Patient Clinical Intake Form

(Please Use **BLACK** or **BLUE** Ink Only)

IDENTIFICATION DATA

Name: _____ Date of Birth: _____

Referred by: _____ Today's Date: _____

Gender: ☐ Male ☐ Female

MEDICATION HISTORY

List ALL medications you are currently taking as well as the dosage, frequency, and duration *(prescription, over the counter, herbals, supplements, etc.)*:

_____

_____

_____

_____

_____

ALLERGIES

List any medication you are allergic to and your reaction: ☐ *No Known Allergies*

Medication	Reaction

MEDICAL HISTORY

Please list all surgeries, hospitalizations, and/or serious injuries including date: ☐ *None*

FAMILY HISTORY

List immediate family members who have died *(Father, Mother, etc)*:

_____

_____

Check illnesses immediate family members have had:

☐ Allergies	☐ Asthma	☐ Cancer	☐ High Blood Pressure
☐ Depression	☐ Diabetes	☐ Glaucoma	☐ Hay Fever
☐ Heart Disease	☐ Obesity	☐ Sickle Cell Anemia	☐ Tuberculosis

SOCIAL & WORK HISTORY

Marital Status: ☐ M ☐ Sep ☐ D ☐ W ☐ Single Children: ☐ No ☐ Yes- #Sons:___#Daughters:___

Lives Alone: ☐ Yes ☐ No Do you feel safe in your environment? ☐ Yes ☐ No

Tobacco Usage: ☐ Current ☐ Never ☐ Former Type:_____ #Years: _____

Drinks Alcohol: ☐ Yes ☐ No ☐ Formerly Type: _____ Frequency:_____*(x per wk)*

Drug Use/Abuse: ☐ Yes ☐ No ☐ Formerly Type: _____ Frequency:_____*(x per wk)*

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired

Highest Level of Education:

