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INITIAL PAIN INTAKE

Pain:

We want to know what brings you to the clinic. When we see you we will be asking you more details and writing them in the "Intake Notes" boxes. For now, please let us know some of your basics.

Where is your pain? ______________________________

When did your pain start? ______________________________

How did your pain start? ______________________________

Please describe your pain: ______________________________

____

What makes your pain better? ______________________________

____

What makes your pain worse? ______________________________

____

What are your goals for treatment? ______________________________

____

INITIAL PAIN INTAKE

Activities of Daily Living:

Unrelieved pain affects a person's daily routine. How has your pain impacted you in these activities of daily living?

1. Sleep Patterns: __ Difficulty going to sleep __ Difficulty staying asleep __ Difficulty waking
__ Frequent napping __ Chronic Fatigue

Other: ____

2. Eating Habits: __ Weight Loss __ Weight gain __ Nausea
__ Vomiting __ Changes in taste
__ Change of appetite or diet __ Difficulty swallowing

Other: ____

3. Hygiene/elimination habits:
__ Incontinence __ Difficulty grooming __ Difficulty bathing
__ Urgency to urinate __ Diarrhea __ Constipation

Other: ____

4. Ability to move: __ Generalized weakness __ Numbness/tingling __ In/out of car
__ Crutches/walker/cane __ Wheel Chair __ Shortness of breath
__ Limited range of motion __ Lifting/carrying __ Climbing stairs
__ No longer athletic

Other: ____

5. Sexual functioning: __ Decreased interest __ Decreased mobility __ Fear of pain

6. Physical appearance changed: Yes / No How? ______________________________________

7. Energy level: __ Better __ Worse How? ______________________________________

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Medical History:

How satisfied are you with communication with your doctor/medical team? ________________________

Please list all medications you are prescribed (feel free to attach medication sheet):

Name	Dose and Frequency	Reason	Who Prescribes

Allergies:

Medication or substance	Reaction

Other conditions for which you are being treated:____

____

Height:___________ Weight:___________

Has a doctor ever told you to find a new provider? **Yes** **No**

If so, why? ____

____

INITIAL PAIN INTAKE

Many people use substances besides their prescribed medications to help them cope.

Do you use any of these?

Tobacco? Yes / No — Cigarettes / Cigars / Pipe / Snuff / Chew / Other: _______________
How much per day/week/month? _________

Alcohol? Yes / No — What kind? _________
How much per day/week/month? _________

Coffee? Yes / No — How many cups per day? _________

Caffeinated soft drinks? Yes / No — How many per day/week/month? _________

Marijuana? Yes / No — How often? _______________
Do you have a medical marijuana card? Yes / No

Other recreational drugs? Yes / No — What/How often? ______________________________

Past drug or alcohol history? Yes / No — Explain: ____________________________________

Do you take opiates? Yes / No — What kinds? ____________________________________

Have you ever had to take more medication than what was prescribed? Yes / No
Explain: ____

Have your medications ever been stolen? Yes / No

Are they secure? Yes / No — If yes, how? ____________________________________

Have you ever taken drugs/medications not prescribed by your doctor? Yes / No

Have you ever bought or obtained medications from other than a pharmacy? Yes / No

Have you ever tried to stop using alcohol or other chemicals? Yes / No

Has anyone (family, friend, professional) ever told you they were worried about your usage of these? Yes / No

Have people annoyed you by criticizing your drinking or drug use? Yes / No

Have you ever felt bad or guilty about your drinking or drug use? Yes / No

Have you ever had a drink or used drugs first thing in the morning (eye-opener) to steady your nerves, get rid of hangover or get the day started? Yes / No

Has anyone in your biological family had problems with drugs or alcohol? Yes / No
Who? ____

Do you gamble? Yes / No

Are there any other addictive behaviors that are or have been a problem for you? Yes / No
Explain: ____

Have you ever been in alcohol or drug treatment including AA / NA? Yes / No

INITIAL PAIN INTAKE

Emotional:

Pain and emotions are often strongly linked. These questions will help us better understand that connection.

Symptom Checklist

Sleep:	☐ No problems ☐ Nightmares	☐ Not enough ☐ Too much sleep	☐ Trouble getting up
Appetite:	☐ No problems ☐ Carbohydrate craving	☐ Decreased appetite	☐ Increased appetite
Energy:	☐ Normal ☐ Up and down	☐ Increased	☐ Low
Interest in Sex:	☐ Normal	☐ Increased	☐ Low
Concentration:	☐ Normal	☐ Poor	☐ Terrible
Memory:	☐ Good	☐ Some difficulty remembering	☐ Poor
Depressed or Sad:	☐ All the time ☐ Not at all	☐ Most days	☐ Some days
Suicidal thoughts:	☐ All the time ☐ Not at all	☐ Most days	☐ Some days
Past Suicidal Attempts:	☐ No	☐ Yes	

If yes, please give details: ____

Anxiety:	☐ Panic attacks ☐ Some days	☐ All the time ☐ Not at all	☐ Most days
Anger / Irritation:	☐ All the time ☐ Not at all	☐ Most days	☐ Some days
Unusual experiences:	☐ Hear things that others do not hear ☐ See things that others do not see ☐ Fear that others are planning or want to harm you		

Have you ever been given a mental health diagnosis? Yes / No Hospitalized? Yes / No

What was the diagnosis? ____

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Intake Notes (Clinician Use Only):

PHQ9 ________

INITIAL PAIN INTAKE

Self Care:

Some people find counseling sessions or support groups can help them cope with stressful situations.

Have you ever been in counseling? Yes / No Are you in counseling now? Yes / No

If so, who is your Counselor? ____________________

What activities would you do if you could? ____________________

____

____

How many years of education and/or degrees or certificates do you have? ____________________

What type of work have you done in the past? ____________________

Which supports do you use when you are upset, uncomfortable or in pain?

__ Self __ Friends __ Family __ God/Spirit __ Work __ Exercise

Name of main support person: ____________________

How helpful is this person to you? ____________________

How comfortable are you with sharing your feelings / fears with your loved ones? ____________________

Does anything make sharing difficult for you? ____________________

Does spirituality have a role in helping you cope? Yes / No

How? ____________________

INITIAL PAIN INTAKE

Family / Social History:

Where were you born? ____________________

Where were you raised? ____________________

How many brothers and sisters do you have?

Brothers ____________________

Sisters ____________________

What was growing up like for you? ____________________

Were you ever in foster care? ____________________

Current relationship with parents and siblings, if any? ____________________

Do you have children? Yes / No

Ages and custody status: ____________________

Trauma / Loss:

Past stressful and traumatic events can impact us in the present, and often have a connection to pain.

What kinds of stress have you had to handle in the past?

__ Job loss __ Homelessness __ Illness __ Accidents

__ Child Abuse __ Sexual Abuse __ Family Violence

__ Custody issues __ Incarceration

Other: ____________________

Losing people who are important to us often affects us deeply.

Have you suffered any significant loss? Yes / No

__ Break up __ Separation __ Divorce __ Death of a person __ Death of an animal

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Intake Notes (Clinician Use Only): Group? Y / N Date: _______ Pain Spec.? Y / N Date: _______ ROIs ____ ORT ____ Forms ____