Peninsula Pain Clinic, PLLC

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Initial Intake Form

Date:_______________

Patient Name:_______________________________________ **Patient Date of Birth**: __________________________

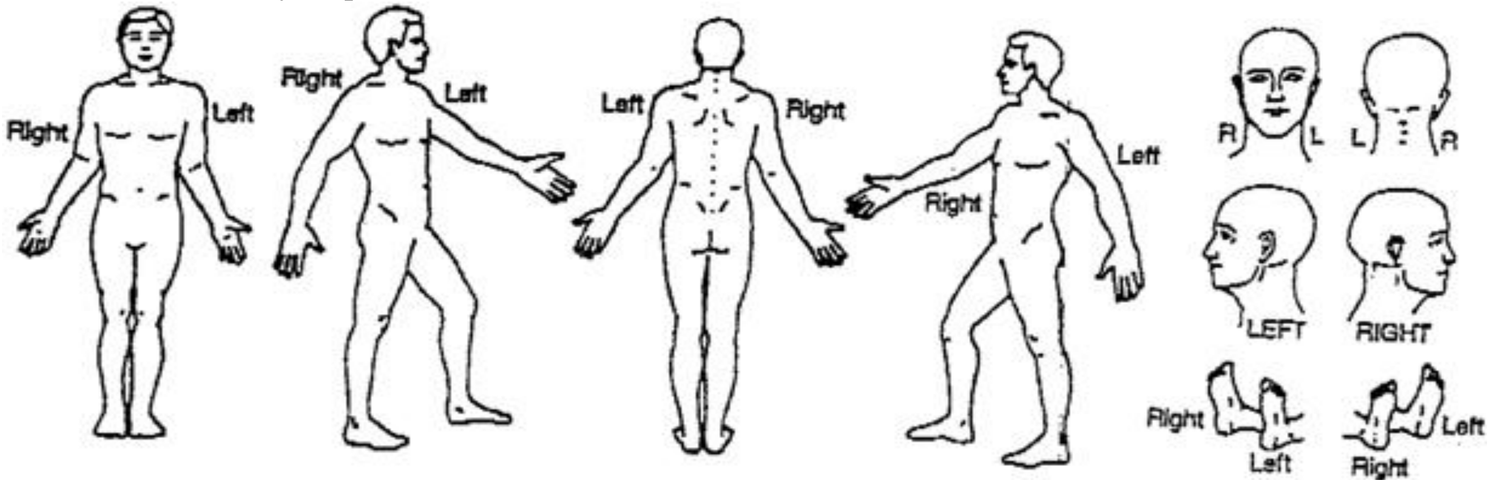
Referring Physician: _________________________________

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

Patient Name: ____

Pain History (cont.)

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. ____

Pain History (cont.)

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. ______________________________________

6. ______________________________________ 7. ______________________________________

Medical History (cont.)

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: ____