Peninsula Pain Clinic, PLLC

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Admin Use Only:
HT: WT: RM#:
BP: P: R:
UDT Done Today ☐

Initial Intake Form

Date: _____

Patient Name: _____ **Patient Date of Birth**: _____

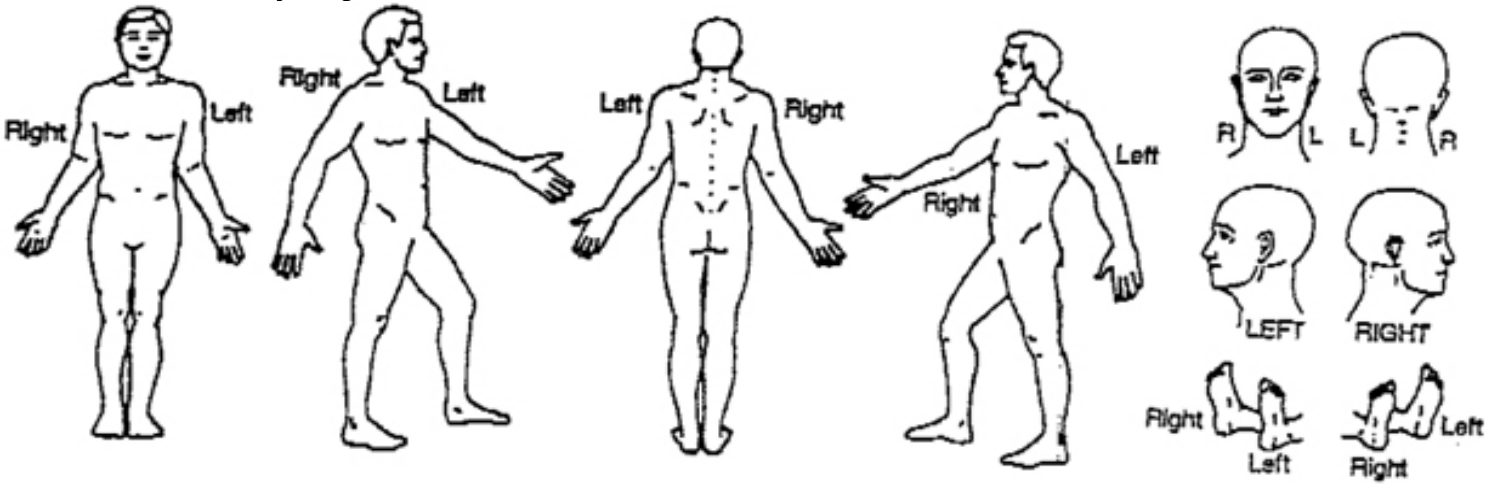
Referring Physician: _____

Section 1: Pain History

Where is your pain? Be specific and list in order of most severe pain to least severe pain:

1. _____ Most severe
2. _____
3. _____
4. _____
5. _____ Least severe

Please indicate where your pain is located.



When did your pain begin? _____

How did your pain occur?
Accident at Work Accident at home Following illness Following surgery Motor Vehicle Accident
Other: _____

If accident, please describe: _____

Which words describe your pain?
Aching Burning Exhausting Gnawing Miserable Nagging Numbing Penetrating Sharp
Shooting Stabbing Tender Throbbing Tiring Unbearable

Turn page over

Patient Name: _____ Date: _____

Does your pain radiate to another place? _____ If yes, Where? _____

Please describe your pain at different intervals using the following ratings:

Your pain when its least painful: 0 1 2 3 4 5 6 7 8 9 10

Your pain when its most severe: 0 1 2 3 4 5 6 7 8 9 10

Your pain on average: 0 1 2 3 4 5 6 7 8 9 10

Time of day your pain is worse:
Morning upon rising Later in the morning Afternoon Evening Night Continuous

What makes your pain better?
Alcoholic drinks Heat Lying down Medication Relaxation Sitting Sneezing Standing Walking

What makes your pain worse?
Coughing Lying down Physical Activity Sitting Sneezing Standing Walking

Which words describe your pain interference?
Ability to concentrate Appetite Enjoyment of life General Activities Mood Normal Routine Sleep
Social Activities Walking

Overall, has your pain?
Increased Decreased Stayed the same

Have you have had any of the following diagnostic tests regarding your pain?
EMG: Date: _____CT Scan: Date: _____MRI: Date: _____ Myelogram: Date: _____X-rays: _____

