

## New Patient Intake Form

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Patient ID Sticker

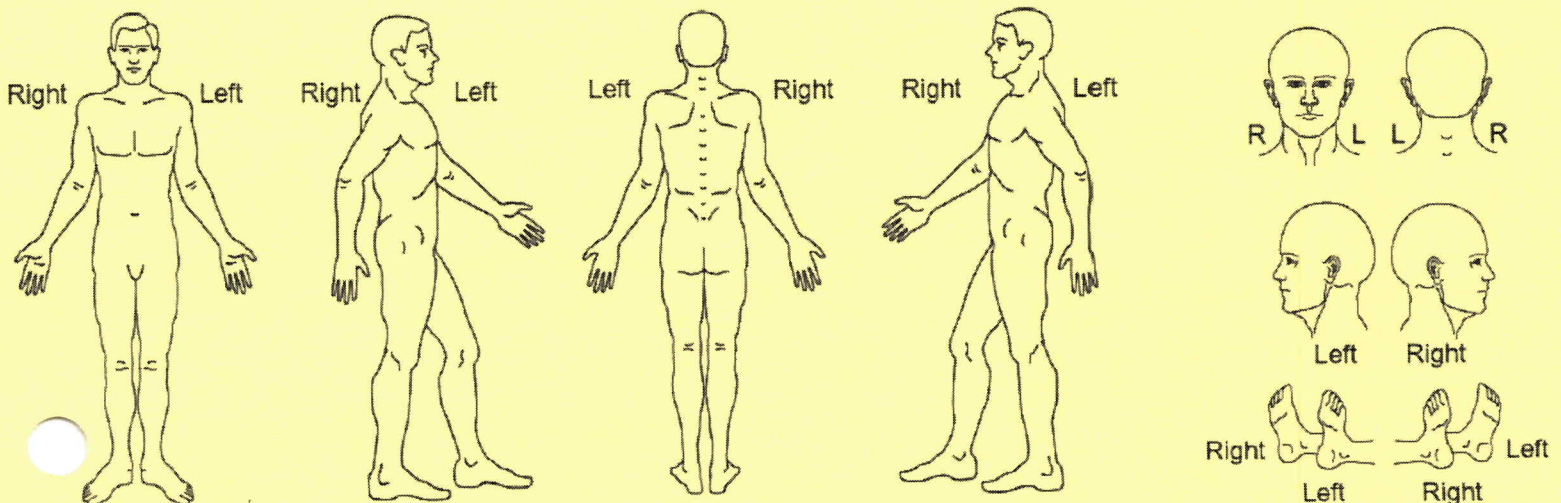
May we contact you via email? ☐ Yes ☐ No

Email: \_\_\_\_\_

**Please note that only one area of pain 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)*

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## 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)

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

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**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                | Not Effective            |
| <b>Pain Clinic</b>           |                          |                          |
| • steroid injections         | <input type="checkbox"/> | <input type="checkbox"/> |
| • nerve blocks               | <input type="checkbox"/> | <input type="checkbox"/> |
| • medications                | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Neurosurgery</b>          | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Orthopedic Surgery</b>    | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Rheumatology</b>          | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Psychological Therapy</b> |                          |                          |
| • Psychiatry                 | <input type="checkbox"/> | <input type="checkbox"/> |
| • Counselling                | <input type="checkbox"/> | <input type="checkbox"/> |
| • Hypnosis                   | <input type="checkbox"/> | <input type="checkbox"/> |
| • Relaxation                 | <input type="checkbox"/> | <input type="checkbox"/> |
| • Mindfulness                | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Occupational Therapy</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Other Therapy</b>         |                          |                          |
| • Physiotherapy              | <input type="checkbox"/> | <input type="checkbox"/> |
| • Chiropractic               | <input type="checkbox"/> | <input type="checkbox"/> |
| • IMS                        | <input type="checkbox"/> | <input type="checkbox"/> |
| • Acupuncture                | <input type="checkbox"/> | <input type="checkbox"/> |
| • Prolotherapy               | <input type="checkbox"/> | <input type="checkbox"/> |
| • TENS                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Biofeedback                | <input type="checkbox"/> | <input type="checkbox"/> |

Other: \_\_\_\_\_

### Major Surgeries

Please list all past major surgeries

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

## 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: \_\_\_\_\_

## 6. Family Medical History

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

| Condition                                            | Relative(s) | Relative(s)                                         |
|------------------------------------------------------|-------------|-----------------------------------------------------|
| <input type="checkbox"/> Cancer (specify type) _____ |             | <input type="checkbox"/> Depression/Anxiety _____   |
| <input type="checkbox"/> Chronic pain _____          |             | <input type="checkbox"/> Psychiatric disorder _____ |
| <input type="checkbox"/> Low back pain _____         |             | <input type="checkbox"/> Fibromyalgia _____         |
| <input type="checkbox"/> Substance abuse _____       |             | <input type="checkbox"/> Rheumatoid arthritis _____ |
| <input type="checkbox"/> Heart disease _____         |             | <input type="checkbox"/> Osteoarthritis _____       |
| <input type="checkbox"/> Stroke _____                |             | <input type="checkbox"/> Other: _____               |
| <input type="checkbox"/> Diabetes _____              |             | <input type="checkbox"/> 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?

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

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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

