COMPREHENSIVE PAIN MANAGEMENT of Central Connecticut

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INITIAL PAIN/ MEDICAL HISTORY INTAKE FORM

Please fill in ALL information as accurately as possible

Patient Name: _____ **DOB**: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated # of Children: _____

Describe the location of your pain: _____

Circle those that apply: Aching / Burning / Cramping / Sharp / Shooting / Electric / Numbing / Pins and Needles

Pain worse with: Sitting / Standing / Walking / Lying Down / Any position for too long / Leaning forward / Leaning back

Circle which applies: Constant pain/ Comes and Goes / Worse in AM/ Worse in PM **When did it start?** _____

Motor Vehicle Accident? □ Yes □ No **Law suit Pending?** □ Yes □ No **Work related injury?** □ Yes □ No

Please check all that you have tried for your pain:

□ Physical Therapy/ Exercise □ Cognitive Behavioral Therapy □ Chiropractor

□ Acupuncture □ Pain Medications □ Surgery

□ Steroid Injections/ Nerve Blocks **Which helped you the most?** _____

Please list any pain medications you take NOW (list dosage and frequency you take them): _____

_____

Please list any pain medications you have taken IN THE PAST (with dosage): _____

_____

List medical problems: _____

Do you have diabetes? □ Yes □ No **Do you take blood thinners?** □ Yes □ No

List past surgeries: _____

List Allergies to medications only: _____

Do you smoke? □ Yes □ No If yes, how many packs/day and when did you start? _____

Do you drink alcohol? □ Yes □ No If yes, how many drinks/day? _____

Do you use illegal drugs? □ Yes □ No If yes, which ones? _____

Have you ever had a problem with alcohol or drug abuse in the past or now? □ Yes □ No If yes, please explain:

_____

Have you ever had any problems with physical, sexual, or emotional abuse in the past? □ Yes □ No If yes, please explain:

_____

Do you have depression or anxiety? □ Yes □ No **If so, in counseling?** □ Yes □ No **Ever hospitalized for depression?** □ Yes □ No

Please check if you experience any of the below on a <u>REGULAR BASIS</u>:

□ Fast/irregular heartbeat	□ Cough	□ Weight Loss	□ Swelling	□ Fever
□ Vomiting/ Nausea	□ Wheezing	□ Shortness of Breath	□ Muscle Cramps	□ Chills
□ Headaches	□ Constipation	□ Pain w/ urination	□ Bone Pain	□ Blurry Vision
□ Heartburn	□ Diarrhea	□ Blood in urine	□ Feeling Tired	□ Balance problems

What do you currently do for work? If not currently working, reason why not? When is the last time you worked?

_____

What are your goals in pursing pain management? (Examples are return to work, take care of self at home, etc.)

_____