☐ Some High School ☐ High School Diploma/GED ☐ Some College ☐ Associates Degree

☐ Bachelor's Degree ☐ Graduate/Professional Degree ☐ Technical College

Did you stop working because of your pain? ☐ Yes ☐ No

Have you received financial compensation related to your pain? ☐ Yes ☐ No

Are you now bringing a lawsuit because of your pain? ☐ Yes ☐ No

Have you already filed suit for compensation? ☐ Yes ☐ No

Is this visit related to Worker's Compensation? ☐ Yes ☐ No

A. *If so, what was your initial date of injury?*_____

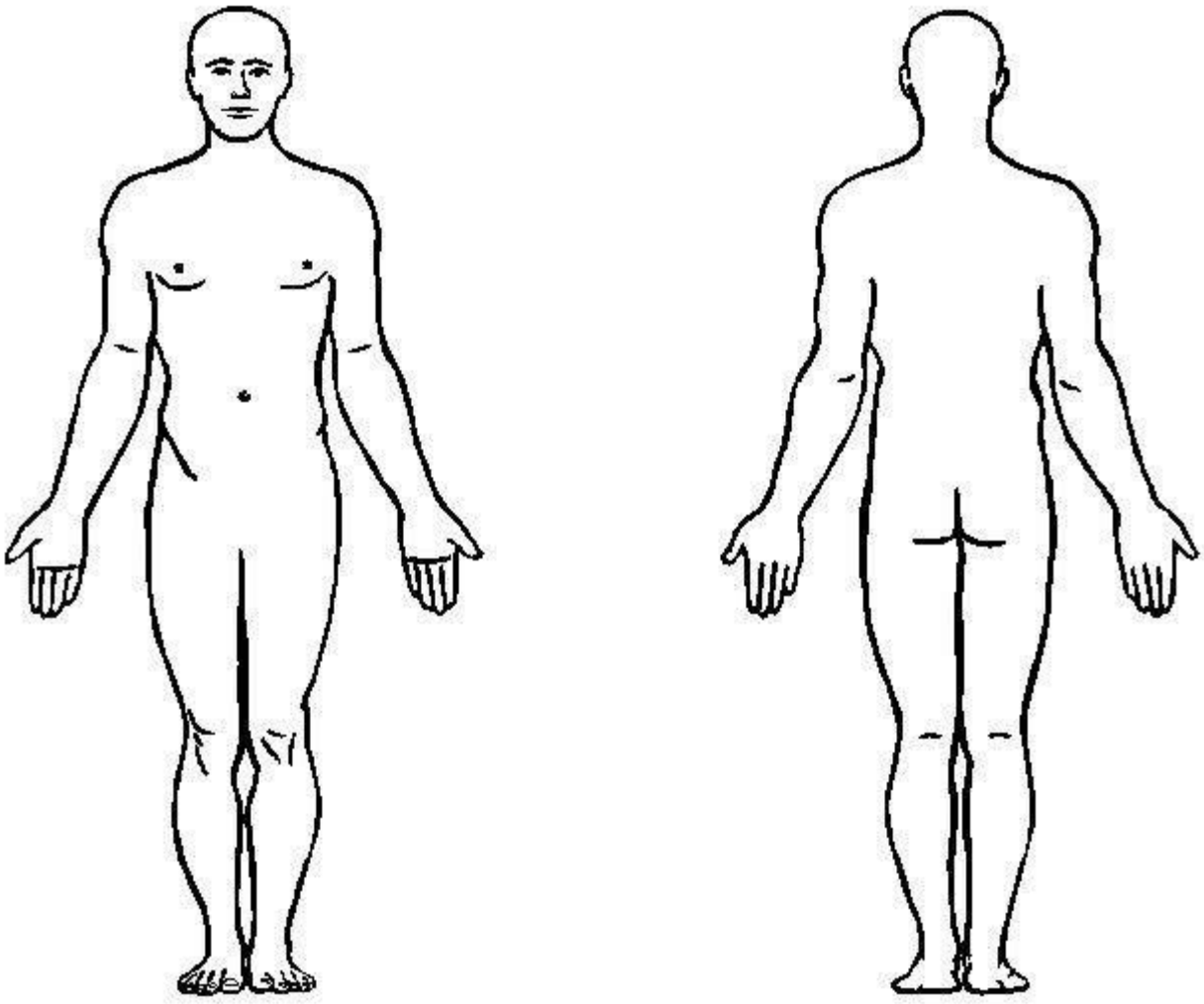
B. *What is the location of your injury?*_____

C. *What is the name and contact information of your case adjuster?*

Name: _____ *Phone Number:* _____

BRIEF PAIN INVENTORY

On the diagram, shade the areas where you feel pain. Put an "X" on the area that hurts the most.



How long has it been since you first learned of your diagnosis?

Current Level of Pain 1 – 10 *(10 is worst)*:

Describe the frequency of your pain:

☐ Intermittent ☐ Constant ☐ Occasional ☐ Rare

Select the words that describe your pain:

☐ Ache ☐ Burning ☐ Deep ☐ Discomforting ☐ Dull ☐ Numbness

☐ Piercing ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing

What makes your pain worse?

☐ Movement ☐ Sitting ☐ Standing ☐ Stress ☐ Walking ☐ Other: _____

BRIEF PAIN INVENTORY, continued

What relieves your pain?

☐ Exercise ☐ Heat ☐ Ice ☐ Injections ☐ Medication ☐ Physical Therapy ☐ Rest ☐ Sitting

Other methods you use to relieve your pain?

☐ Warm Compress ☐ Cold Compress ☐ Relaxation/Distraction Techniques ☐ Biofeedback

☐ Hypnosis ☐ Other:

Rate your pain by choosing the ONE number that best describes your pain at its *worst* last week.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — *Worst Pain Imaginable*

Rate your pain by choosing the ONE number that best describes your pain at its *least* last week.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — *Worst Pain Imaginable*

Rate your pain by choosing the ONE number that best describes your pain on *average*.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — *Worst Pain Imaginable*

In *the past week* how much relief have pain treatments or medications provided?

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

No Relief — *Complete Relief*

Considering your pain over *the past week*, choose the number that best describes how it has interfered with your-

General Activity:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Mood:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Walking Ability:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

BRIEF PAIN INVENTORY, continued

Normal Work:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Relations with Other People:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Sleep:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Enjoyment of Life:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Have you ever had pain due to your present disease? ☐ Yes ☐ No

When you first received your diagnosis, was pain a symptom? ☐ Yes ☐ No ☐ Uncertain

Have you had surgery in the past month? ☐ Yes ☐ No

If YES, what kind? _____

I believe my pain is due to:

The effects of treatment *(ex. Medication, surgery, radiation, prosthetic device)* ☐ Yes ☐ No

My primary disease *(the disease currently being treated and evaluated)* ☐ Yes ☐ No

A medical condition unrelated to my primary disease *(ex. arthritis)* ☐ Yes ☐ No

What treatments or medications are you receiving for your pain?

