NEBRASKA PAIN INSTITUTE

Getting you back to the good life

Name_____ **Return Patient**
DOB _____ **Intake Form**

How would you rate your pain on a scale from 0-10 with 0 being no pain and 10 being the worst pain imaginable:

Without Medication/Intervention

(●) 1 2 3 4 5 6 7 8 9 10

With Medication/Intervention

0 1 2 3 (●) 5 6 7 8 9 10

How frequent is your pain?

Constant☐ Occasional☐ Rare☐ Bursts of Pain☐

When is your pain the worst?

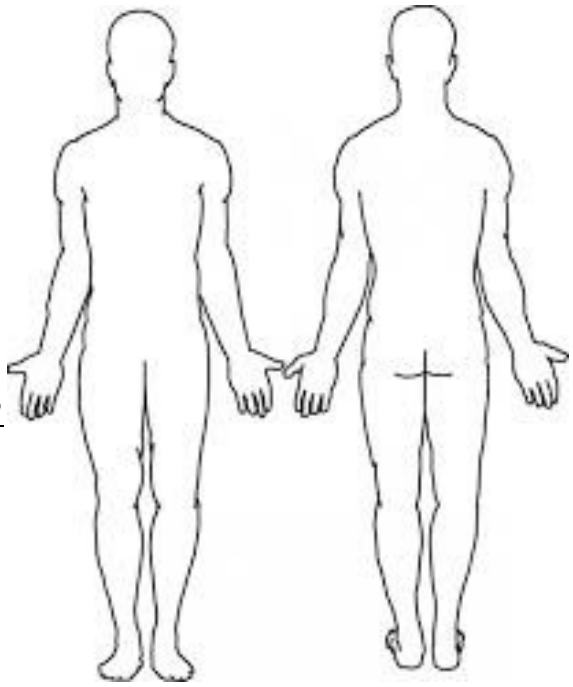
Mornings☐ Daytime☐ Evenings☐ Middle of the night☐
With weather changes☐ All the time☐

How would you describe your pain?

☐Burning	☐Aching	☐Sharp	☐Constant
☐Electric	☐Throbbing	☐Stabbing	☐Occasional
☐Prickling	☐Dull	☐Shooting	☐Frequent
☐Numbing	☐Cramping	☐Stinging	☐Rare
☐Other _____			

Please designate your pain location and mark W for worst pain

Front Back



Since your last visit

How has your pain changed?

Improved☐ Stayed the same☐ Worsened☐

Any changes in your health?

_____

_____

Do your medications/interventions improve your ability to do the activities you like to do? ☐Yes / No☐

If so, what two activities are improved with your treatment regimen?

(ex, sleep, exercise, walk, work, socialize, etc.) _____

_____

Do you experience any side effects to your treatment regimen?

Constipation☐ Drowsiness☐ Nausea/Vomiting☐ Confusion☐
Dizziness☐ Difficulty concentrating☐ None☐

REVIEW OF SYSTEMS: (Please circle any symptoms you have experienced within the last month.)

GENERAL: ☐Appetite Change ☐Chills ☐Sweating ☐Fever ☐Fatigue ☐Weight Change
HENT: ☐Neck Pain ☐Neck Stiffness ☐Ear Pain ☐Sore Throat ☐Congestion ☐Sinus Pressure
EYES: ☐Vision changes ☐Eye Pain ☐Eye Redness ☐Eye Discharge
RESPIRATORY: ☐Apnea ☐Shortness of breath ☐Wheezing ☐Cough
CARDIOVASCULAR: ☐Chest pain ☐Swelling ☐Palpitations ☐Chest Pressure
GASTROINTESTINAL: ☐Nausea /Vomiting ☐Constipation ☐Diarrhea ☐Heartburn
ENDOCRINE: ☐Thyroid Problems ☐Elevated Glucose ☐Sexual Difficulties
GENITOURINARY: ☐Incontinence ☐Hesitancy ☐Urgency
MUSCULOSKELETAL: ☐Joint Pain ☐Back Pain ☐Gait Disturbance Joint Swelling ☐Muscle Pain ☐Fibromyalgia
SKIN: ☐Color Changes ☐Rash ☐Wounds ☐Pain to Light Touch
NEUROLOGICAL: ☐Headache ☐Dizziness ☐Numbness ☐Weakness ☐Confusion ☐Seizures
HEMATOLOGIC: ☐Anticoagulation ☐HIV ☐Hepatitis ☐Bleeding disorder
PSYCHIATRIC: ☐Depression/anxiety ☐Substance abuse ☐Suicidal Thoughts