vancouver island health authority

INTERDISCIPLINARY PAIN MANAGEMENT CLINIC

Nanaimo Regional General Hospital
Tel: 250-739- 5978

# New Patient Intake Form

**Name:** _____ **Age:** _____

Patient ID Sticker

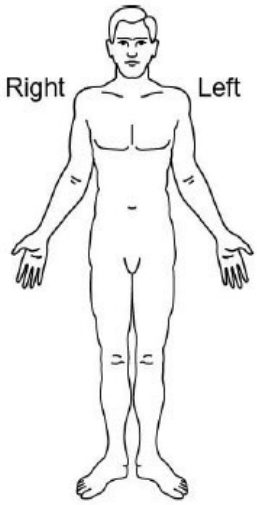
May we contact you via email? □ *Yes* □ *No*

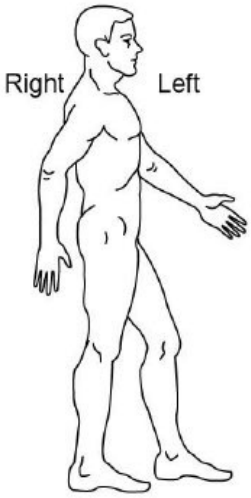
Email: _____

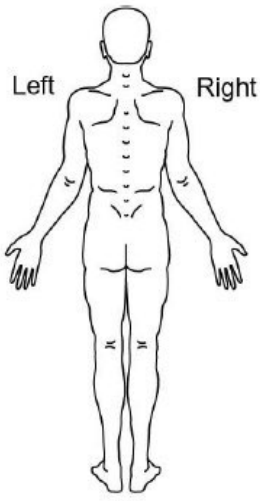
**Please note that only <u>one area of pain</u> will be addressed at this visit (ex: low back, neck, leg, etc…)**
If you have more than one area of pain, your GP will need to submit a referral for each area.

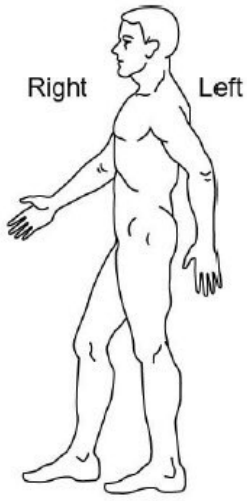
**Please use the diagram below to draw out your area of pain:**

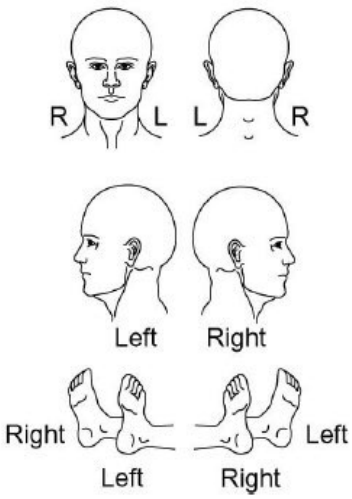
1. Most painful area: ***shade in darkly***
2. Less painful areas: *shade in lightly*
3. Pain shooting down arm or leg: indicate with an arrow



## 1. How did your pain start?

**When did your pain problem begin?** **Month:** _____ **Year:** _____

Is your pain related to an injury? ☐ Yes ☐ No

If Yes, please specify: ☐ Car accident ☐ Fall ☐ Job related injury

☐ Other: _____

**Please provide the details of your accident or mechanism of injury (ie: describe what happened)**

*(Do not provide details of your pain or injuries here, you will be able to describe these on the following pages)*

_____

_____

_____

## 2. Describe Your Pain

**Which words best describe your pain?** *(please circle)*

Electric / Burning / Shooting  Dull / Aching  Stabbing / Sharp  Other: _____

**When is your pain the worst?** *(please circle one)*

Morning  Noon  Night Time  Always the same

**NEW Symptoms**

Are you experiencing any NEW symptoms since your pain started?

☐ NEW Weakness *where?*_____

☐ NEW Numbness *where?*_____

☐ NEW changes in bowel/bladder function

**Associated Symptoms**

If you have pain in your arms or legs, do you have:

☐ Increase sweating in the hand or foot?

☐ Temperature changes in the hand or foot?

☐ Colour changes in the hand or foot?

☐ Swelling in the hand or foot?

☐ Increased sensitivity to touch in the arm or leg?

**What makes your pain WORSE?** (eg: walking, sitting, bending, lifting, cold, heat)

_____

**What makes your pain BETTER?** (eg: medications, lying down, heat, cold, physical therapy)

_____

**Does your pain wake you from sleep?** □ Yes □ No

**Is your pain getting:** □ Worse □ Better □ Staying the same

**Please circle the level of your pain for the following**
(0 = No Pain, 10 = Worst Pain Imaginable)

*WORST daily level of pain:*

0 1 2 3 4 5 6 7 8 9 10

*BEST daily level of pain* (i.e. at rest or after medications):

0 1 2 3 4 5 6 7 8 9 10

Using the same scale, what level of pain is ACCEPTABLE for you?

