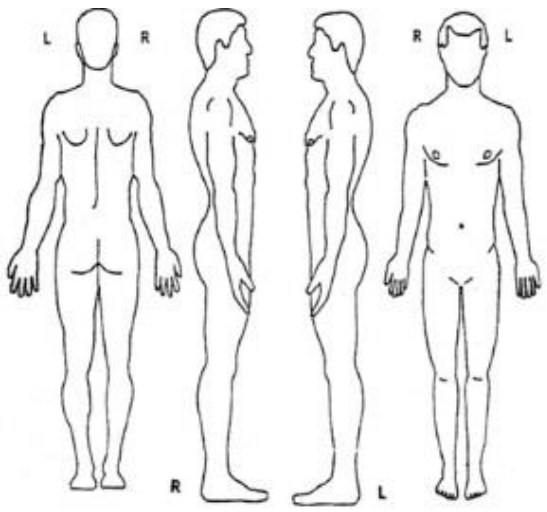
Name: _____ Date of Birth: _____/_____/_____

Pain Management Intake

On the figures to the right, please clearly mark areas of pain.
Use a scale from 1-10 for the amount of
pain you feel. (1 = least, 10 = most)



Onset of pain:

What event/events led to your present pain?

□ Accident □ Cancer □ Stress
□ Operation □ Other_____

How long have you had this pain?

_____

How often does this pain occur?

□ Continuously □ Several times a day
□ 1-2 times a day □ Several times a week
□ Less than 3-4 times per month

How does your pain affect your ability to work or otherwise be active?

□ No effect □ Some physical restrictions
□ Need limited assistance □ Need assistance often
□ Can't care for self

Factors that affect your pain:

Better	Worse	Better	Worse
□	□ Heat	□	□ Walking
□	□ Cold	□	□ Noise
□	□ Soft Pressure	□	□ Coughing
□	□ Hard Pressure	□	□ Particular position_____
□	□ Lying Down	□	□ Anxiety / Emotions
□	□ Sitting	□	□ Climate Change
□	□ Standing	□	□ Humidity
□	□ Other: _____		

Quality of Pain:

□ Sharp □ Fixed □ Burning □ Moving □ Cramping □ Aching □ Dull
□ Stabbing □ Other: _____

Other treatment modalities you have used to manage your pain:

□ Chiropractic □ Massage □ Physical Therapy □ Surgery □ Acupuncture
□ Relaxation Training □ Biofeedback □ Exercise □ Medication
□ Other: _____

Is there anything else about your pain management that you feel we should know about?

_____
_____