MPC
MICHIGAN PAIN CONSULTANTS, PC

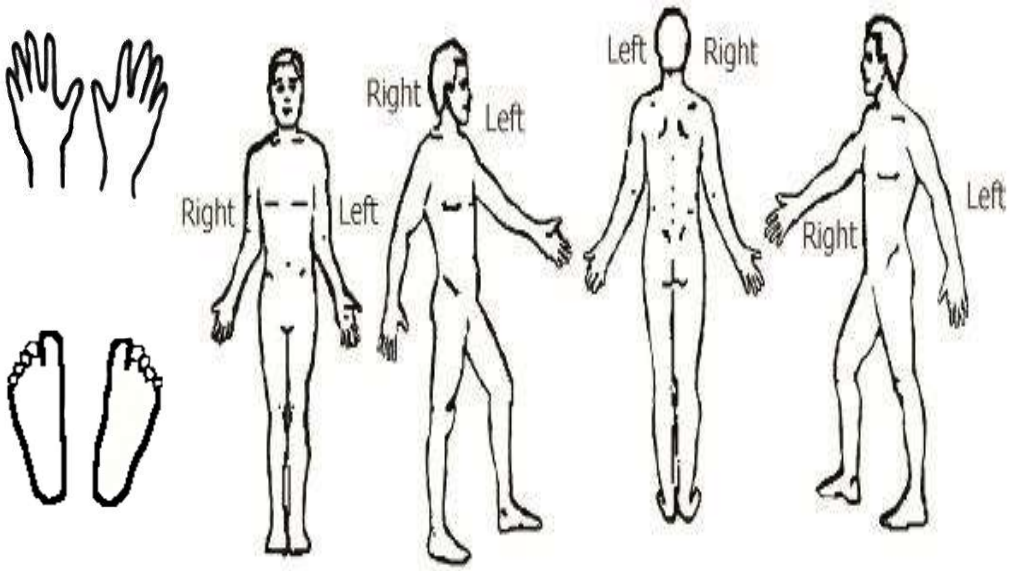
# Patient Intake Information

**Patient Data**

A. Name:_____ DOB: _____

Family Physician: _____ Spouse Name:_____

B. Mark your pain on the diagrams.




| Nurse Use Only |
|---|
| BP _____ P _____ |
| R ____ SPO2 _____ |
| Temp _____ |
| Ht: _____ |
| Wt: _____ |

**Pain Rating**

Scale used 0-10 (10=worst pain)

Worst Pain: _____

Best Pain: _____

**Description of Pain and Influencing Factors**

How long have you had this problem?

Please describe how your pain first began (e.g. accident, illness, etc.):

Please circle any of the following symptoms that you are experiencing.

Is your problem: constant, intermittent, frequent, occasional, infrequent

Is the pain: dull, aching, throbbing, cramping, sharp, burning, shooting, stabbing, tingling

Is your problem: mild, moderate, severe, excruciating

**What makes your pain worse?**

| | | | | |
|---|---|---|---|---|
| Heat | Sitting | Bending | Climbing Stairs | Weather |
| Cold | Standing | Twisting | Touch | Lifting |
| Physical Activity | Walking | Lying Down | Running | Moving Affected Limb |
| | | | | Sexual Activity |

**What are you doing to reduce your pain?**

| | | | |
|---|---|---|---|
| Rest | Heat | Massage | Using a walker or shopping cart |
| Sitting Down | Cold | Stretching | Walking |
| Lying Down | Changing Positions | Medications | Exercise/PT |

**Do you have:**

| | | | | | |
|---|---|---|---|---|---|
| Numbness or tingling? | O Yes | O No | Muscle weakness? | O Yes | O No |
| Swelling in the affected area? | O Yes | O No | Muscle spasms or cramps? | O Yes | O No |

**Does your pain affect your:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Sleep | O Yes | O No | Appetite | O Yes | O No | Eating | O Yes | O No |
| Physical activity | O Yes | O No | Emotions | O Yes | O No | Bathing | O Yes | O No |
| Relationships | O Yes | O No | Concentration | O Yes | O No | Using the toilet | O Yes | O No |
| Dressing | O Yes | O No | Getting out of bed or chair | O Yes | O No | | | |