0 1 2 3 4 5 6 7 8 9 10

If your pain could be reduced, but not completely, how much of a reduction would there need to be for you to feel you could live with it? _____%

## 3. Medications

**Previous Medications**
Please list all medications you have previously taken for this pain and are no longer taking.
(you may obtain a list from your pharmacy)

| Medication | Was it effective? |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

**Current Medications**
Please list all medications you are currently taking, including those that are not for your pain. List all over the counter medications, herbal supplements and vitamins here as well.

| Medication | Dose / Number of pills | Is it effective? |
|---|---|---|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |
| 7. _____ | _____ | _____ |
| 8. _____ | _____ | _____ |
| 9. _____ | _____ | _____ |

**Blood Thinners**
Are you currently taking any blood thinners? (eg: Plavix, Warfarin, etc…) □ Yes □ No

Please indicate type and dose: _____

**List any allergies to Medications, Latex, Dyes or Adhesives**
1. _____
2. _____
3. _____

## 4. Treatment History

**Have you been previously assessed and/or treated by anyone for this pain?** ☐ Yes ☐ No
Please provide details in table below.

| Discipline | Result: *Effective* | Result: *Not Effective* |
|---|---|---|
| **Pain Clinic** | | |
| • steroid injections | ☐ | ☐ |
| • nerve blocks | ☐ | ☐ |
| • medications | ☐ | ☐ |
| **Neurosurgery** | ☐ | ☐ |
| **Orthopedic Surgery** | ☐ | ☐ |
| **Rheumatology** | ☐ | ☐ |
| **Psychological Therapy** | | |
| • Psychiatry | ☐ | ☐ |
| • Counselling | ☐ | ☐ |
| • Hypnosis | ☐ | ☐ |
| • Relaxation | ☐ | ☐ |
| • Mindfullness | ☐ | ☐ |
| **Occupational Therapy** | ☐ | ☐ |
| **Other Therapy** | | |
| • Physiotherapy | ☐ | ☐ |
| • Chiropractic | ☐ | ☐ |
| • IMS | ☐ | ☐ |
| • Acupunture | ☐ | ☐ |
| • Prolotherapy | ☐ | ☐ |
| • TENS | ☐ | ☐ |
| • Biofeedback | ☐ | ☐ |

**Other:** _____

## 5. Past Medical History

**Medical Conditions**
Please **circle** any condition that applies to you and whether it is a **current** or **past** problem.

**Cancer** In Remission? ☐ Yes ☐ No

Please list type: _____

**Lung problems**
COPD / Asthma / Sleep apnea
Other: _____

**Heart problems**
Heart attack / Heart stent / high blood pressure / congestive heart failure
Other: _____

**Kidney problems**
Chronic renal failure
Other: _____

**Liver problems**
History of liver failure / hepatitis
Other: _____

**Neurological problems**
MS / diabetic neuropathy / stroke
Other: _____

**Diabetes**
type 1 / type 2
Well controlled? ☐ Yes ☐ No

**Clotting or Bleeding problems**
Specify: _____

**Infectious Disease**
Hepatitis / HIV
Other: _____

**Arthritis**
Rheumatoid / lupus / ankylosing spondylitis
Other: _____

**Fibromyalgia**

**Other**: _____

**Major Surgeries**
Please list all past major surgeries

| Date | Surgery | Date | Surgery |
|---|---|---|---|
| 1. | | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

## 6. Family Medical History

**Please check all that apply and indicate affected relative(s)**

| Condition | Relative(s) | | Relative(s) |
|---|---|---|---|
| ☐ Cancer (specify type) | | ☐ Depression/Anxiety | |
| ☐ Chronic pain | | ☐ Psychiatric disorder | |
| ☐ Low back pain | | ☐ Fibromyalgia | |
| ☐ Substance abuse | | ☐ Rheumatoid arthritis | |
| ☐ Heart disease | | ☐ Osteoarthritis | |
| ☐ Stroke | | ☐ Other: | |
| ☐ Diabetes | | ☐ Other: | |

**Employment Status**

☐ Employed
Occupation: _____
- ☐ Limited due to pain at work
- ☐ Have taken time off due to pain in past 12 months. How much time?

☐ Unemployed
- ☐ Planning on returning to work
- ☐ Disabled
- ☐ Retired

**Sources of income**
Check all that apply

☐ Worker's compensation
☐ Disability benefits
☐ Unemployment benefits
☐ Social assistance

Do you have an active ICBC, WCB or DND claim related to this area of pain? ☐ Yes ☐ No
**Claim Number**: _____
Are you involved in any other type of legal action related to your pain, or considering this in the future? ☐ Yes ☐ No

**Social History**

Smoking Status: ☐ Never smoked ☐ Used to smoke, quit on: _____ ☐ Currently smoking ____ / day

Alcohol Use: _____ drinks per day / week / month

Recreational Drug Use: _____

**Mental and Emotional Health**

Check all that apply

☐ Anxiety
☐ Depression
☐ Other: _____

Rate your level of distress (0 = low, 10 = high)
1 2 3 4 5 6 7 8 9 10

**Relationship and Living Status**

☐ Married
☐ Single
☐ In a relationship
☐ Common Law
☐ Widowed

Who do you live with?
_____

Number of dependents:
_____

## 8. Goals and Expectations

1. What would you like to get out of your visit today?

_____

_____

_____

_____

2. What do you believe is the cause of your pain

_____

_____

3. Do you think your pain may be due to a serious disease, which doctors have not found or have not told you about?

□ Yes □ No □ Not sure

4. What Questions would you like answered following your assessment at this pain clinic?

a) _____

b) _____

c) _____

d) _____

e) _____

**Patient Specific Functional Scale**

Step 1: Pick 1 to 3 activities that are important to you which you cannot perform or have difficulty with doing as a result of your pain.

Step 2: Circle one number that best rates your ability to perform the activity.
(0 = Unable to perform activity, 10 = Able to perform activity at Pre-problem level)

Activity 1: _____

0 1 2 3 4 5 6 7 8 9 10

Activity 2: _____

0 1 2 3 4 5 6 7 8 9 10

Activity 3: _____

0 1 2 3 4 5 6 7 8 9 10