ACTIVITIES AND YOUR PAIN: Does your pain limit your ability to walk? ☐ Yes ☐ No

How long can you sit? ☐ None ☐ 30 minutes ☐ 1 hour ☐ > 2 hours

How long can you stand? ☐ None ☐ 30 minutes ☐ 1 hour ☐ > 2 hours

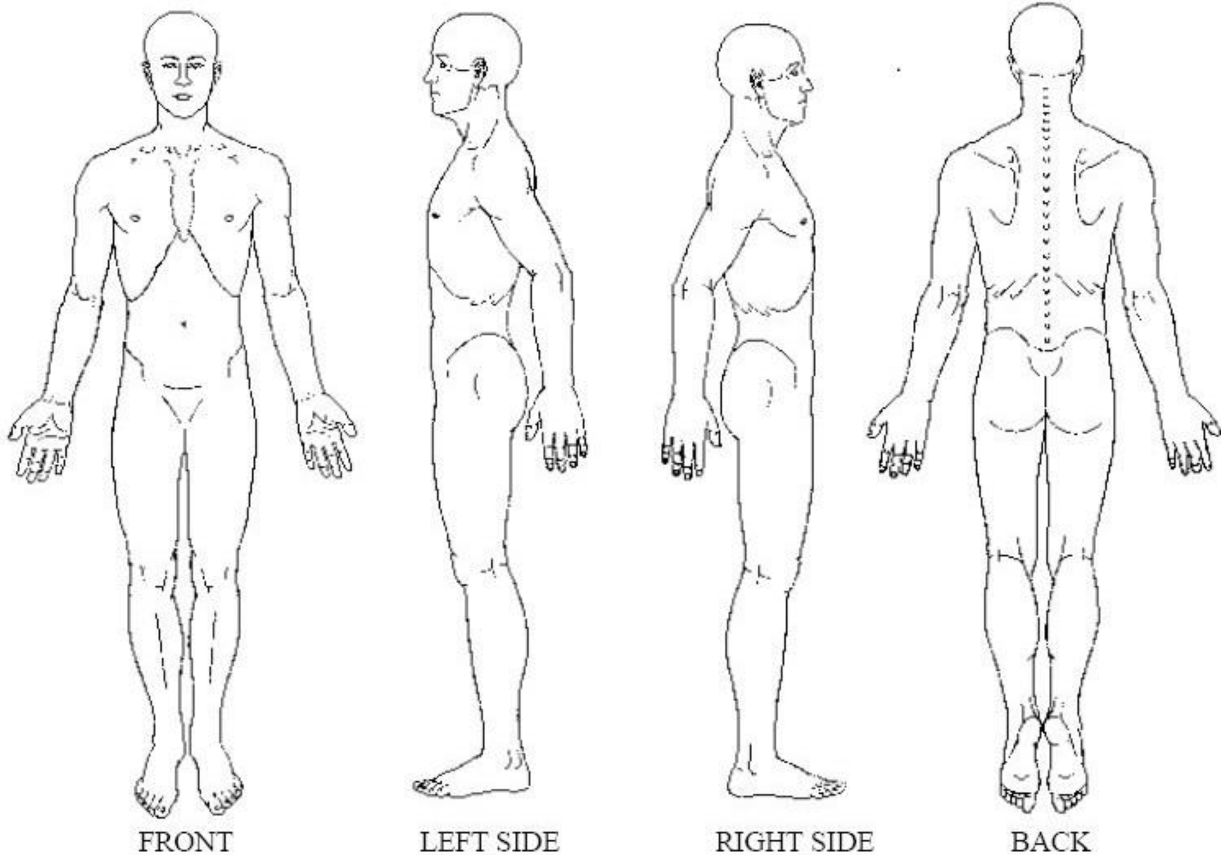
To assist in walking, I use a: ☐ Cane ☐ Walker ☐ Wheelchair ☐ No assistive devices

Are there activities that you are **NOT** able to perform? (check all that apply)

☐ Going to work ☐ Performing household chores ☐ Doing yardwork or shopping

☐ Exercising ☐ Socializing with friends ☐ Participating in recreational activities

PAIN LOCATION: Please mark the location(s) of your pain on the diagrams below with a "X". If whole area is painful, please shade in these areas.



RELIEVING AND AGGRAVATING FACTORS: How do the following affect your pain (check one for each item)

	DECREASE	NO CHANGE	INCREASE
LAYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
RELAXATION			
BENDING			
DRIVING/RIDING			
BOWEL MOVEMENTS			

PREVIOUS PAIN TREATMENTS: (check all that apply)

☐ Surgery ☐ Nerve Block/Injection ☐ Physical Therapy ☐ Exercise ☐ Biofeedback

☐ Heat Treatment ☐ Cold/Ice Treatment ☐ Psychotherapy ☐ TENS ☐ Massage

☐ Psychotherapy ☐ Chiropractic Manipulation ☐ Oral/Topical Medication ☐ Acupuncture

☐ Alternative Medicine/Herbal therapy ☐ Bracing/Traction ☐ Other: _______________________

PRIOR PAIN MEDICATIONS: Please check **ALL** medications you have ever used in the past for treatment.

