SCNM SOUTHWEST COLLEGE OF NATUROPATHIC MEDICINE & HEALTH SCIENCES

PAIN RELIEF CENTER

PAIN RELIEF CENTER SPECIFIC FORM

Legal Name:

Referring Specialist:

CONCERNS

Thank you for taking the time to fill out this intake form. We know it is comprehensive, but by gathering this information about your health history and goals helps provide your naturopathic doctors a more complete understanding of you. We want to help you reach your optimal health.

Most important concern you would like to address?

Additional concerns?

HISTORY OF PRESENT ILLNESS

What caused your illness? (Please check all that apply.)

- ☐ Injury at work
- ☐ Injury at home
- ☐ Following illness
- ☐ Following surgery
- ☐ Burn
- ☐ After dental care
- ☐ Motor Vehicle Accident
- ☐ Infection
- ☐ Poisoning
- ☐ Herpes zoster (Shingles)
- ☐ No cause

How often do you have pain?

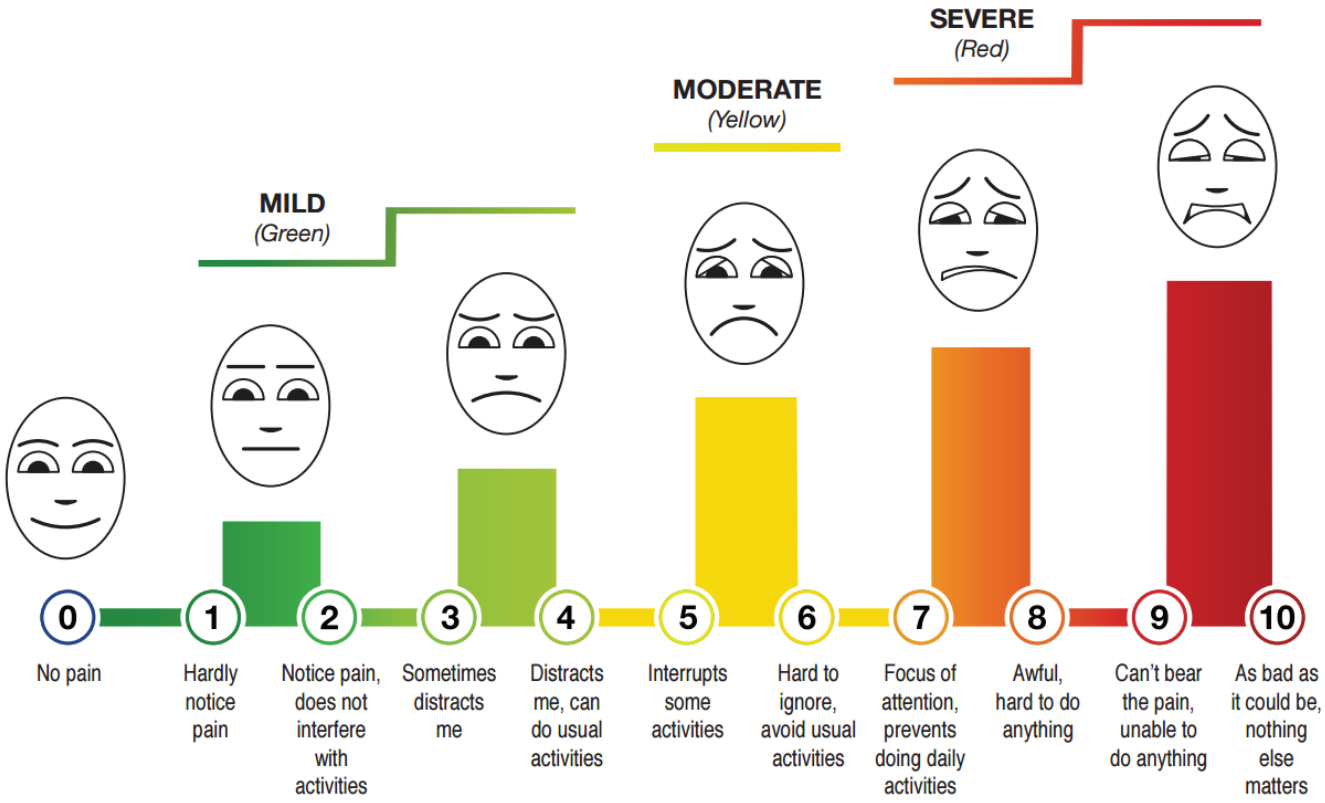
- ☐ Constant (100% of the time)
- ☐ Nearly Constant (80-90% of the time)
- ☐ Fairly Constant (50-80% of the time)
- ☐ Frequently (25-50% of the time)
- ☐ Intermittent (Less than 25% of the time)

