

Intake Information

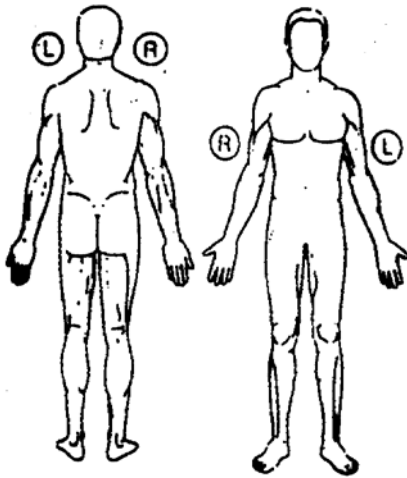
_____ Male Female Date _____
 Last Name First Name Age

List Doctors you have seen & City

Circle words that describe your pain

Burning Stabbing Depressing Constant Freezing Hot
 Shooting Comes and goes Electric shock Dull ache Tightness
 Unbearable Entire body throbbing Muscle spasm

Shade in where you have pain



What started the pain?

Please describe any accidents you have had related to this pain:

What was the date of injury? _____

What makes the pain better? _____

What makes the pain worse? _____

Pain Level: Place an X along this line to indicate how severe your pain is today.

No pain _____ 0 _____ 5 _____ 10 _____ Worst pain possible.

How many minutes can you walk until you must stop due to pain? _____

What **specific activities** is the pain preventing you from doing? _____

Please circle any of the following treatments you have had:

Physical Therapy Pool Therapy Biofeedback Tens Unit Acupuncture Nerve Blocks
 Trigger Point Injections Epidural Steroids Back Surgery Chiropractic Manipulation
 Psychological counseling for pain Other _____

Please list all **surgeries** you have had _____

Are you working now? **Y** **N** What kind of work do you do? _____

What was your last date of work? _____ Is this a work related injury? **Y** **N**

Was there ever a law suit regarding your pain? **Y** **N** Have you ever been on disability? **Y** **N**

Your attorney's name _____

Address _____ Phone number _____

Intake Information

Who do you live with at home? _____

Are you single married separated divorced widowed

Please check any medical problems that you have had and the approximate year when you first had it. Place a (F) next to it if one of your family members has the problem.

Stomach problems	High blood pressure
Asthma/Bronchitis	Irregular heart beats
Depression	Heart disease/heart attack
Decreased appetite	Shortness of breath
Treatment by a Psychiatrist	Loud snoring
Cancer	Difficulty sleeping
Epilepsy	Pneumonia
Fainting spells	Headaches
Bleeding problems	Kidney problems
Emotional changes	Night sweats, fever
Decreased concentration	Weight loss or weight gain
Unexplained crying	Diabetes
Constipation	Numbness
Liver problems/yellow skin	Weakness
Stroke	Change in bowel, bladder or sexual function

Please list any other medical problems you have _____

Have you ever smoked? **Y** **N** What year did you stop? _____ Do you smoke now? How much? _____

Were you ever a heavy drinker of alcohol? **Y** **N** When did you stop? _____
How much do you drink now? _____

Have you ever used street drugs? (Please circle: Marijuana, Speed, Amphetamines, Cocaine, IV drugs)?

Please circle if you have had any of the following:

<u>TESTS</u>	<u>Approx date</u>	<u>Which Hospital</u>
X-ray	_____	_____
MRI	_____	_____
CT- scan	_____	_____
Nerve test	_____	_____

Are you allergic to any medication?
Please list:

Please list all medications you are taking (including over the counter such as Tylenol), **or** give your list to our staff to copy for your records.

Medications used in past?
Any problems you had?
