

PAIN INTAKE FORM

Patient Name: _____ **Date:** _____

1) When and how did your pain start? _____

2) Has the pain gotten better, worse, or unchanged? _____

3) As far as you know, what is the cause of your pain (diagnosis)? _____

4) Is pain constant or are there pain free periods? _____

5) Is your pain worse during the day or at night? _____

6) Have you seen any other Physicians for this problem? YES NO
If yes, Physician's name _____

7) Weight: _____ Height: _____

8) What tests and studies have been performed (MRI, X-rays, Nerve tests) ? _____

9) What makes your pain better? (Example: heat, rest, medication) _____

10) What makes your pain worse? (Example: standing, sitting, walking, lifting, bending forward, backwards, cold, or damp weather) _____

11) Do symptoms change with coughing or sneezing? _____

12) Do you have any of the following that are related to your pain? Numbness, tingling, weakness, problems with bowel or bladder. _____