Other:

Approximate date of original onset/injury:

PAIN SCALE

Circle (○) the number that describes your pain level on a ***GOOD*** day and place a square (☐) around the number that describes your pain on a ***BAD*** day.



EMPLOYMENT

Type of work:

Years on the job:

Workman's Compensation:

- ☐ Yes
- ☐ No

Case Workers Name:

Case Number:

Does your pain keep you for working?

- ☐ Yes
- ☐ No
- ☐ Retired

Is there litigation involved?

- ☐ Yes
- ☐ No

LOCATION OF PAIN

Please mark the diagram below indicating the **TYPE** of pain(s)/sensations(s) you are having and the location on your body.

Please use the following symbols:

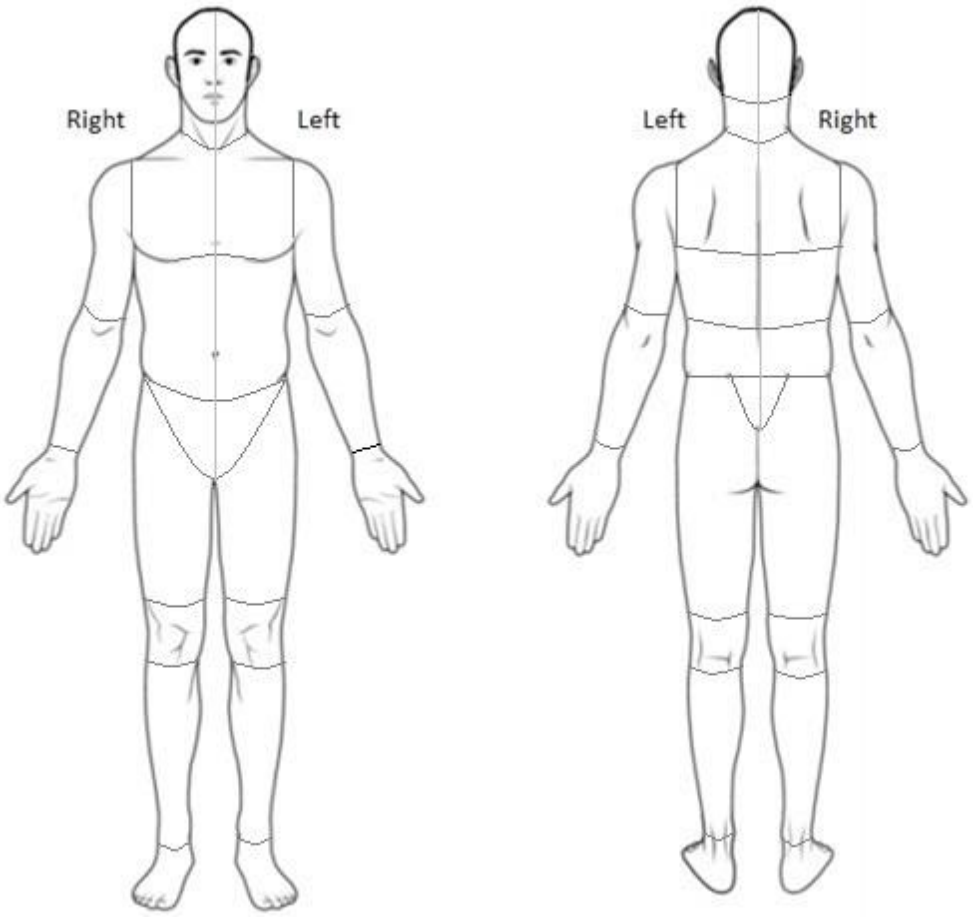
Solid Circles ● for **Stabbing Pain**

Open Circles ○ for **Pins & Needles**

Circles with X's ⊗ for **Numbness**

X's for **Burning Pain**

Triangles Δ for **Aching Pain**



DESCRIPTION OF PAIN

Describe your pain in each of your troubled areas. Use the following descriptors: Aching, Annoying, Burning, Cold, Constant, Cramping, Dull, Heavy, Hot, Intense, Numbing, Radiating, Sharp, Shooting, Sore, Stabbing, Stinging, Tight, Tingling, Transient, Unbearable.