Have you had any nerve blocks/injections for this problem?
Yes No If yes, please describe: Date: _____ Type of procedure: _____
Provider: _____

Please circle any non pharmacologic approaches you have had for this problem, and if they helped.
Acupuncture: Biofeedback Bed Rest Chiropractic Heat Therapy Hypnosis
Physical Therapy Psychotherapy TENS unit

List all health care providers and any other treatments you have had, related to your pain.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient Name: _____ **Date:** _____

Section 2: Medication History

Medication Allergies: _____

Please list all of your current medications with dosages: (Please list any side effects you are experiencing)

1. _____ Side effects? Yes No Explain:_____
2. _____ Side effects? Yes No Explain:_____
3. _____ Side effects? Yes No Explain:_____
4. _____ Side effects? Yes No Explain:_____
5. _____ Side effects? Yes No Explain:_____

Please list all medications with dosages you have taken for pain in the past:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Section 3: Medical History

Please list your medical problems, other then pain. (such as heart attack, diabetes, stroke, hypertension)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have any allergies not related to medications?
Yes No If yes, please list:

1. _____ 2. _____
3. _____ 4. _____

Please list any prior surgeries or hospitalizations with dates:

1. _____ 2. _____
3. _____ 4. _____

Patient Name: _____ **Date:** _____

Please list immediate family members with chronic illness or pain problems:

1. _____
2. _____
3. _____
4. _____
5. _____

Section 4: Social History

Marital Status: _____

Are you employed? Yes No Occupation: _____

If unemployed, how long? _____ Is this due to your pain? _____

Do you plan to go on disability? _____

Are you currently involved in a lawsuit? (Circle one)
Yes No If yes, explain: _____

If this is an injury, are receiving compensation? (Circle one)
Yes No If yes, explain: _____

Do you use tobacco: Currently Formerly Never

Do you use Alcohol: Currently Formerly Never

Do you have a history with substance abuse?
Yes No If yes, explain: _____

Are there any substance abuse issues in your household?
Yes No If yes, explain: _____

Have you ever had psychiatric treatment?
Yes No If yes, explain: _____

Is there any history with emotional, physical, or sexual abuse in your household?

Yes No If yes, explain: _____

Review of Symptoms

Patient Name: _____ Date: _____

(Circle all that apply)

General/Constitutional:
No problems General weakness Change in appetite Chills Fatigue Fever Headache/Migraine
Lightheadedness Night Sweats Sleep disturbance Weight gain Weight loss

Ophthalmologic:
No problems Blurred vision Diminished visual acuity Flashes of light in the visual field

Ear/Nose/Throat:
No problems Dry mouth Hearing Loss Nosebleeds Ringing in the ears Trouble swallowing

Cardiovascular:
No problems High Blood Pressure Blood Clots Blood Thinner Chest Pain Fainting Dizziness
Palpitations Swelling in feet

Respiratory:
No problems Chronic lung disease Cough Shortness of Breath with exertion Wheezing

Gastrointestinal/Hepatic:
No Problems Liver Disease/problems Bleeding ulcers Abdominal pain Blood in Stool Constipation
Heartburn Nausea Vomiting

Genitourinary:
No Problems Vaginal discharge Incontinence Dysuria Hematuria Urinary frequency Amenorrhea
Menorragia Abnormal vaginal bleeding Pelvic pain

Musculoskeletal:
No problems Arthritis Gout Pain in feet Osteoporosis Bursitis Carpal Tunnel Joint Stiffness
Muscle Aches Painful joints Swollen joints

Skin Symptoms:
No problems Chronic infections Chronic ulcers Hives Infections Itching Rash

Neurologic:
No problems Stroke Dizziness Loss of strength Loss of use of extremity Memory loss Seizures
Tingling/Numbness Tremor

Psychiatric:
No problems Anxiety Depression Mental/Physical Abuse Stress Substance abuse Suicidal thoughts

Endocrine:
No problems Diabetes Dry Mouth Thyroid Steroid use Excessive sweating Excessive thirst
Heat intolerance

Hematology:
No problems Immunologic Anemia Easy bruising Prolonged bleeding Swollen glands

Allergy/Immunology: No problems Allergies Cough Hives Itching Rash Immunology