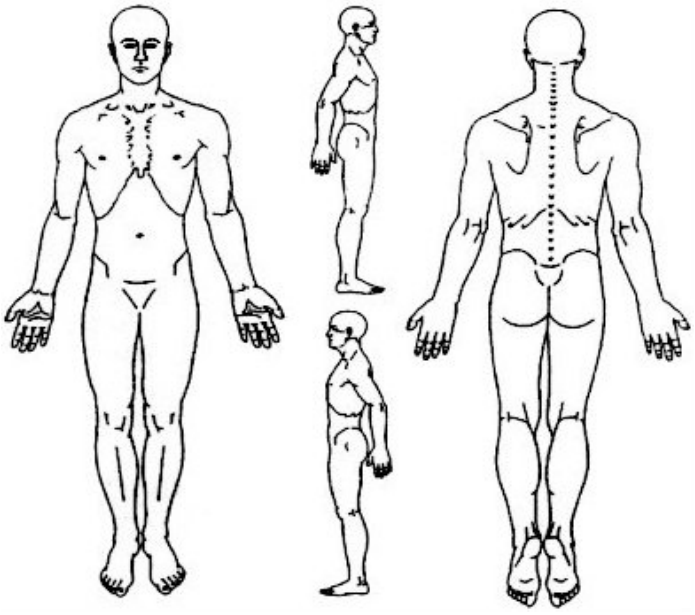
Name: _____ Date of Birth: _____/_____/_____

**Pain Management Intake**

On the figures below, please clearly mark areas of pain and indicate any scars. Use a scale from1-10 for the amount of pain you feel. (1 = least, 10 = most)



**Onset of pain:**

What event/events led to your present pain?

□ Accident □ Cancer □ Stress
□ Operation □ No known cause

How long have you had this pain? _____

How often does this pain occur?

□ Continuously □ Several times a day
□ 1-2 times a day □ Several times a week
□ Less than 3-4 times per month

How does your pain affect your ability to work or otherwise be active?

□ No effect □ Some physical restrictions
□ Need limited assistance □ Need assistance often
□ Can't care for self

**Factors that affect your pain:**

| Better | Worse | Better | Worse |
|---|---|---|---|
| □ | □ Heat | □ | □ Walking |
| □ | □ Cold | □ | □ Noise |
| □ | □ Soft Pressure | □ | □ Coughing |
| □ | □ Hard Pressure | □ | □ Particular position |
| □ | □ Lying Down | □ | □ Anxiety / Emotions |
| □ | □ Sitting | □ | □ Climate Change |
| □ | □ Standing | | |
| □ | □ Other: _____ | | |

Which? _____

**Quality of Pain:**

□ Sharp □ Fixed □ Burning □ Moving □ Cramping □ Aching □ Dull
□ Other: _____

**Other treatment modalities you have used to manage your pain:**

□ Chiropractic □ Massage □ Physical Therapy □ Surgery □ Acupuncture □ Relaxation Training
□ Biofeedback □ Exercise □ Medication □ Other: _____

Is there anything else about your pain management that you feel we should know about? _____

_____

_____