vancouver island health authority

INTERDISCIPLINARY PAIN MANAGEMENT CLINIC

Nanaimo Regional General Hospital
Tel: 250-739- 5978

New Patient Intake Form

Name: _____ **Age:** _____

Patient ID Sticker

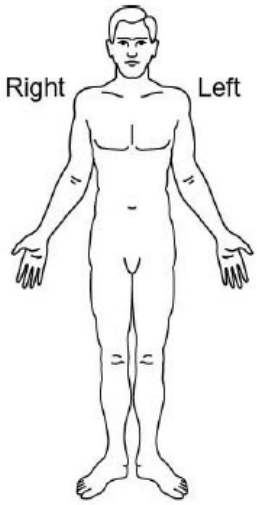
May we contact you via email? □ *Yes* □ *No*

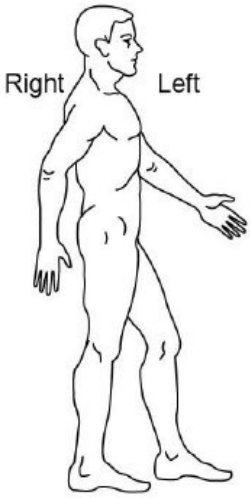
Email: _____

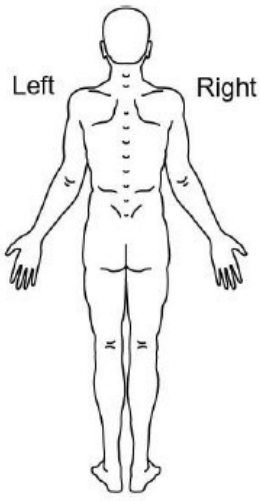
Please note that only <u>one area of pain</u> will be addressed at this visit (ex: low back, neck, leg, etc…)
If you have more than one area of pain, your GP will need to submit a referral for each area.

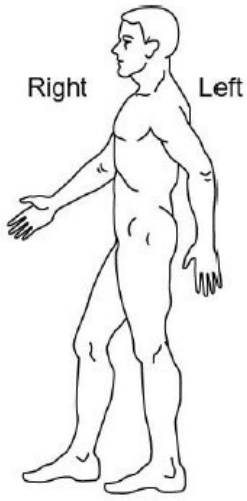
Please use the diagram below to draw out your area of pain:

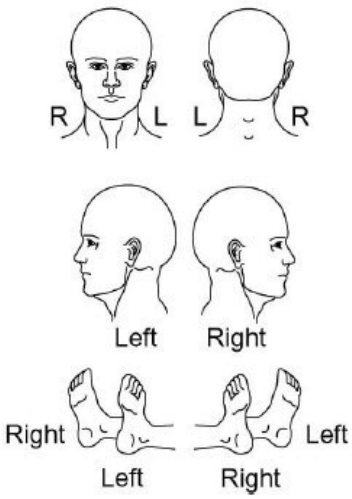
1. Most painful area: ***shade in darkly***
2. Less painful areas: *shade in lightly*
3. Pain shooting down arm or leg: indicate with an arrow











1. How did your pain start?

When did your pain problem begin? **Month:** _____ **Year:** _____

Is your pain related to an injury? ☐ Yes ☐ No

If Yes, please specify: ☐ Car accident ☐ Fall ☐ Job related injury

☐ Other: _____

Please provide the details of your accident or mechanism of injury (ie: describe what happened)

(Do not provide details of your pain or injuries here, you will be able to describe these on the following pages)

_____

_____

_____

2. Describe Your Pain

Which words best describe your pain? *(please circle)*

Electric / Burning / Shooting Dull / Aching Stabbing / Sharp Other: _____

When is your pain the worst? *(please circle one)*

Morning Noon Night Time Always the same

NEW Symptoms

Are you experiencing any NEW symptoms since your pain started?

☐ NEW Weakness *where?*_____

☐ NEW Numbness *where?*_____

☐ NEW changes in bowel/bladder function

Associated Symptoms

If you have pain in your arms or legs, do you have:

☐ Increase sweating in the hand or foot?

☐ Temperature changes in the hand or foot?

☐ Colour changes in the hand or foot?

☐ Swelling in the hand or foot?

☐ Increased sensitivity to touch in the arm or leg?

What makes your pain WORSE? (eg: walking, sitting, bending, lifting, cold, heat)

_____

What makes your pain BETTER? (eg: medications, lying down, heat, cold, physical therapy)

_____

Does your pain wake you from sleep? □ Yes □ No

Is your pain getting: □ Worse □ Better □ Staying the same

Please circle the level of your pain for the following
(0 = No Pain, 10 = Worst Pain Imaginable)

WORST daily level of pain:

0 1 2 3 4 5 6 7 8 9 10

BEST daily level of pain (i.e. at rest or after medications):

0 1 2 3 4 5 6 7 8 9 10

Using the same scale, what level of pain is ACCEPTABLE for you?

0 1 2 3 4 5 6 7 8 9 10

If your pain could be reduced, but not completely, how much of a reduction would there need to be for you to feel you could live with it? _____%

3. Medications

Previous Medications
Please list all medications you have previously taken for this pain and are no longer taking.
(you may obtain a list from your pharmacy)

Medication	Was it effective?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Current Medications
Please list all medications you are currently taking, including those that are not for your pain. List all over the counter medications, herbal supplements and vitamins here as well.

