Pain Care Clinics – New Patient Intake Form

Patient Information

First Name:_____ Last Name:_____ D.O.B(YYYY-MM-DD):_____

Address:_____ City:_____ Province:_____ Postal:_____

Home Phone #:_____ Cell Phone #:_____ Email:_____

OHIP #:_____ Version Code:_____

Gender Identity:☐ Male ☐Female ☐Other Height:_____Weight:_____ ☐Left handed ☐Right handed

Occupation:_____ ☐Full time ☐Part Time ☐Retired ☐Disability ☐Unemployed

Martial status**:** ☐Single ☐Married ☐Common Law ☐Divorced ☐Widow

Reside with: ☐Partner ☐Children ☐Dependents Children/Dependent(s) Age(s):_____

Emergency Contact Name: _____Phone number:_____

Practitioner and Pharmacy

Family Doctor:_____ Address:_____ City:_____

Phone:_____ Fax:_____

Pharmacy:_____ Address:_____ City:_____

Phone:_____ Fax:_____

Insurance information

Extended Health Benefits Company:_____ Policy #:_____ Group #:_____

Motor vehicle accident/WSIB Claims

Is your pain related to a motor vehicle accident? ☐Yes ☐No (Skip to next section)

Date of Accident:_____ MVA Claim #:_____

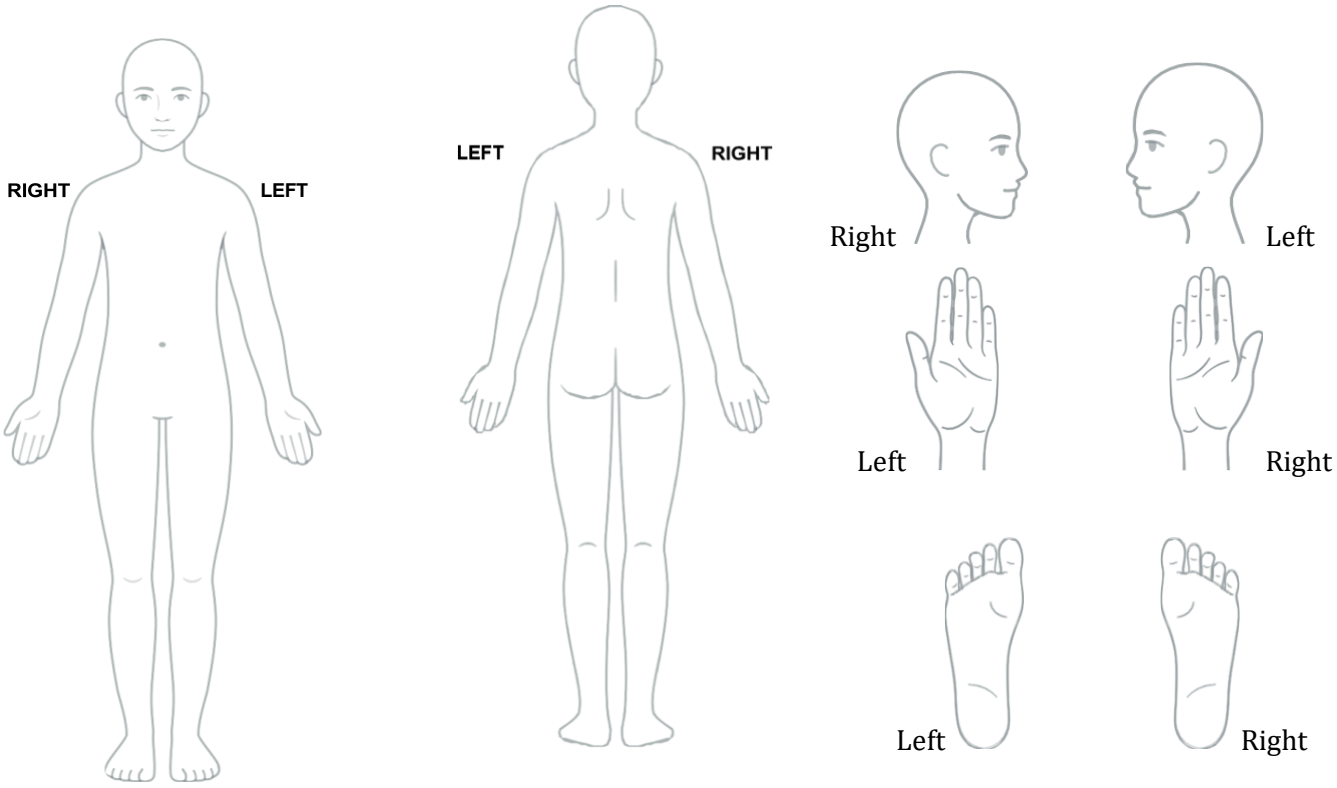
Auto Insurance Company:_____

Is your pain related to a WSIB injury? ☐Yes ☐No (Skip to next page)

WSIB Claim #:_____ WSIB Contact:_____ Number:_____

WSIB Claim Referral #:_____

Pain Diagram (Please indicate pain area(s)):



Main Complaint & Symptom History

When did your pain start? _____ Cause(ie. injury, illness, unknown): _____

Describe your pain (check all that apply):
☐ Dull ☐ Sharp ☐ Achy ☐ Burning ☐ Tingling ☐ Numbness ☐ Other: _____

Pain increases with: ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down ☐ Other: _____

Pain decreases with: ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down ☐ Other: _____

Frequency of pain: ☐ Constant ☐ Intermittent ☐Morning ☐Afternoon ☐Evening

Pain radiates from: _____ to _____

Indicate Below Pain Rating (0 = No Pain - 10 = Worst Possible Pain)

