KC Pain Centers: Patient Intake Form

Patient Information

Your Name: _____ Date of Birth: _____

Referring Physician: _____ Primary Care: _____

Pain History

Chief Complaint (reason for visit): _____

Approximately when did the pain begin? _____

What caused your pain episode? _____

If pain "0" is no pain and "10" is worse pain you can imagine, how would you rate your pain?

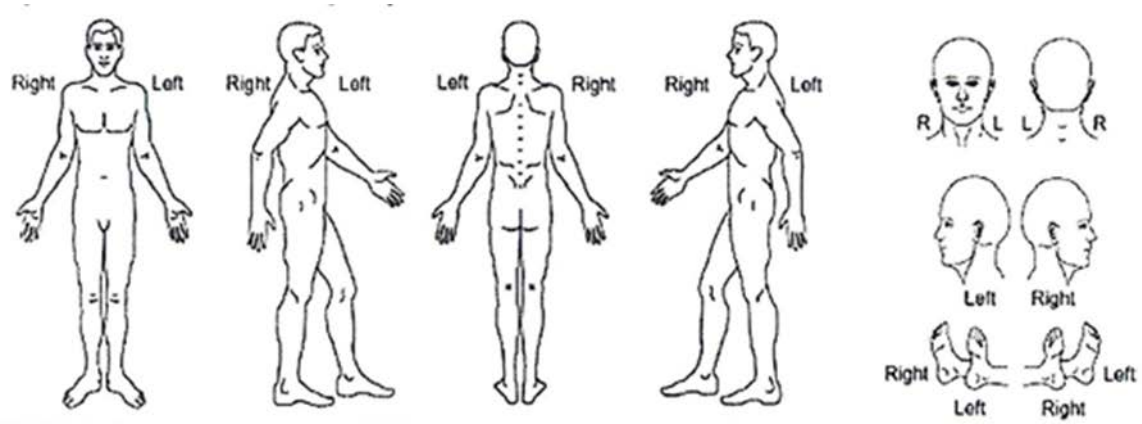
Right Now: _____ The best it gets: _____ The worst it gets: _____

How did your current pain episode begin? ☐Gradually ☐Suddenly

Since your pain began, has it changed? ☐Improved ☐Worsened ☐Stayed the Same

When is your pain at its worst? ☐Morning ☐Daytime ☐Evenings ☐Middle of Night

Use the diagram below to indicate the area of pain. Mark with an "X"



Pain Description

Check all the following that describe today's pain:

☐Dull/Aching ☐Hot/Burning ☐Shooting ☐Stabbing/Sharp ☐Tender ☐Sore ☐Radiating ☐Tingling
☐Cramping ☐Numbness ☐Spasming ☐Throbbing ☐Tight ☐Squeezing ☐Pins and Needles

How often does the pain occur?

☐Constant ☐Changes in severity but always present ☐Intermittent (Comes and Goes)

Things that make my pain better: _____

Things that make my pain worse: _____

Conservative Therapies

Treatment/Therapy	Effective (Y/N)	How Long Did you Try It
NSAIDS(Advil, Ibuprophen, etc)		
Physical Therapy		
Yoga		
Chiropractor		
Acupuncture		
Massage		
Hot/Cold Packs		
Narcotics		

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Mark all the following tests that you have had related to your current pain:

☐MRI of the : _____ Date: _____

☐X-Ray of the: _____ Date: _____

☐CT Scan of the: _____ Date: _____

☐EMG/NCV Study: _____ Date: _____

☐I have not had ANY diagnostic test for my current pain issue.

Past Surgical History

Please list ANY surgical procedures you have done in the past including the date:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Family History

Any family medical history (Father, Mother, Grandparents, Siblings)

_____

_____

_____

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐No

If Yes, please list all medications you are allergic to:

Medication Name	Allergic Reaction
1. _____	_____
2. _____	_____
3. _____	_____

Other Allergies: ☐Latex ☐Iodine ☐Tape ☐IV Contrast

Medications

Pharmacy Name: _____ Phone Number: _____

Are your currently taking any blood thinners or anti-coagulants? ☐Yes: _____ ☐No

Please list all medications you are currently taking. Attach sheet if additional space is required:

Medication Name	Dose	Frequency
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Social History

Alcohol Use: ☐Social Use ☐History of alcoholism ☐Current alcoholism ☐Never ☐Daily Use

Tobacco Use: ☐Current User: Packs Per Day? _____ ☐Former User ☐Never Used

Recreational Drug's: ☐Current User: Type: _____ How Often: _____ ☐Former ☐Never

Caffeine Use:☐Daily ☐Weekly ☐Monthly Amount: _____

Goals: What is your goal for treatment of your pain?

☐ **To be Pain Free** ☐**Reduced Pain** ☐ **Help with living with pain**