# A Renaissance Health Center for Natural Medicine

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## COMPREHENSIVE PAIN INTAKE

**DATE:** ___________________

**PT. NAME:** ___________________________________________ **SEX M F DOB** _________**AGE** _____
**ADDRESS** ______________________________________________________________________________
**CITY** _______________________ **STATE** _________**ZIP**___________ **HOME PH**______________________
**WORK PH** ______________________ **EMAIL** _________________________________________________
**PRIMARY DOCTOR** __________________________________________ **PH** _________________________
**EMERGENCY CONTACT** ______________________________________**PH** __________________________
**WHO REFERRED YOU TO CENTER FOR CARE?**

_____________________________________________________________________________________________

**Have you been diagnosed with a pain condition/limitation? Please describe here:**

_____________________________________________________________________________________________

| Where is your pain? | **Previous Medications:** |
|---|---|
| Does it go anywhere else? | NSAIDS: aspirin, ibuprofen,advil, motrin, naprosyn |
| Where? | Relaxants: flexeril, valium, xanax, ativan, librium |
| When did it start? | Sleep Meds: ambient, restoril, benedryl, halcion |
| How long have you had pain? | Anti-Depressants: elavil, amitryptilline, Prozac, effexor, Zoloft, deseryl, paxil, pamelor, serozone, desipramine, remeron |
| Did it start _ gradually _ suddenly | Narcotics: vicodin, darvocet, tylenol3, tylox, codeine, Percocet, percodan, MS Contin, oxycontin, Demerol, morphine, methadone |
| How often do you have pain?<br><br>_Continuously _comes & goes | Neuropathic Pain Meds: neurontin, klonopin, tegretol, dilantin, baclofen, utram, prozocin, mexitil, prazocin |
| How often? _ minutes _ hours | On average it takes ____minutes/hours to fall asleep. |
| It is _getting better _ getting worse _staying the same | I awake ___ times/night.<br>. |
| How did the pain start?<br><br>_accident (date _/_) _ work injury _ other injury<br>_ following operation _ cancer _ no cause | It takes me __ minutes/hours to get back to sleep |
| What makes your pain better?<br><br>_sitting _ pain meds<br>_walking _ standing<br>_heat _ cold<br>_exercise _ stretching<br>_brace _ immobilization | What treatments have you tried for your pain?<br><br>_ exercise _massage<br>_acupuncture _chiropractor<br>_warm back _physical therapy<br>_surgery _ice pack<br>_psychologist _TENS unit |
| What makes your pain worse?<br><br>_sitting _ pain meds<br>_walking _ standing<br>_heat _ cold<br>_exercise _ stretching<br>_brace _ immobilization | **Pain “0” = NO PAIN – Pain “10” WORST PAIN**<br><br>Pain Level NOW: _____<br>Pain Level at ONSTART: _____<br>Pain Level at BEST: _____<br>Pain Level at WORST: _____ |

## MEDICAL HISTORY

Have you ever been told you have any of the following: (Check all that apply)

**CARDIOVASCULAR**

__ Chest Pain
__ Heart Disease
__ Blocked Artery
__ Heart Attack
__ Congestive Heart Failure
__ High Blood Pressure
__ Peripheral Vascular Disease
__ Abnormal Heart Beat
__ Pacemaker
__ Angioplasty or heart cath
__ Rheumatic Fever
__ Damaged heart valve

ALLERGIES

______________________________________
______________________________________
______________________________________

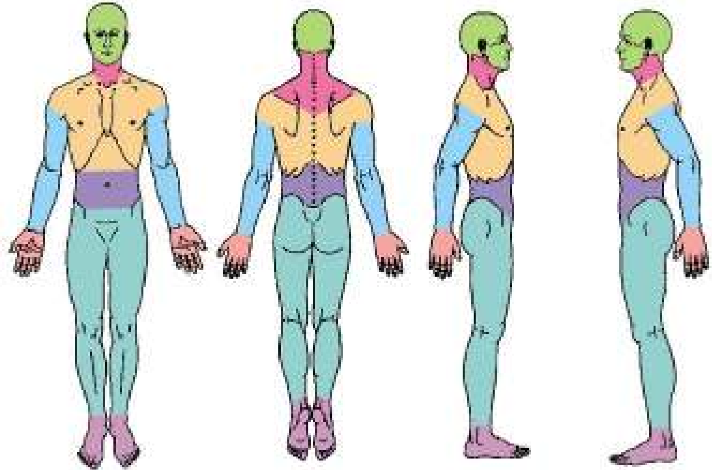
**NEUROLOGICAL**

__ Epilepsy or seizures
__ Fainting spells or dizziness
__ Stroke
__ Headache/migraines

**GASTROINTESTINAL**

__ Ulcers, heartburn, reflux
__ Diverticulitis or colitis
__ Other _____________

**CANCER** _________________



**Circle area(s) that pertain to your current pain**

**Other**

__ Chronic numbness or pain
__ Depression or anxiety
__ Other nervous problem
__ Dentures __ glasses __ hearing aid

**Current Medications you are taking:**

| Med | Dose | How Often | Last Dose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Previous Surgeries:**

____________________________________________________________
____________________________________________________________
____________________________________________________________

Any legal./occupational issues pending in regard to your pain conditions? Yes No

With whom do you live? Self _ Spouse _ Children_ Parents _ Friends _ Partner _

PATIENT SIGNATURE ________________________________________ DATE____________