Opioids	**NSAIDs / Tylenol**	**Anti-Depressants/ Anti-Anxiety**
☐ Hydrocodone/Vicodin/Norco	☐ Acetaminophen/Tylenol	☐ Trifluoperazine/Stelazine
☐ Propoxyphene/Darvocet	☐ Aspirin	☐ Risperidone/Risperdal
☐ Codeine/Tylenol #3	☐ Ibuprofen/Motrin	☐ Olanzapine/Zyprexa
☐ Fentanyl	☐ Naproxen/Aleve/Anaprox	☐ Ziprasidone/Geodon
☐ Hydromorphone/Dilaudid	☐ Etodolac/Lodine	☐ Quetiapine/Seroquel
☐ Morphine/MS Contin	☐ Indomethacin/Indocin	☐ Lurasidone/Latuda
☐ Meperidine/Demerol	☐ Ketoprofen	☐ Fluoxetine/Prozac
☐ Levorphanol/Levo Dromoran	☐ Nabumetone/Relafen	☐ Escitalopram/Lexapro
☐ Methadone	☐ Piroxicam/Feldene	☐ Sertraline/Zoloft
☐ Oxycodone/Percocet	☐ Celecoxib/Celebrex	☐ Citalopram/Celexa
☐ OxyContin	☐ Diclofenac/Voltaren	☐ Venlafaxine/Effexor
☐ Tramadol/Ultram	☐ Oxaprozin/Daypro	☐ Bupropion/Wellbutrin
☐ Tapentadol/Nucynta	☐ Ketorolac/Toradol	☐ Paroxetine/Paxil
☐ Oxymorphone/Opana	☐ Meloxicam/Mobic	☐ Vortioxetine/Trintellix
☐ Buprenorphine/Butrans	☐ Vioxx	☐ Clonazepam/Klonopin
☐ Suboxone/Belbuca	☐ Salsalate/Trilisate	☐ Diazepam/Valium
☐ Butorphanol/Stadol	☐ Sulindac/Clinoril	☐ Chlordiazepoxide/Librium
☐ Pentazocine/Talwin	☐ Tolmetin	☐ Lorazepam/Ativan
☐ Nalbuphine/Nubain	☐ Meclofenamate	☐ Temazepam/Restoril
Muscle Relaxers	☐ Flurbiprofen/Ansaid	☐ Alprazolam/Xanax
☐ Baclofen/Ozobax	☐ Mefenamic acid/Ponstel	☐ Hydroxyzine/Vistaril/Atarax
☐ Carisoprodol/Soma	☐ Fenoprofen/Nalfon	☐ Buspirone/BuSpar
☐ Cyclobenzaprine/Flexeril	☐ Arthrotec	☐ Doxepin
☐ Amrix	☐ Cataflam	☐ Trazodone/Oleptro
☐ Methocarbamol/Robaxin	**Neuroleptics/Nerve Pain**	☐ Maprotiline
☐ Metaxalone/Skelaxin	☐ Gabapentin/Neurontin	☐ Aripiprazole/Abilify
☐ Chlorzoxazone/Lorzone	☐ Horizant	☐ Desvenlafaxine/Pristiq
☐ Parafon Forte	☐ Pregabalin/Lyrica	☐ Duloxetine/Cymbalta
☐ Orphenadrine	☐ Carbamazepine	☐ Amitriptyline/Elavil
☐ Tizanidine/Zanaflex	☐ Milnacipran/Savella	☐ Nortriptyline/Pamelor
☐ Dantrolene/Dantrium	☐ Oxcarbazepine	☐ Imipramine/Tofranil

1. Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain? Yes No Not Sure/Maybe ____

2. When was your last medical checkup? _________________________________

3. Has there been any change in your general health in the past year? If yes, please explain. Yes No Not Sure/Maybe ____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them. Yes No Not Sure/Maybe ____

5. Do you have any allergies? If yes, please list them using the categories below: Yes No Not Sure/Maybe

a) medications: ____

b) latex/rubber products: ____

c) other (e.g. hay fever, seasonal/environmental, foods): ____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. Yes No Not Sure/Maybe ____

7. Do you have or have you ever had asthma? Yes No Not Sure/Maybe

8. Do you have or have you ever had any heart or blood pressure problems? Yes No Not Sure/Maybe

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Yes No Not Sure/Maybe

10. Do you have a prosthetic or artificial joint? Yes No Not Sure/Maybe

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? Yes No Not Sure/Maybe

12. Have you ever had hepatitis, jaundice or liver disease? Yes No Not Sure/Maybe

13. Do you have a bleeding problem or bleeding disorder? Yes No Not Sure/Maybe

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. Yes No Not Sure/Maybe ____

15. Do you have or have you ever had any of the following? Please check.

- ▫ chest pain, angina
- ▫ rheumatic fever
- ▫ pacemaker
- ▫ steroid therapy
- ▫ seizures (epilepsy)
- ▫ heart attack
- ▫ mitral valve prolapse
- ▫ lung disease
- ▫ diabetes
- ▫ kidney disease
- ▫ stroke, TIA
- ▫ tuberculosis
- ▫ stomach ulcers
- ▫ thyroid disease
- ▫ shortness of breath
- ▫ heart murmur
- ▫ cancer
- ▫ arthritis
- ▫ drug/alcohol/cannabis use or dependency
- ▫ osteoporosis medications (e.g. Fosamax, Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.

Yes No Not Sure/Maybe ____

17. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)?

Yes No Not Sure/Maybe ____

18. Do you smoke or chew tobacco products? Yes No Not Sure/Maybe

19. Are you nervous during dental treatment? Yes No Not Sure/Maybe

20. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? Yes No Not Sure/Maybe ____

21. Do you identify as a patient with a disability? If yes, please explain. Yes No Not Sure/Maybe

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