

## Pain Management Intake

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Onset and Frequency of your pain

Please circle the event or events that led to your present pain:

(If you experience more than one kind of pain, please write in separate sets of answers for each type of pain you have.)

Accident \_\_\_\_\_

Cancer \_\_\_\_\_

Following an Operation \_\_\_\_\_

No Obvious Cause \_\_\_\_\_

How long have you had this pain? \_\_\_\_\_

How often does this pain occur? (Circle your answer)

Continuously

Several times a day

Once or twice a day

Several days a week

Less than 3-4 times per month

How has the intensity of the pain changed throughout the time you have had it?

Increased

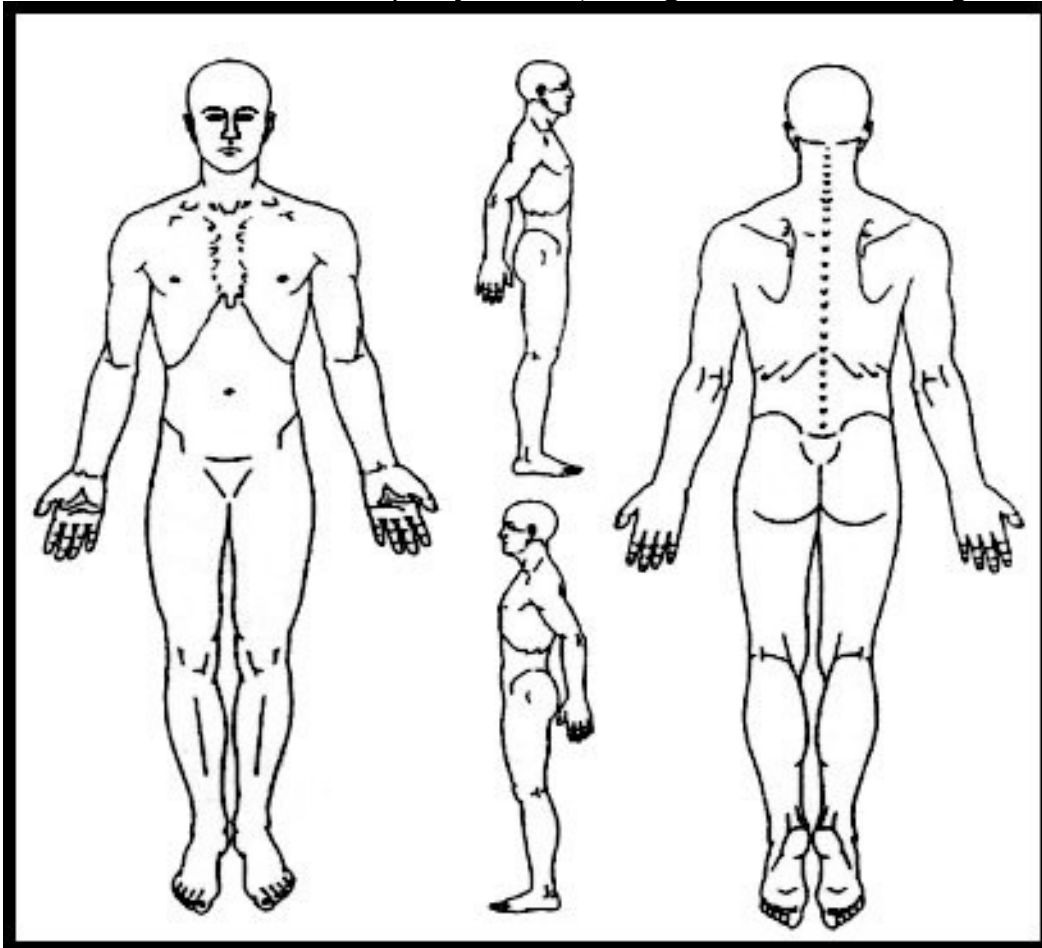
Decreased

Stayed the same

### Location of Pain

On the diagram, shade in the areas where you feel pain.

Use scale from 1 to 10 for the amount of pain you feel. (1 being the least and 10 being the most)



**Intensity of Pain**

On a scale of 0-10, how much are you having right now? \_\_\_\_\_

On this scale, indicate the highest level of pain you have had in the past week. \_\_\_\_\_

On this scale, indicate the lowest level of pain you have had in the past week. \_\_\_\_\_

**Quality of Pain**

From the list of words below, circle the words that describe you pain:

Throbbing	Shooting	Stabbing	Sharp	Contracting/Tight
Hot Burning	Aching	Heavy	Cramping	Distending
Radiating	Numb	Pins & Needles	Wandering	Pounding

**Factors that affect your pain**

In what manner do the following factors affect your pain?

Heat	Better	Worse	Sitting	Better	Worse
Walking	Better	Worse	Coughing	Better	Worse
Climate Change	Better	Worse	Cold	Better	Worse
Standing	Better	Worse	Fatigue	Better	Worse
Anxiety/emotions	Better	Worse	Massage	Better	Worse
Noise	Better	Worse	Rubbing	Better	Worse
Particular Position	Better	Worse	Lying Down	Better	Worse

**Effect that pain has on your quality of walking and sleeping**

(1 being terrible, 10 being normal)

Walking \_\_\_\_\_ Sleep \_\_\_\_\_

Sleep during the past week

Average number of hours slept each night \_\_\_\_\_

Average number of times you awoken each night \_\_\_\_\_

**Other treatment modalities you have used to manage your pain**

Chiropractic	Massage Therapy	Physical Therapy	Surgery
Acupuncture	Relaxation Training	Biofeedback	Exercise Program
Medication			

If you have used medications, which ones and how often? \_\_\_\_\_

\_\_\_\_\_

Any other information about your pain that you think I should know about: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_