Example: Knee – Aching, Annoying, Constant, Sore, Dull

AREA OF MOST CONCERN:

SECOND AREA:

THIRD AREA:

ACTIONS THAT MODIFY PAIN

For each area of pain, please mark **(+)** Increases pain, **(-)** decreases pain, or leave blank for no change or no effect.

AREA OF MOST CONCERN:

Action	(+/-)	Action	(+/-)	Action	(+/-)
No movement		Sleeping		Coughing/Sneezing	
Sitting		Lying on your back		Bowel movements	
Standing		Lying on your stomach		Urination	
Standing after sitting		Lying on your side		Sexual intercourse	
Walking		Getting out of bed		Loud noises	
Driving/Riding in car		Weather Changes		Bright lights	
Fatigue		Heat		Breathing	
Tension/Stress		Cold			

SECOND AREA:

Action	(+/-)	Action	(+/-)	Action	(+/-)
No movement		Sleeping		Coughing/Sneezing	
Sitting		Lying on your back		Bowel movements	
Standing		Lying on your stomach		Urination	
Standing after sitting		Lying on your side		Sexual intercourse	
Walking		Getting out of bed		Loud noises	
Driving/Riding in car		Weather Changes		Bright lights	
Fatigue		Heat		Breathing	
Tension/Stress		Cold			

THIRD AREA:

Action	(+/-)	Action	(+/-)	Action	(+/-)
No movement		Sleeping		Coughing/Sneezing	
Sitting		Lying on your back		Bowel movements	
Standing		Lying on your stomach		Urination	
Standing after sitting		Lying on your side		Sexual intercourse	
Walking		Getting out of bed		Loud noises	
Driving/Riding in car		Weather Changes		Bright lights	
Fatigue		Heat		Breathing	
Tension/Stress		Cold			

If necessary, please write down other activities not listed and specify if they increase or decrease your pain:

PAIN MEDICATION

Please list the PAIN medicines you are **currently taking**. List your other medicines in the next section.

☐ I do not take medicine for pain.

MEDICINE	STRENGTH	TIMES/DAY	FIRST TAKEN	PRESCRIBER	EFFECTIVE?

Please list other pain medicines you have tried, **but no longer take**, for your **PAIN**.

MEDICINE	STRENGTH	TIMES/DAY	FIRST TAKEN	PRESCRIBER	EFFECTIVE?

Please check any over-the-counter medicines you take.

- ☐ None
- ☐ Antacids
- ☐ Aspirin containing products
- ☐ Bowel products
- ☐ Cold/Cough medicine
- ☐ Eye Drops
- ☐ Herbal / Homeopathic Remedies
- ☐ Other:
- ☐ Laxatives
- ☐ Sleep Medicine
- ☐ Vitamins

Have you taken cortisone or other steroid medicine within the last year?

- ☐ Yes
- ☐ No

If Yes, which drug and what reason? Was it effective? ☐ Yes ☐ No

Are you on any anticoagulant(s)/anti-platelet/blood thinner(s) e.g., aspirin, Coumadin, ibuprofen, Plavix?

- ☐ Yes
- ☐ No

If Yes, please write drug information below. Date of last blood test:

MEDICINE	STRENGTH	TIMES/DAY	REASON FOR TAKEN	PRESCRIBER

ADDITIONAL INFORMATION

Do you have any other current medical problems or personal issues that need to be addressed?

☐ No

☐ If yes, please describe:

The information provided above is correct to the best of my knowledge.

_____ **Print Patient Name**

_____ **MR Number** (Office Use Only)

_____ **Patient or legally authorized individual signature**

_____ **Date**

_____ **Printed legally authorized individual name**

_____ **Relationship (parent, legal guardian, personal representative, etc.)**