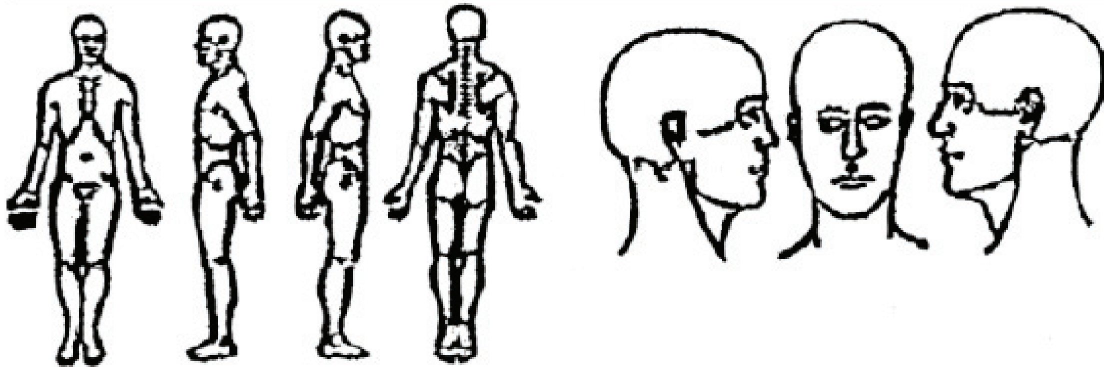
VITAL SIGNS ON INTAKE: T:____ HR:____ RR:____ BP:____/____ SpO2:____
Ht:_____ Wt:_____

1. Please describe the events that caused your pain and tell us when it began:____________________
____
____

2. Please shade the areas where you feel pain, on the diagram below:



3. Mark the words that best describe your pain:

□ Sharp □ Dull □ Aching □ Throbbing □ Burning □ Stinging □ Shooting □ Numbing □ Cramping

4. How often does your pain present?

□ Constantly □ Frequently □ Occasionally □ Rarely

5. What tends to make your pain worse?

□ Sneezing □ Coughing □ Bending □ Twisting □ Lifting □ Lying down □ Sitting up □ Walking
□ Cold exposure □ Bright light □ Loud noises □ Going up or down stairs □ Eating

6. What tends to help your pain?

□ Lying down □ Sitting up □ Walking □ Bending forward □ Leaning back □ Position change
□ Heat/ice □ Massage □ Bracing/Traction/TENS □ Exercise/Physical Therapy □ Meditation
□ Medication □ Injections □ Chiropractic Care □ Acupuncture

7. Please rate the AVERAGE severity of your pain over the course of a 24 hour period:

With my *current* medication regimen: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN AT ALL — WORST PAIN IMAGINABLE

Without my *current* medication regimen: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN AT ALL — WORST PAIN IMAGINABLE

Patient Name:____________________________

DOB:____________________

(or use patient label)

Name / MR # / Label

8. Please advise us if you have been diagnosed with any of the following medical problems:

☐ Stroke ☐ Frequent headaches ☐ Seizure disorder ☐ Memory problems ☐ Other neurologic disease
____

☐ Heart failure ☐ Heart attack ☐ Heart rhythm disturbance ☐ Other heart disease
____

☐ High blood pressure ☐ Poor circulation ☐ Blood clots ☐ Bleeding disorder ☐ Use of blood thinners
____

☐ Asthma ☐ COPD ☐ Sleep apnea ☐ Other lung disease
____

☐ Kidney stones ☐ Kidney failure ☐ Bladder problems ☐ Prostate problems ☐ Erectile dysfunction
____

☐ Hepatitis ☐ Fatty liver ☐ Jaundice ☐ Stomach ulcers ☐ GERD ☐ IBS ☐ Other GI disease
____

☐ Diabetes ☐ Thyroid problems ☐ Vitamin deficiencies ☐ Other hormone/endocrine disease
____

☐ Recurrent infections ☐ HIV ☐ Tuberculosis ☐ Meningitis ☐ Other immune/infectious disease
____

