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PAIN INTAKE

Thank you for taking the time to fill out this form! This information provides your Practitioner with a comprehensive understanding of your pain and its ramifications, so that they can help you reach your optimal health.

Date:	
Legal Name:	
Referring Specialist:	

CONCERNS

Please list the most important pain concern(s) that you would like to address **(maximum of 2):**

Please list any additional pain concern(s) that you would like to address **(maximum of 2):**

EMPLOYMENT

Type of work currently:

Number of years at this job: _____

Does your pain keep you from working?

- ☐ Yes
- ☐ No
- ☐ Retired

Is there litigation involved?

- ☐ Yes
- ☐ No

Workman's Compensation: ☐ Yes ☐ No

Case Worker's Name:	
Case Number:	

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HISTORY OF CURRENT ILLNESS

Date of initial onset or injury:

_____

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

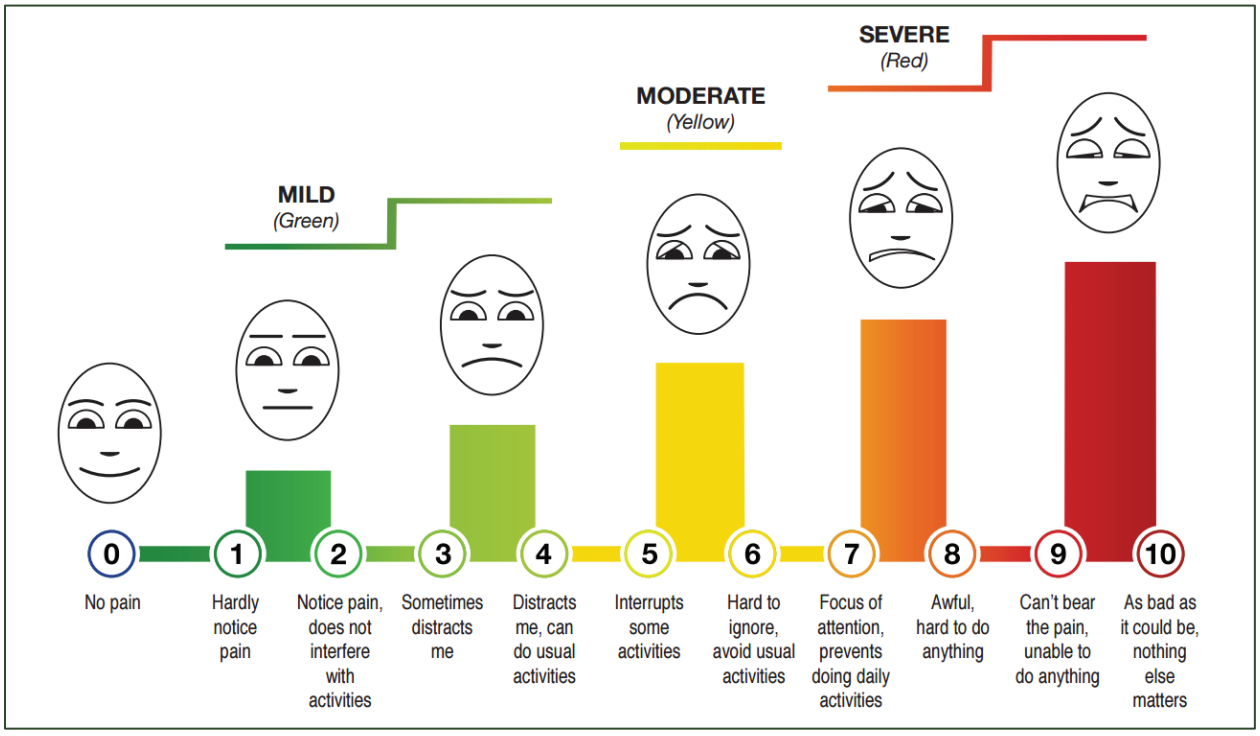
☐ Following dental care	☐ Herpes zoster (Shingles)	☐ Motor Vehicle Accident
☐ Following immobilization	☐ Other Infection	☐ Childbirth
☐ Following illness	☐ Injury at work	☐ Burn
☐ Following surgery	☐ Injury at home	☐ Other:_____

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)

PAIN SCALE

On the chart below, circle (¡) the number that describes your pain level on a ***GOOD*** day and place a square (o) around the number that describes your pain on a ***BAD*** day.