Worst pain in past week: ____/10 **Least** pain in past week: ____/10 **Average** pain: ____/10
Pain **right now**: ____/10

How much has pain interfered with your:
General activity: ____/10 Mood: ____/10 Enjoyment of life: ____/10 Walking: _____/10
Sleep:____/10 Relations with others:____/10 Work function:____/10

Does pain affect your sleep? ☐Yes ☐No **Do you take medications for sleep?** ☐Yes ☐No

Does your pain affect your sexual function? ☐Yes ☐No

Substance Use	
Indicate all that applies to you:	**Frequency**
☐Nicotine-Vaping, Smoking, Patches, Chewing, Pouches	Years:_____ Packs per day:_____
☐Alcohol	Years:_____ Drinks per week:_____
☐Cannabis	Years:_____ Dose per day:_____
☐Cocaine ☐Heroin ☐Ecstasy ☐Steroids ☐ Amphetamines ☐Prescription:_____	Last used: _____

Medication History

Current pain medications (Please include dose and frequency):

Name	Dose	Frequency	Hours of relief	Percentage of relief with your current medications 0-100%
				_____%

I prefer to take my medication: ☐On a regular basis ☐As needed ☐I don't take medication

Do you feel your current pain medication regime is effective? ☐Yes ☐No

Please list any side effects from your <u>current</u> pain medications:_____

_____

Previous pain medications trialed:

Medication Name	How long did you take it for?	Why did you stop?

Are you currently taking any blood thinners? ☐Yes ☐No If yes, please indicate medication below

List below all your regular medications:

Name	Dose	Frequency	Name	Dose	Frequency

List any medication allergies (and reactions) :

_____

_____

Have you or a family member ever had a reaction to a local or general anesthetic? ☐Yes ☐ No

Medical History

Do you have history of the following:

☐High blood pressure	☐HIV/AIDS or Blood borne disease	☐Rheumatoid Arthritis	☐Liver disease	☐Seizure
☐Stroke	☐Lung disease	☐Osteoarthritis	☐ Kidney disease	☐Headaches
☐Heart disease	☐Asthma	☐Osteopenia	☐Cancer	☐Depression
☐Blood clots	☐Sleep Apnea	☐Joint replacement	☐Thyroid disease	☐Anxiety
☐Blood disorder	☐Multiple sclerosis	☐ Fracture	☐Diabetes	☐Glaucoma

Additional health history:_____

_____

_____

Surgical history:

Type of surgery	**Date**	**Type of surgery**	**Date**

Most recent diagnostic tests:

Diagnostic test	**Area of body**	**Date**
MRI		
CT		
Ultrasound		
X-Ray		
EMG/Nerve Conduction		

Complementary care:

Have you tried?.....	**Comments (Active? Providing relief? Stopped?...)**
☐Physiotherapy	
☐Chiropractor	
☐Massage Therapy	
☐Acupuncture	
☐Other	

Please list any **Family History (Mother/Father, Brother/Sister)** Including any history of drug (Prescription or street) or alcohol abuse:

_____

_____

_____

HADS

Please reach each statement below and circle the number which best describes how true the feeling is for you

Please circle one number per question	Yes, Always	Yes, sometimes	No, not much	No, not at all
1. I wake early and then sleep badly for the rest of night	3	2	1	0
2. I get very frightened or have panic feeling for apparently no reason at all.	3	2	1	0
3. I feel miserable and sad	3	2	1	0
4. I feel anxious when I go out of the house	3	2	1	0
5. I lost interest in things	3	2	1	0
6. I get palpitations or sensations of butterflies in my stomach or chest	3	2	1	0
7. I have a good appetite	0	1	2	3
8. I feel scared or frightened	3	2	1	0
9. I feel life is not worth living	3	2	1	0
10. I still enjoy the things I used to	0	1	2	3
11. I am restless and can't keep still	3	2	1	0
12. I am more irritable than usual	3	2	1	0
13. I feel as if I have slowed down	3	2	1	0
14. Worrying thoughts constantly go through my mind	3	2	1	0

A Score= 2 + 4 + 6 + 8 + 11 + 12 + 14

D Score= 1 + 3 + 5 + 7 + 9 + 10 + 13

Fibromyalgia Rapid Screening Tool

(Check each statement that applies)

1) ☐I have pain all over my body

2) ☐My pain is accompanied by a continuous and unpleasant general fatigue

3) ☐My pain feels like burns, electric shocks, or cramps

4) ☐My pain is accompanied by other unusual sensations throughout my body, such as: tingling, pins and needles, or numbness

5) ☐My pain is accompanied by other health problems such as: digestive problems, urinary problems, headaches or restless legs

6) ☐My pain has significant impact on my life, particularly on my sleep and my ability to concentrate. Making me feel slower generally. ___/6

DN4 Neuropathic Pain Questionnaire

INTERVIEW OF THE PATIENT

QUESTION 1:

Does the pain have one or more of the following characteristics?	**YES**	**NO**
Burning	❑	❑
Painful cold	❑	❑
Electric shocks	❑	❑

QUESTION 2:

Is the pain associated with one or more of the following symptoms in the same area?	**YES**	**NO**
Tingling	❑	❑
Pins and needles	❑	❑
Numbness	❑	❑
Itching	❑	❑

EXAMINATION OF THE PATIENT

QUESTION 3:

Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?	**YES**	**NO**
Hypoesthesia to touch	❑	❑
Hypoesthesia to pinprick	❑	❑

QUESTION 4:

In the painful area, can the pain be caused or increased by:	**YES**	**NO**
Brushing?	❑	❑

YES = 1 point

NO = 0 points

Patient's Score: /10

Patient Signature: _____ Date: _____