North Kansas City Hospital Pain Management Clinic
Patient Intake Form

PainClinicForms

Please Print Clearly

Today's Date_____

Name_____ Date of birth_____/_____/_____
Address_____
Home phone_____ Cell Phone_____
Primary Care Physician_____ Referring Physician_____
Height _____ Weight _____ Last menstrual period if applicable_____

CHIEF CONCERN:

- Describe in your own words, why you came to the Pain Clinic today:_____
  _____
- What are you expecting from your visit to the Pain Clinic today?_____
  _____

PAIN:

Please use the following scale, 0 to 10, to rate your pain:
("0" means no pain and "10" means the worst pain you have ever had or can imagine)
May pain at **BEST** is_____ My pain **NOW** is_____ My pain at its **WORST** is _____

HISTORY OF PRESENT ILLNESS:

When did you first notice your pain/problem?	What do you think caused your pain/problem?
Where is your pain?	Is your pain worse on one side than the other, If so which side?
Describe your pain (dull, sharp, burning, achy, etc.):	Does your pain move to other parts of your body, if so where?
List the things that make your pain **better**:	List the things that make your pain **worse**:
How is your sleeping?	Have you had any changes in your mood (irritable, sad, not eating, etc.), if so, please explain:
What did other physicians tell you is causing your pain?	Is this pain the result of a work related accident? If yes, is legal action or an insurance settlement pending?
	If yes to the above question, describe the current status of such an action:
	If no, do you plan to pursue legal action or insurance settlement in the future?

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Has your physician prescribed or have you tried any of the following activities as treatments for pain relief? If so please note the date(s) you tried or began treatment, the effectiveness (good, bad, varied, etc.) and the percentage of pain relief if any.

Activity	Date(s)	Effectiveness	% pain decreased (0% to 100% decreased)
Restricting activity			
Medication(s)			
Ice/Heat			
Physical/Occupational Therapy			
TENS unit			
Chiropractic			
Biofeedback/Counseling			
Nerve blocks/Injections			
Surgery			

Have you had any of the following pain related evaluations and if so, please give the date(s) and the facility in which you had these evaluations?

Procedure	Date(s)	Facility
Bone Scans		
CT Scans		
MRI		
Myelogram		
Nerve/Muscle Tests (EMG)		
X-rays		

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Previous Medical and Surgical History:

Have you ever been diagnosed with any of the following medical conditions and if so, when?

Medical Condition	Date	Medical Condition	Date
Asthma/COPD		Hepatitis	
Bleeding Tendencies		High Blood Pressure	
Cancer		Kidney Disease	
Diabetes		Pacemaker/Defibrillator	
Heart Disease		Ulcers/GERD	
Surgeries	**Date**	**Surgeries**	**Date**

Allergies: Please list any allergies and reactions

Medication	Reaction

Medications: Please list all medications including over the counter medications, vitamins, herbal supplements (including CBD) and dosages

Medication	Dosage		Medication	Dosage

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Please answer the following questions, even though they may have been addressed elsewhere:

	Yes	List medication	No
Do you take any antidepressants?			
Do you take any herbal supplements			
Do you take any medications that may thin your blood?			

Have you taken any of the following medications and the last dose taken:

Medication	Yes	Last dose took	No
Aggranox			
Aggrastat (tirofiban)			
Aleve (naproxen)			
Arixtra (fondaparinux)			
Aspirin (Bayer or Excedrin)			
Brilinta (ticagrelor)			
Coumadin (warfarin)			
Diclofenac (Voltaren)			
Effient (prasurgel)			
Eliquis (apixaban)			
Elmiron			
Feldene (piroxicam)			
Ibuprofen (Advil or Motrin)			
Indomethacin			
Integrillin (eptifibatide)			
Ketorolac (Toradol)			
Lodine (etodalac)			
Mobic (meloxicam)			
Nabumetone (Relafen)			
Oxaprozin (Daypro)			
Persantine (dipyridamole)			
Plavix (clopidogrel)			
Pietal (cilostazol)			
Pradaxa (dabigatron)			
Repro (Abciximab)			
Xaralto (rivaroxabin)			

Pharmacy:

Name	Phone Number	Address

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Social History: Please answer the following questions

	Yes	Explain as indicated	No
I currently work		Where?	
I am retired		From where?	
I have missed work in the last month due to pain		How many days?	
I smoke, chew tobacco		How many packs/day? How many years? I quit when?	
I drink alcohol		My drink of choice is: How much per day?	
I have a history of alcohol abuse		I quit drinking when?	
I use illicit drugs		I use: How much per day?	
I have a history of opioid abuse		I quit when?	
I am pregnant		My due date is	
I am planning on becoming pregnant		When?	
Does anyone live with you?		Who?	
I am (circle): • Single • Married • Divorced • Widowed		I completed (circle): • GED • High School • College • Technical School • Other	

Family History: Have any of your immediate family been diagnosed with

	Heart disease	Lung disease	Bone disease	Cancer	Deceased
Father					
Mother					
Brother					
Sister					

Review of systems: Please answer the following questions

	Yes	Describe	No
General (circle): Fever, chills, weight change			
Eyes, Ears, Nose (headaches; eye, ear or nose problems)			
Cardiovascular (chest pain, murmur, fluttering in chest, irregular heart beat)			