_____

_____

_____

I prefer take my pain medicine:

☐ On a regular basis ☐ Only when necessary ☐ Do not take medicine

BRIEF PAIN INVENTORY, continued

If you take pain medication, how many hours does it take before the pain returns?

☐ 1 hour ☐ 2 hours ☐ 3 hours ☐ Pain medication does not help

☐ 4 hours ☐ 5 to 12 hours ☐ 12+ hours ☐ I do not take pain medication

I take my pain medicine *(in a 24 hour period)*:

☐ Not every day ☐ 1 to 2 times per day ☐ 3 to 4 times per day

☐ 5 to 6 times per day ☐ More than 6 times per day

Do you feel you:

Need a stronger type of pain medication? ☐ Yes ☐ No ☐ Uncertain

Need to take more than what the doctor has prescribed? ☐ Yes ☐ No ☐ Uncertain

Need to receive more information about your pain medication? ☐ Yes ☐ No ☐ Uncertain

Are you concerned that you use too much pain medication? ☐ Yes ☐ No ☐ Uncertain

If yes, why? _____

Do you have side effects from your pain medication? ☐ Yes ☐ No ☐ Uncertain

If yes, which side effects? _____

Medications NOT prescribed by my doctor that I take for pain are:

_____

REVIEW OF SYSTEMS

Please check if your medical history includes:

Date of last Dental Exam:

EYE, EAR, NOSE, THROAT

Ear Infection ☐
Eye Problems ☐
Hay Fever ☐
Hearing Loss ☐

GASTROINTESTINAL

Change in Bowel Habits ☐
Jaundice *(hepatitis)* ☐
Rectal Bleeding ☐
Stomach Pain ☐
Ulcers ☐

CARDIO-RESPIRATORY

Activity Limitation ☐
Asthma ☐
Chest X-Ray Date ☐
Congestive Heart Failure ☐
Cough *(if chronic)* ☐
EKG Last Date ☐
Pacemaker/Defibrillator ☐
Pneumonia ☐
Rheumatic Fever ☐
Trouble Breathing ☐

REVIEW OF SYSTEMS continued

GENITO-URINARY

Difficulty Starting Stream	☐
Kidney Disease	☐
Night Time Urination	☐
Urinary Infection	☐

SKELETAL

Arthritis	☐
Back Problems	☐
Joint Pain/Swelling	☐
Neck Pain/Stiffness	☐

NEURO-MUSCULAR

Disorientation	☐
Migraine/Headaches	☐
Multiple Sclerosis	☐
Muscle Pain	☐
Numbness	☐
Paralysis	☐
Seizures/Epilepsy	☐
Speech	☐
Stroke	☐
Tingling	☐
Tremors	☐
Weakness	☐

ENDOCRINE

Diabetes	☐
Hyperlipidemia	☐
Recent Wt. Gain/Loss *(#10)*	☐
Thyroid Problems	☐

HEMATOLOGIC

Anemia	☐
Bleeding Tendencies	☐
Sickle Cell Disease	☐
Thrombophlebitis/Blood Clot	☐

VASCULAR

Arteriosclerosis	☐
Coronary Artery Disease	☐
Hypertension	☐
Peripheral Artery Disease	☐
Peripheral Vascular Disease	☐

RHEUMATOLOGY

Ankylosing Spondylitis	☐
Fibromyalgia	☐
Osteoarthritis	☐
Osteoporosis	☐
Polymyalgia Rheumatica	☐
Psoriatic Arthritis	☐
Rheumatoid Arthritis	☐
Systemic Lupus Erythematosus	☐
Other	☐

OTHER

Cancer	☐
Mental/Emotional Problems	☐
Tetanus Immunization Date	☐
V.D. History	☐

WOMEN ONLY

☐ Irregular Periods ☐ Abnormal Flow ☐ PID/Pelvic Pain ☐ Breast Disease

Last Menstrual Period, Date: _____ Last Pelvic/Pap Smear Date: _____

Birth Control? *If so, what type:* _____ #Pregnancies: _____ #Births: _____