☐ Acne ☐ Psoriasis ☐ Skin cancer ☐ Cellulitis ☐ Other skin condition
____

☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Lupus ☐ Fibromyalgia ☐ Other rheumatoid disease
____

☐ Depression ☐ Anxiety ☐ Bipolar ☐ Hospitalization for mental illness ☐ Other psychiatric disease
____

9. Please list the surgeries you have had in the past, specifying date and side (where applicable):

____

____

____

____

10. Which of the following problems run in your family? Please specify mother/father/sibling, etc.

☐ Cancer (type) ____
☐ Heart disease ____
☐ Chronic pain ____
☐ Substance abuse ____
☐ Diabetes ____
☐ Bleeding disorder ____
☐ Mental illness ____
☐ Stroke ____

11. Who is your primary care provider? ___________________________________

12. Which other doctors/office have previously treated your pain?_______________________

____

Patient Name:____________________________

DOB:______________________

(or use patient label)

Name / MR # / Label

13. Please tell us more about your social situation:

- ☐ Married ☐ Single ☐ Divorced ☐ Widowed
- ☐ Children: ____ (ages)
- ☐ Level of education completed: ____
- ☐ Employer: ________________________ Position: ____________________________
- ☐ Homemaker ☐ Searching for work ☐ Long-term disability ☐ Short-term disability
- ☐ Never smoker ☐ Current smoker ____ (packs/day) ____ (age started)
- ☐ Former smoker ____ (years smoked) ____ (year quit)
- ☐ Alcohol use ____ (glasses of wine/beer per day) ☐ History of alcoholism
- ☐ Illicit drug use, current or history of ____________________
- ☐ Live alone ☐ Live with family ☐ Live with friends ☐ Live in a long-term care facility
- ☐ Sexually active ☐ Not sexually active
- ☐ Routine exercise ☐ No routine exercise
- ☐ Involved in a lawsuit regarding your pain ☐ Receiving compensation related to your pain

14. Please let us know if you routinely experience any of the following:

☐ Activity change	☐ Shortness of breath	☐ Abdominal pain	☐ Dizziness
☐ Appetite change	☐ Cough	☐ Constipation	☐ Headaches
☐ Chills	☐ Wheezing	☐ Diarrhea	☐ Numbness
☐ Night sweats	☐ Chest tightness	☐ Nausea/vomiting	☐ Weakness
☐ Fever	☐ Chest pain	☐ Blood in stool	☐ Tremors
☐ Weight change	☐ Leg swelling	☐ Rectal pain	☐ Seizures
	☐ Palpitations		☐ Memory difficulties
☐ Neck pain/stiffness		☐ Joint swelling	
☐ Facial swelling	☐ Hot/cold intolerance	☐ Joint pain	☐ Anxious feelings
☐ Ear pain/drainage	☐ Excessive thirst	☐ Muscle aches	☐ Depressed feelings
☐ Hearing loss	☐ Excessive hunger	☐ Muscle spasms	☐ Diff concentrating
☐ Ringing in the ears	☐ Sexual problems	☐ Back pain	☐ Hallucinations
☐ Nosebleeds			☐ Agitation
☐ Congestion	☐ Genital pain/sores	☐ Swollen lymph node	
☐ Eye pain	☐ Menstrual problems	☐ Easy bruising	☐ Skin lesions
☐ Dry eyes	☐ Urinary difficulty/pain	☐ Food allergies	☐ Color change
☐ Vision changes	☐ Incontinence	☐ Enviro allergies	☐ Rashes

Patient Name:______________________________
DOB:______________________

(or use patient label)

Name / MR # / Label

15. Please list your medication allergies (name of medicine and type of allergic response):

____

16. Please list your current medications, including doses and how many times a day your take each:

____

17. Please list medications you have tried in the past to treat your pain (and your response to each):

____

Patient's Signature Date/Time

Signature of Authorized Person Date/Time Relationship to Patient

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted ______________________________ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Patient Name:__________________________

DOB:____________________

(or use patient label)
Name / MR # / Label