Medication	Dose / Number of pills	Is it effective?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____

Blood Thinners
Are you currently taking any blood thinners? (eg: Plavix, Warfarin, etc…) □ Yes □ No

Please indicate type and dose: _____

List any allergies to Medications, Latex, Dyes or Adhesives
1. _____
2. _____
3. _____

4. Treatment History

Have you been previously assessed and/or treated by anyone for this pain? ☐ Yes ☐ No
Please provide details in table below.

Discipline	Result: *Effective*	Result: *Not Effective*
Pain Clinic		
• steroid injections	☐	☐
• nerve blocks	☐	☐
• medications	☐	☐
Neurosurgery	☐	☐
Orthopedic Surgery	☐	☐
Rheumatology	☐	☐
Psychological Therapy		
• Psychiatry	☐	☐
• Counselling	☐	☐
• Hypnosis	☐	☐
• Relaxation	☐	☐
• Mindfullness	☐	☐
Occupational Therapy	☐	☐
Other Therapy		
• Physiotherapy	☐	☐
• Chiropractic	☐	☐
• IMS	☐	☐
• Acupunture	☐	☐
• Prolotherapy	☐	☐
• TENS	☐	☐
• Biofeedback	☐	☐

Other: _____

5. Past Medical History

Medical Conditions
Please **circle** any condition that applies to you and whether it is a **current** or **past** problem.

Cancer In Remission? ☐ Yes ☐ No

Please list type: _____

Lung problems
COPD / Asthma / Sleep apnea
Other: _____

Heart problems
Heart attack / Heart stent / high blood pressure / congestive heart failure
Other: _____

Kidney problems
Chronic renal failure
Other: _____

Liver problems
History of liver failure / hepatitis
Other: _____

Neurological problems
MS / diabetic neuropathy / stroke
Other: _____

Diabetes
type 1 / type 2
Well controlled? ☐ Yes ☐ No

Clotting or Bleeding problems
Specify: _____

Infectious Disease
Hepatitis / HIV
Other: _____

Arthritis
Rheumatoid / lupus / ankylosing spondylitis
Other: _____

Fibromyalgia

Other: _____

Major Surgeries
Please list all past major surgeries

Date	Surgery	Date	Surgery
1.		4.	
2.		5.	
3.		6.	

6. Family Medical History

Please check all that apply and indicate affected relative(s)

Condition	Relative(s)		Relative(s)
☐ Cancer (specify type)		☐ Depression/Anxiety	
☐ Chronic pain		☐ Psychiatric disorder	
☐ Low back pain		☐ Fibromyalgia	
☐ Substance abuse		☐ Rheumatoid arthritis	
☐ Heart disease		☐ Osteoarthritis	
☐ Stroke		☐ Other:	
☐ Diabetes		☐ Other:	

Employment Status

☐ Employed
Occupation: _____
- ☐ Limited due to pain at work
- ☐ Have taken time off due to pain in past 12 months. How much time?

☐ Unemployed
- ☐ Planning on returning to work
- ☐ Disabled
- ☐ Retired

Sources of income
Check all that apply

☐ Worker's compensation
☐ Disability benefits
☐ Unemployment benefits
☐ Social assistance

Do you have an active ICBC, WCB or DND claim related to this area of pain? ☐ Yes ☐ No
Claim Number: _____
Are you involved in any other type of legal action related to your pain, or considering this in the future? ☐ Yes ☐ No

Social History

Smoking Status: ☐ Never smoked ☐ Used to smoke, quit on: _____ ☐ Currently smoking ____ / day

Alcohol Use: _____ drinks per day / week / month

Recreational Drug Use: _____

Mental and Emotional Health

Check all that apply

☐ Anxiety
☐ Depression
☐ Other: _____

Rate your level of distress (0 = low, 10 = high)
1 2 3 4 5 6 7 8 9 10

Relationship and Living Status

☐ Married
☐ Single
☐ In a relationship
☐ Common Law
☐ Widowed

Who do you live with?
_____

Number of dependents:
_____

8. Goals and Expectations

1. What would you like to get out of your visit today?

_____

_____

_____

_____

2. What do you believe is the cause of your pain

_____

_____

3. Do you think your pain may be due to a serious disease, which doctors have not found or have not told you about?

□ Yes □ No □ Not sure

4. What Questions would you like answered following your assessment at this pain clinic?

a) _____

b) _____

c) _____

d) _____

e) _____

Patient Specific Functional Scale

Step 1: Pick 1 to 3 activities that are important to you which you cannot perform or have difficulty with doing as a result of your pain.

Step 2: Circle one number that best rates your ability to perform the activity.
(0 = Unable to perform activity, 10 = Able to perform activity at Pre-problem level)

Activity 1: _____

0 1 2 3 4 5 6 7 8 9 10

Activity 2: _____

0 1 2 3 4 5 6 7 8 9 10

Activity 3: _____

0 1 2 3 4 5 6 7 8 9 10