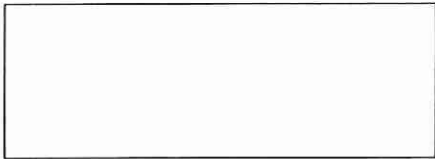


Sibley Memorial Hospital
The Sibley Pain Center



COMPREHENSIVE PAIN MANAGEMENT INTAKE FORM

Date: _____

Name of Referring Physician:	Phone:	Fax:	
Address:	City:	State:	Zip:

Name of Family Physician:	Phone:	Fax:	
Address:	City:	State:	Zip:

A. When did your pain start?

B. What caused your pain?

- Accident
- Other Disease
- No obvious cause
- Cancer (specify type) _____
- Surgery (specify) _____

C. Describe in your own words the pain problem(s) that you would like help with:

D. How often does your pain occur?

- Continuous
- Several times a day
- Once a day
- Several times a week
- Once a week
- Less than once a week
- Never

F. Below is list of words that might describe your pain (check all that apply).

- | | |
|--|--|
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Hot-Burning |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Heavy |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Tender |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Splitting |
| <input type="checkbox"/> Gnawing | <input type="checkbox"/> Tiring-Exhausting |
| <input type="checkbox"/> Sickening | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Punishing-Cruel | <input type="checkbox"/> Other: _____ |

G. Circle the number below to indicate your **highest pain intensity** over the past week:

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate			Severe		Most Severe		

H. Circle the number below to indicate your **lowest pain intensity** over the past week:

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate			Severe		Most Severe		

I. Circle the number below to indicate your **usual pain intensity** over the past week:

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate			Severe		Most Severe		

J. Circle the number below to indicate how much your pain interfered with your activities this week:

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate			Severe		Completely		

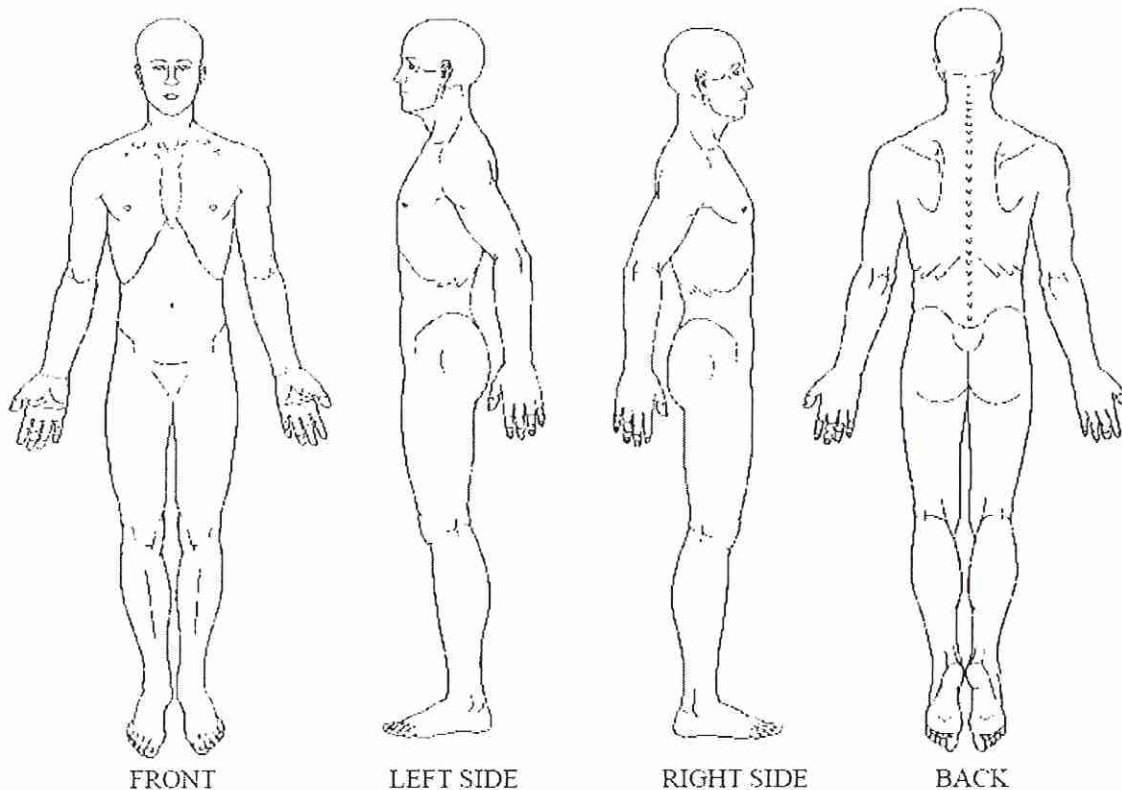
K. What makes your pain better?

