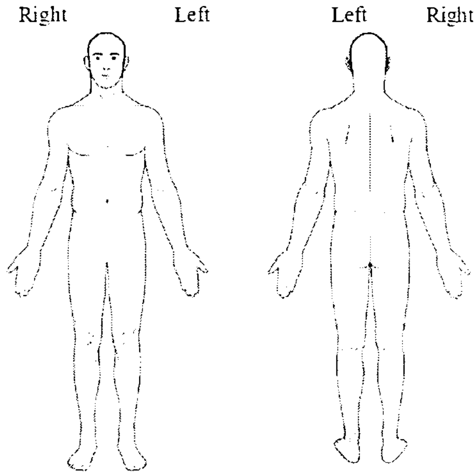
PATIENT INTAKE SELF- REPORT

Pain Location
(Please indicate on the diagram)



Pain Description

Achy Burning Sharp Dull Throbbing Shooting
Cramping Stabbing

What makes your pain worse? (circle)

Heat Cold Activity Sitting Standing Walking Bending Twisting
Lying down Lifting Movement Everything Touch Nothing in particular Physical Therapy Change of Position

What makes your pain better? (circle)

Heat Ice Activity Lying down Sitting Standing Walking Massage
Medication Nothing Rest Physical Therapy
Change of Position TENS unit Steroid Injections Nothing

Pain Ratings

Your pain today: ______ (0-10)

(0= no pain 10= worse possible)

In general, what percentage of your pain is being relieved by your current treatment? _________

How long did relief last from your last procedure?
________________ (days, weeks)

Social History

Smoking Status

- Current
  - Every Day
  - Some Days
  - # ________ cigarettes per day
  - Former: Last Used: _____________
  - Never

Alcohol Use

- Never
- Former
- Rarely
- Occasionally
- Daily

How Often? ____________

How many drinks? _____________

Drug Use

- None
- History of Casual Use
- History of Drug Abuse
- Current User

What Drugs? ________________

Family History

	Mother	Father	Brother(s)	Sister(s)
Cancer				
Depression				
Diabetes				
Heart Disease				
High Cholesterol				
Hypertension				
Unknown				
Healthy				

______ of brother(s)
of sister(s)

Social History :

Marital Status: ___Married ___Single ___Divorced ___Widowed

Children: No / Yes How Many? ___

Work outside home? No / Yes Occupation:____

Retired: No / Yes Disabled? No / Yes

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Have you had two or more falls in the past year?

- YES
- NO

Medical History

Have you ever, or do you now have any of the following conditions? Please circle

Heart Attack/Heart Disease	Depression/ Psych	Closed head injury
High Blood Pressure	Cancer	Anxiety
Substance Abuse/Addiction	Kidney Problems	fibromyalgia
Emphysema	Epilepsy/Seizures	Migraines Headaches
Thyroid Problems	High Cholesterol	Congestive Heart Failure
Diabetes: Type 1 Type 2	Stroke	COPD
Sleep Apnea	GERD/Acid Reflux	

Current Medication List

Name	Dosage	Frequency (how often a day taken)

Allergies:

Do you have any allergies? YES NO. If yes, please list.

Agent/Substance	Reaction

Surgeries:

Name of Surgery	Date (if known)

Pharmacy Name : ______________________________ City: ________________

Revised 09/2020

Sexual orientation and gender identification (SOGI)

This information is now required by governmental programs (CMS) to be documented in each patients chart in order to improve the care provided to each individual person. This information will only be used for your healthcare treatment and will not be shared with anyone.

Birth Sex:

- ___ Male
- ___ Female
- ___ Unknown

Sexual Orientation:

- ___ Lesbian, gay or homosexual
- ___ Straight or heterosexual
- ___ Bisexual
- ___ Do not know
- ___ Choose not to disclose
- ___ Something else, please describe: ____________________

Gender Identity:

- ___ Male
- ___ Female
- ___ Female-to-Male (FTM)/Transgender Male/Trans Man
- ___ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ___ Genderqueer, neither exclusively male nor female
- ___ Choose not to disclose
- ___ Additional gender category or other, please specify: ____________________
- ___ Transgender

Do you have an advance Directive? YES NO

If yes, please circle which directive

Do Not Resuscitate (DNR)	HealthCare Proxy
Full Code	Power of Attorney

Email Address: ________________________________

PAIN CENTERS OF CHICAGO, LLC

Name: ______________________________ Date: ______________________

The following are some questions given to all patients at Pain Centers of Chicago who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information if for our records and will remain confidential. Your answers alone will determine your treatment. Thank you.

Please answer the questions below using the following scale:

0= Never 1=Seldom 2=Sometimes 3=Often 4=Very often

1. How often do you feel that your pain is "out of control?" 0 1 2 3 4
2. How often do you have mood swings? 0 1 2 3 4
3. How often do you do things that you later regret? 0 1 2 3 4
4. How often has your family been supportive and encouraging? 0 1 2 3 4
5. How often have others told you that you have a bad temper? 0 1 2 3 4
6. Compared with other people, how often have you been in a car accident? 0 1 2 3 4
7. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
8. How often have you felt a need for higher doses of medication to treat your pain? 0 1 2 3 4
9. How often do you take more medication than you are supposed to? 0 1 2 3 4
10. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4
11. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
12. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
13. How often have you attended an AA or NA meeting? 0 1 2 3 4
14. How often have you had a problem getting along with the doctors who prescribed your medications? 0 1 2 3 4
15. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
16. How often have you been seen by a psychiatrist or a mental health counselor? 0 1 2 3 4
17. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
18. How often have your medications been lost or stolen? 0 1 2 3 4
19. How often have others expressed concern over you use of medication? 0 1 2 3 4
20. How often have you felt a craving for medication? 0 1 2 3 4
21. How often has more than one doctor prescribed pain medication for you at the same time? 0 1 2 3 4
22. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4
23. How often have you used illegal drugs (for example, marijuana, cocaine, etc) in the past five years? 0 1 2 3 4
24. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Please include any additional information you wish about the above answers on the back side. Thank you.