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INTAKE QUESTIONNAIRE

Name: **Date of Birth:** **Today's date:**

What is the name of the physician who referred you to us?

What is the name of your primary care physician?

Where is your most significant pain?

Where does your pain travel?

When did your pain begin? What was the inciting event, if any?

Circle the following words that describe your pain:
sharp shooting dull achey burning cramping throbbing

Please rate your pain on a scale from zero (no pain) to ten (worst pain imaginable).
Now: 0 1 2 3 4 5 6 7 8 9 10 On average: 0 1 2 3 4 5 6 7 8 9 10
Worst day: 0 1 2 3 4 5 6 7 8 9 10 Best day: 0 1 2 3 4 5 6 7 8 9 10

Circle the things that make your pain better:
rest ice packs heat medications exercise stretching massage Other: _______________
Circle the things that make your pain worse:
sitting bending standing lying down lifting coughing walking Other: _____________

Do you have any arm or leg numbness/tingling? yes / no Where? _________________________
Do you have any arm or leg weakness? yes / no Where? _________________________________

Does your pain make you depressed? yes / no Does it make you anxious? yes / no
Does your pain affect your ability to sleep? yes / no
Is your pain (circle one)… constant or intermittent?

Does your pain keep you from doing household chores? yes / no
Does it affect your ability to walk? yes / no
Circle the furthest you can walk: I can't walk. A few feet. Around the house.
Half a block. One block. A few blocks. Half a mile. One mile. More than a mile.

_________________________________ _____________________
Patient Signature Date

Name: **Date of Birth:** **Today's date:**

Have you underwent any of the following therapies?
Physical therapy: yes / no Warm water pool therapy: yes / no TENS therapy: yes / no
Psychiatric therapy or counseling: yes / no Acupuncture: yes / no Chiropractic: yes / no
Back or neck surgery: yes / no Nerve blocks (epidurals, facet blocks, etc.): yes / no

What medical problems do you have (heart problems, lung problems, diabetes, etc.)

What surgeries have you had (and what years did you have them)?

What **pain medications** are you taking (it is very important that you write the exact amount and dosing of these medications)?

Circle any of the following pain medications that you have tried in the past:
tramadol nucynta darvocet vicodin norco lortab percocet dilaudid morphine oxycontin methadone fentanyl patch lidoderm patches flector patches voltaren gel neurontin lyrica topamax elavil nortriptyline cymbalta SOMA flexeril baclofen skelaxin robaxin zanaflex

What other pain medications have you tried in the past?

What **non-pain medications** are you taking (attach a list if necessary)?

Are you on any blood thinners? yes / no
Which ones (eg. coumadin, plavix, pradaxa, xarelto, apixaban, aggrenox, cilostazol, ticlid, effient, brilinta, etc)?

ARE YOU ALLERGIC TO ANY DRUGS? yes / no **WHICH ONES?** __________________
Are you allergic to iodine or contrast dye? yes / no
Are you allergic to latex? yes / no

What is your marital status? Who do you live with?
Are you currently working? yes / no What was/is your job?
Do you drink alcohol? yes / no How much and how often?
Do you smoke cigarettes? yes / no Do you use any illegal street drugs? yes / no
Have you ever had addiction issues in the past? yes / no If yes, what were you addicted to?
Do you have any family members who suffer from chronic pain? yes / no
What questions do you have today?

______________________________________ ________________________
Patient Signature Date