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:

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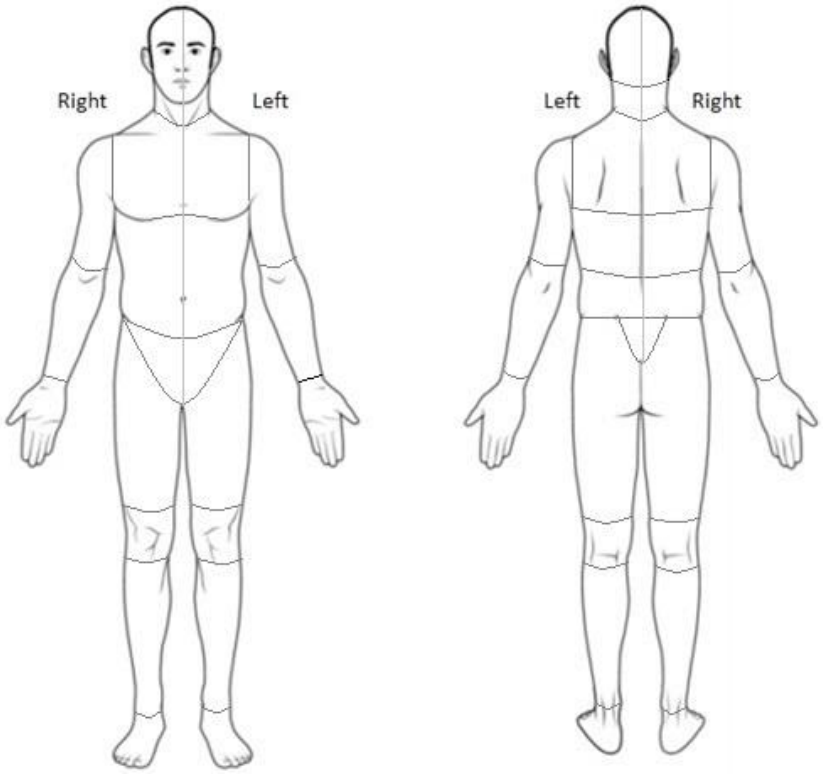
● (solid circle) for **Stabbing Pain**	⊗ (X in circle) for **Numbness**	Δ (triangle) for **Aching Pain**
○ (open circle) for **Pins & Needles**	X for **Burning Pain**	



ACTIONS THAT MODIFY YOUR MOST IMPORTANT PAIN CONCERNS

FIRST AREA OF CONCERN: please place an "X" next to the action if it **INCREASES** pain or leave it blank for no change/effect.

Action	(X)	Action	(X)	Action	(X)
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			

FIRST AREA OF CONCERN: please place an "X" next to the action if it **DECREASES** pain or leave it blank for no change/effect.

Action	(X)	Action	(X)	Action	(X)
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 OF CONCERN: please place an "X" next to the action if it **INCREASES** pain or leave it blank for no change/effect.

Action	(X)	Action	(X)	Action	(X)
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 OF CONCERN: please place an "X" next to the action if it **DECREASES** pain or leave blank for no change/effect.

Action	(X)	Action	(X)	Action	(X)
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 applicable, please note other actions not listed and specify if they increase or decrease your pain:

CURRENT MEDICATION

Please list ALL medications that you are **currently taking**.

☐ I do not take any medication.

MEDICATION	STRENGTH	TIMES/DAY	FIRST TAKEN	PRESCRIBER	EFFECTIVE (Y/N)

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Please check any over-the-counter medicines you are **currently taking:**

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

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

☐ Yes

☐ No

If Yes, which cortisone/ steroid medication and for what reason?

Was it effective? ☐ Yes ☐ No

Are you on any anticoagulant(s)/blood thinner(s) e.g. aspirin, ibuprofen, Coumadin (Warfarin), Plavix, etc.? ☐ Yes ☐ No **If Yes,** please provide the following information below for each.
Date of last blood test: _____

MEDICATION	STRENGTH	TIMES/DAY	REASON	PRESCRIBER

SIGNATURE: Patient or legally authorized individual

Date

PRINT Name: Patient or legally authorized individual

Relationship: (self, parent, legal guardian, personal representative, etc.)