Respiratory (shortness of air, productive cough, asthma)			
Gastrointestinal (diarrhea, constipation, incontinence)			
Neurologic (weakness, loss of balance, falls, numbness or tingling)			
Skin (rashes, hives, areas that don't heal, eczema)			
Mental health (depression, anxiety, suicidal)			
Endocrine (diabetes, thyroid, hormone replacement)			
Hematologic (bleeding problems, anemia, swollen lymph nodes, Sickle cell)			
Allergy/Immunologic (Seasonal allergies, hay fever)			

Latex Screening:

	Yes	Explain	No
Have you ever been tested for a latex allergy		When and results?	
Do you have swelling, itching, hives or other symptoms after contact with any of the following, (circle): • Balloons • Dental exams or procedures • Vaginal or rectal exams • Diaphragm or condom • Rubber gloves			
Are you allergic to any of the following foods, (circle): Bananas Avocados Kiwi fruit Chestnuts			
Have you experienced an unexplained anaphylactic episode? (rapid heart rate, swelling of your throat and respiratory distress all at the same time)			

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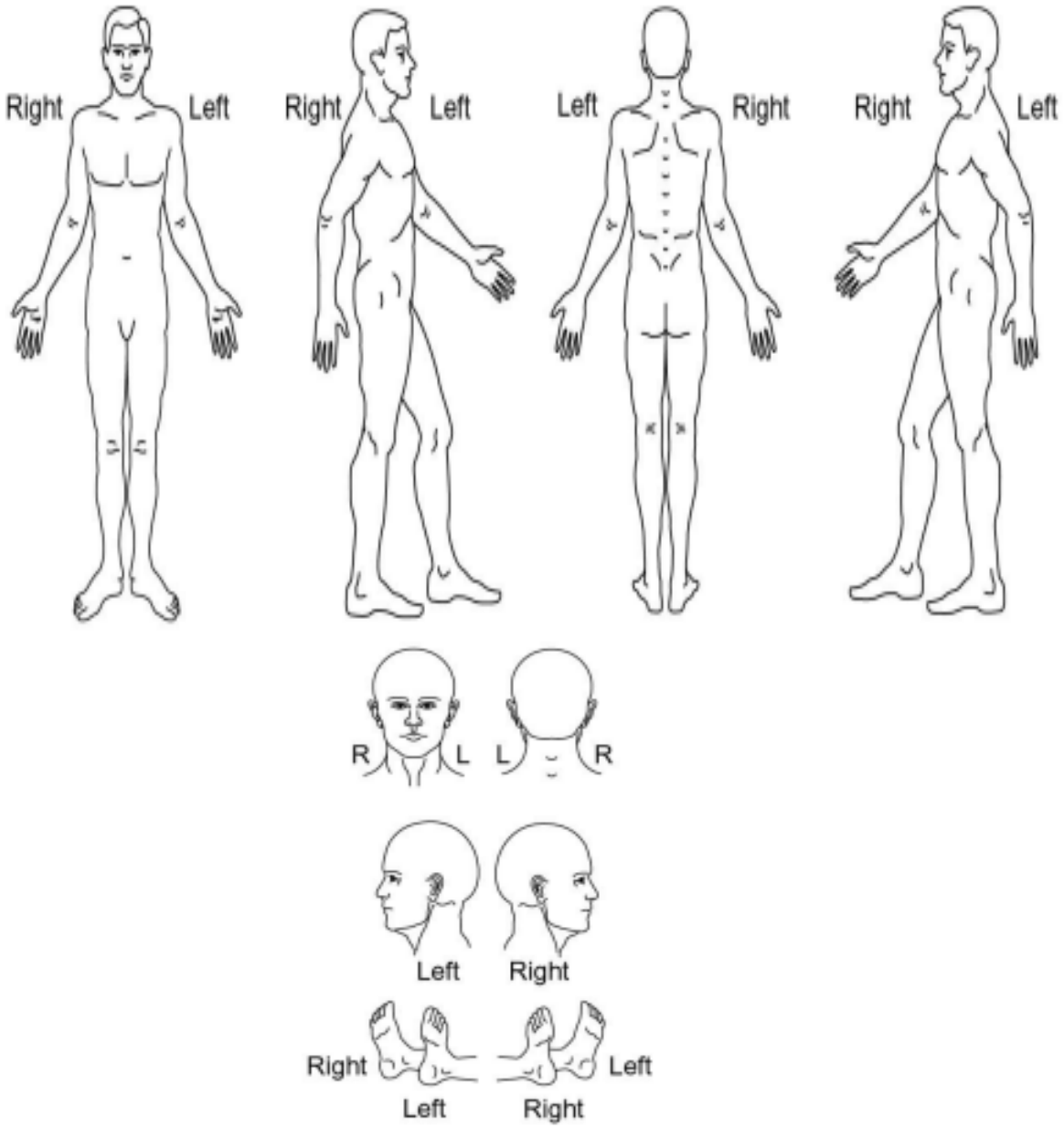
*****NOTE TO NURSING: IF PATIENT ANSWERS YES TO ANY OF THE ABOVE QUESTIONS IN THE LATEX SCREENING, NOTE LATEX ALLERGY ON THE FRONT OF THE CHART*****

Shade the areas where you feel pain.



Patient intake form completed per patient responses.

Patient Signature	**Date and Time**	**RN Signature**	**Date and Time**

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(FOR DOCTOR'S USE ONLY)

DIAGNOSIS:_____

_____

_____

_____

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_____

PLAN:

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PHYSICIAN SIGNATURE **DATE AND TIME**

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