Advanced Pain Clinic
New Pain Solutions

Dr. James Robles
Advanced Pain Clinic
412 E. 18th Street
Weslaco, TX
956-447-9396

INITIAL HEALTH INTAKE QUESTIONAIRE- *Please fill out all the fields* **DATE:** _____ **20**_____

LAST NAME: _____ **FIRST NAME:** _____ **BIRTHDATE:** _____ **19**_____

Past Medical History: (*Please circle)*

Angina Arthritis Asthma Bleeding Cancer Diabetes Hearth Disease

Hypertension Multiple Sclerosis Renal Disease Seizure Stroke Other_____

Social Medical History:

Smoke ☐ no ☐ yes _____packs /day Alcohol ☐ no ☐ yes _____drinks / day

Living Situation: ☐ Alone/ Independent ☐ Married ☐ Children _____ ☐ Employed/Disabled

List all surgeries you have had:

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Pain Medications Tried:

Medications:	**Results:**

Treatments Tried:

Therapy	**Results:**

How would you rate your general stress level?

☐ Little or no stress ☐ Mild stress ☐ Moderate stress ☐ Severe stress

General physical activity?

☐ No regular exercise ☐ Light exercise ☐ Moderate exercise ☐ Heavy exercise

Physical activity at work?

☐ Mild manual labor ☐ Manual labor ☐ Heavy manual labor ☐ Sitting more than 50% of workday

ADDITIONAL COMMENTS OR CONCERNS: _____

_____

Height _____Weight _____ Allergies: _____

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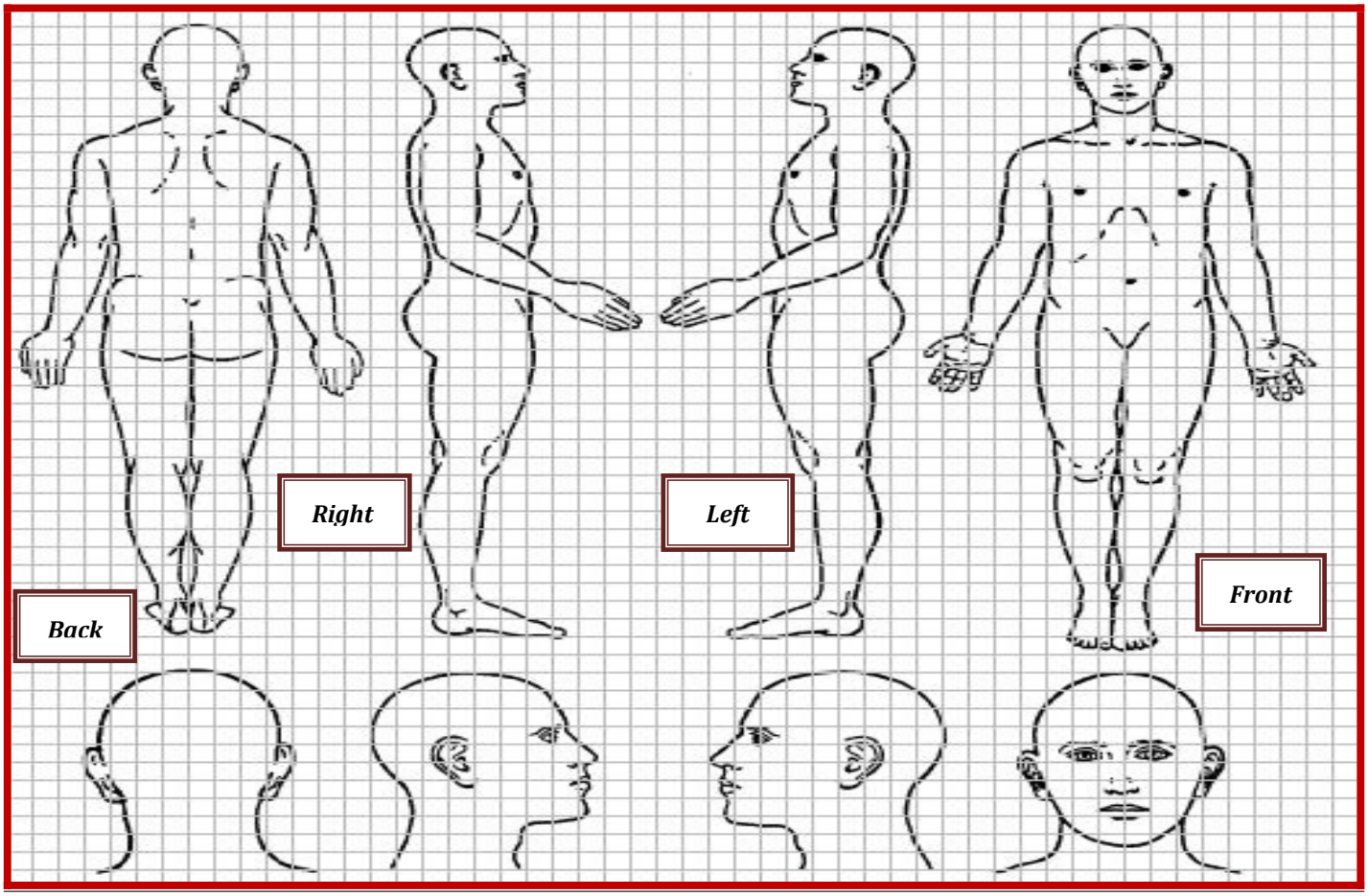
Please mark the location of your pain, and use the codes below to describe the pain.

SS = Sharp/Stabbing	N = Numbness	B = Burning	SO = Soreness	D = Dull	A = Aching
E = Electrical	T = Tingling	P = Pins and Needles	W = Weakness		



What is your pain score today? *Circle on the right.*

Comments:_____

_____

1. When did your pain start? _____Is this work related? No ☐ yes ☐
2. How did your pain start? _____
3. What is the maximum pain in the **past 24 hours**?____/10. Comments: _____
4. What is your **ideal/ target** pain goal? ____/10. Comments: _____
5. Do you sleep normally? Yes ☐ No, ☐ Describe why not _____
6. What increases ↑ your pain? _____
7. What decreases ↓ your pain? _____