- | | | |
|---|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Coughing/Sneezing | <input type="checkbox"/> Nothing | |
| <input type="checkbox"/> Medication (specify) _____ | | |

L. What makes your pain worse (check all that apply).

- Sitting
- Standing
- Walking
- Bending
- Lying Down
- Driving
- Coughing/Sneezing

M. Please indicate where you have pain by marking the areas on your body.



N. Have you had any of the following tests to evaluate your pain (please provide details).

- X-Rays _____
- MRI _____
- CT Scan _____
- Myelogram _____
- EMG _____
- Blood Tests _____
- Bone Scan _____
- Discogram _____

O. Do you have any of the following conditions associated with your pain? (indicate all that apply):

- Bowel/Bladder Incontinence
- Muscle Weakness
- Numbness/Tingling/Pins/Needles

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P. Please indicate any previous treatments you have tried for your pain and whether they helped your pain:

- | | | |
|---|------------------------------|-----------------------------|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Traction | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> TENS Unit | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Alternative Medicine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Epidural Injections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other: (specify) _____

Q. Medical History: (Please check only those that apply)

Respiratory Disease?.....

- Asthma Emphysema Bronchitis Shortness of Breath Chronic Cough
 Sleep Apnea Other: _____

Heart Disease?.....

- Heart Attack within 6 months Chest Pain Angina
 Irregular Heart Beats Palpitations Heart Failure High Blood Pressure
 Low Blood Pressure Mitral Valve Prolapse Pacemaker or Defibrillation device
 High Cholesterol Other: _____

Infectious Disease?.....

- Hepatitis HIV Mono Tuberculosis Other: _____

G.I. Disease?.....

- Ulcer Hiatal Hernia Gall Bladder Nausea Weight Loss Constipation
 Blood in stool Abdominal Pain Diarrhea Black bowel movement
 Other: _____

Liver Disease?.....

Jaundice Cirrhosis Bleeding Disorder(specify)_____

Other:_____

Endocrine Disease?.....

Diabetes Hypoglycemia Thyroid Disease Other:_____

Neurological Disease?.....

Convulsions Stroke Loss of Sensation Back or Neck Pain or Injury Dizziness

Fainting Headache Weakness/Paralysis of the arms and legs

Other :_____

Kidney Disease?.....

Kidney Stones or Infections Bladder Infections Difficulty Urinating

Bladder Incontinence Tumor Urinary Frequency Other:_____

Psychiatric?.....

Depression Anxiety Other:_____

Musculoskeletal?.....

Arthritis Joint Replacements Easy Bruising Swelling History of Falls

Assistive Devices Other:_____

Do you wear or have any?.....

Contacts Lens Hearing Aids Implant Glasses

Are you pregnant?..... Yes No

Past Surgical History (please indicate type of surgery, date and physician's name)

Surgery

Date

Surgeon

R. Do you have any allergies to medications? (Please specify):

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Do you have any Environmental allergies (Non medication/food/Latex etc)? _____

S. How would you rate your mood?

0	1	2	3	4	5	6	7	8	9	10
Worst	Poor		Fair			Good		Best		

T. Do you have problems with any of the following? (check all that apply)

- Sleep Mood Depression Self-worth Concentration Anxiety
- Suicidal thoughts Homicidal thoughts

U. Family History

Mother: Living/Deceased Cause: _____
 Father: Living/Deceased Cause: _____
 Siblings: Living/Deceased Cause: _____
 Siblings: Living/Deceased Cause: _____

Relationship Status

- Single Married Separated Divorced Widowed Domestic Partnership

What is your current employment status?

- Employed full-time Employed part-time Self-employed Retired
- Homemaker Unemployed due to pain

Are you on disability? Yes No

Y. Do you have an attorney or legal action pending related to this pain or any other health problems? Yes No

If so, please list attorney's name: _____

Do you drink alcohol? Yes No
If so, specify _____

Do you smoke? Yes No
If so, specify what and how often _____

Do you currently or have you ever abused recreational drugs?
 Yes No

If so specify what and how often: _____

Patient Signature: _____ Date/Time: _____

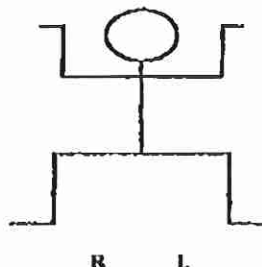
*****PHYSICIAN ONLY*****

Musculoskeletal:

- SLR Slump Spurling
 FABER/Patrick Ganselen

Other: _____

Reflexes:



Palpation:

- TTP
 MTrP: _____

RADIOGRAPHIC DATA:

IMPRESSION:

- 1.
 - 2.
 - 3.
 - 4.
 - 5.
 - 6.
 - 7.
-

PLAN:

- 1.
 - 2.
 - 3.
 - 4.
 - 5.
 - 6.
 - 7.
-

PHYSICIAN SIGNATURE

MD#: _____ DATE/TIME: _____