PAINLESS CENTER

1608 Lemoine Avenue, Suite 101
Fort Lee, NJ 07024
Tel: 201-592-7246 Fax: 201-540-9978

Evaluation Intake Form

Patient Name: _____ Date: _____

1. When did your pain start? _____
2. How did your pain start?

   ☐ Accident
   ☐ Cancer/Other Disease
   ☐ Surgery (Specify) _____
   ☐ No obvious cause

3. How often does your pain occur? (Circle one)

   Continuous Several times/day One time/day Several times/week
   One time/week Less than one time/week Never

4. Circle the average duration of your pain.

   Weeks Days Hours Minutes Seconds None

5. Select all types of pain you are experiencing:

   ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Burning
   ☐ Gnawing ☐ Cramping ☐ Sharp

6. Select the corresponding number that indicates your **highest pain intensity** over the past week:

0	1	2	3	4	5	6	7	8	9	10
None										High
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7. Select the corresponding number that indicates your **lowest pain intensity** over the past week:

0	1	2	3	4	5	6	7	8	9	10
None										High
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. Your pain is alleviated by:

   ☐ Sitting ☐ Standing ☐ Resting ☐ Medication
   ☐ Bending ☐ Lying Down ☐ Coughing ☐ Sneezing

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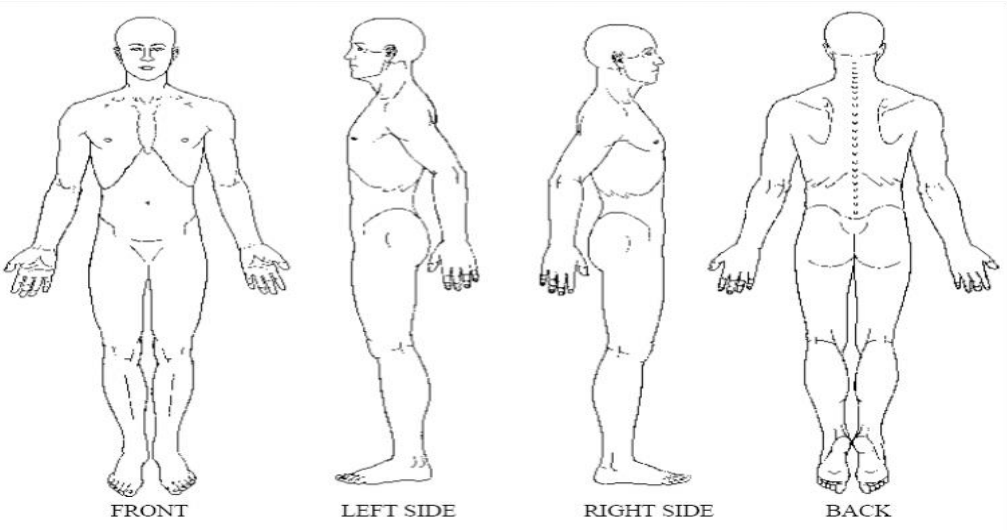
9. Your pain is worsened by: (Check all that apply)

☐ Sitting ☐ Standing ☐ Walking ☐ Driving
☐ Bending ☐ Lying Down ☐ Coughing ☐ Sneezing

10. Please indicate where you have pain by marking the corresponding regions on the diagram below.



11. Please select all testing/procedures you have received as a result of your pain.

☐ X-Rays ☐ MRI ☐ CT Scan ☐ Myelogram
☐ EMG ☐ Blood Tests ☐ Bone Scan ☐ Discogram

Explain (when/where/of what area/body part, etc?): _____

_____

12. Please select all treatments you have tried as a result of your pain, and indicate whether they helped alleviate your pain.

Specialty	**Pain Alleviated?**	
Acupuncture	☐ Yes	☐ No
Chiropractor	☐ Yes	☐ No
Biofeedback	☐ Yes	☐ No
Traction	☐ Yes	☐ No
TENS Unit	☐ Yes	☐ No
Physical Therapy	☐ Yes	☐ No
Massage	☐ Yes	☐ No
Psychologist	☐ Yes	☐ No
Psychiatrist	☐ Yes	☐ No
Alternative Medicine	☐ Yes	☐ No
Surgery	☐ Yes	☐ No

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13. Have you received pain management epidurals/injections in the past? If yes, please explain

☐ No ☐ Yes When: _____ Where: _____

14. Past Medical History (Check all that apply):

☐ Arrhythmia	☐ Atrial Fibrillation	☐ High Blood Pressure	☐ Angina
☐ Heart Disease	☐ Heart Attack	☐ Heart Failure	☐ Emphysema
☐ Asthma	☐ COPD	☐ Stroke ☐ Cancer	☐ Seizures
☐ Arthritis	☐ Diabetes	☐ Migraines	☐ Psychiatric Illness

15. Past Surgical History (Please list any past surgeries, if applicable):

Surgery Type	Date	Surgeon

16. Allergies, including medications, latex, and foods. Please be specific, and explain the type of reaction you experience: _____

_____

_____

17. Current Medications:

Name	Dose	Times/Day

18. If you are currently taking blood-thinners, select all that apply:

☐ Enoxaparin (Lovenox) ☐ Heparin ☐ Clopidogrel (Plavis) ☐ Warfarin (Coumadin)

☐ Fondaparinux (Artixtra) ☐Dabigatran (Pradaxa) ☐ Apixaban (Eliguis)

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19. What is your current mood? (Circle one)

Worse Poor Fair Good

20. Please select any/all difficulties you are currently experiencing.

☐ Sleep ☐ Mood ☐ Depression ☐ Self-worth ☐ Suicidal/Homicidal Thoughts

21. Family History: Please list medical history of immediate family members: _____

_____

- Mother: ☐ Living ☐ Deceased
- Father: ☐ Living ☐ Deceased

22. Relationship status:

☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐ Domestic partnership

23. With whom do you live? ☐ Self ☐ Spouse ☐ Children ☐ Parents ☐ Assisted Living

24. What is your current employment status?

☐ Full-time ☐ Part-time ☐ Self-employed ☐ Homemaker ☐ Unemployed ☐ Retired

25. Do you have an attorney or legal action pending related to this pain or any other health problems?

☐ Yes ☐ No

26. Do you drink alcohol? ☐ No ☐ Yes ____ drinks/week

27. Do you smoke? ☐ No ☐ Yes ____ cigarettes / packs per day

28. Do you currently or have you ever abused recreational drugs? (If yes, please explain)

☐ No ☐ Yes _____

29. Review of symptoms (Select all that apply)

☐ Fever	☐ Night Sweats	☐ Rash	☐ Sputum Production	☐ Wheezing
☐ Chest Pain	☐ Abdominal Pain	☐ Diarrhea	☐ Blood in stool	☐ Headache
☐ Dizziness	☐ Easy Bruising	☐ Difficulty urinating		☐ Weight Loss
☐ Bowel/Bladder incontinence		☐ Weakness	☐ Paralysis of the arms/legs	
☐ Swelling	☐ Cough	☐ Shortness of breath		☐ Chest pain
☐ Palpitations	☐ Constipation	☐ Black bowel movement		☐ Nausea
☐ Lightheadedness	☐Vision Changes	☐ Urinary Frequency		☐ Pregnancy

Thank you for completing The Painless Center's Evaluation Intake Form. Please present your identification and insurance information to the front desk. The doctor will be with you shortly.