Other, _____

**Previous Treatments:**

| Treatment | Yes/No | How Helpful Was This? |
|---|---|---|
| Nerve Blocks | | |
| Surgery | | |
| TENS Unit | | |
| Physical Therapy/OT | | |
| Chiropractic | | |
| Biofeedback/Hypnosis | | |
| Psychological Therapy | | |
| Other Pain Physician | | |

Patient's Goals for Treatment:

_____

_____

_____

_____

_____

**What pain medications have you previously used?** _____

_____

**Review of Symptoms:** Please check any that you currently have or had in the past.

***Constitutional***
_____ Recent fevers/sweats
_____ Unexplained weight loss/gain
_____ Unexplained fatigue/weakness

***Eyes***
_____ Change in vision

***Ears/Nose/Throat/Mouth***
_____ Difficulty hearing/ringing in ears
_____ Hay fever/allergies/congestion
_____ Trouble swallowing

***Musculoskeletal***
_____ Muscle/joint pain
_____ Recent back pain
_____ Weakness

***Cardiovascular***
_____ Chest pains/discomfort
_____ Palpitations/irregular heartbeat
_____ Short of breath

***Respiratory***
_____ Cough/wheeze
_____ Coughing up blood
_____ Asthma

***Gastrointestinal***
_____ Blood or change in bowel movement
_____ Nausea/vomiting/diarrhea

***Genitourinary***
_____ Painful/bloody urination
_____ Leaking urine
_____ Nighttime urination
_____ Discharge: penis or vagina
_____ Unusual vaginal bleeding
_____ Concern with sexual functions

***Endo***
_____ Cold/heat intolerance
_____ Increase thirst/appetite

***Skin***
_____ Rash
_____ Sores

***Neurological***
_____ Headaches
_____ Numbness
_____ Tremors
_____ Poor balance

***Psychiatric***
_____ Anxiety/stress
_____ Sleep problem
_____ Depression

***Blood/Lymphatic***
_____ Unexplained lumps
_____ Easy bruising/bleeding

**Medical History**

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

O Heart Attack/Heart Disease
O Irregular Heart Rate
O Chest Pain
O High Blood Pressure
O Stomach/Intestinal Problems
O Arthritis
O Substance Abuse/Addiction
O Bleeding/Bruise Easily
O Emphysema
O Asthma
O Thyroid Problems
O Diabetes O Type 1 O Type 2
O Depression/Psych
O Other, _____
O Cancer
O Stroke
O Kidney Problems
O Epilepsy/Seizures
O Cigarette Use
O Alcohol Use (per week)

**List any Surgeries you have had:**

| Type of Surgery | Date | Type of Surgery | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Recent Hospitalizations:**

(If you have been hospitalized in the past year, when was it and for what reason.) _____

_____

**Family History:**

(Please list any illnesses that are present in your family or the cause of their death.) _____

_____

_____

**List all Medication you are currently using and how often you use them. Please indicate below:**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

**Allergies:** _____

**List any TESTS you have had:**

| Tests | Date & Place Done | Results | Tests | Date & Place Done | Results |
|---|---|---|---|---|---|
| X-rays | | | X-rays | | |
| MRI | | | MRI | | |

**Social History:**

**Tobacco Use**
Cigarettes: O Never O Quit: date _____ Current smoker: packs/day _____ # of years _____

Other Tobacco: O Pipe O Cigar O Snuff O Chew
Are you interested in quitting? O No O Yes

**Alcohol Use**
Do you drink alcohol? O No O Yes, # of drinks/week _____
Is your alcohol use a concern for you or others? O No O Yes

**Drug Use**
Do you use any recreational drugs? O No O Yes
Have you ever used needles to inject drugs? O No O Yes

**Other Concerns:**

**Caffeine Intake:** O None O Coffee/tea/soda _____ cups/day
**Weight:** Are you satisfied with your weight? O No O Yes

**Diet:** How do you rate your diet? O Good O Fair O Poor
Do you eat or drink four servings of dairy or soy daily or take calcium supplements? O No O Yes

**Exercise:** Do you exercise regularly? O No O Yes
What kind of exercise? _____
How long (minutes)? _____
How often? _____
If you do not exercise, why? _____

**Marital Status/Support**
O Single O Married O Widowed O Separated O Divorced
Is there any person or organization that you rely on to help you cope with your pain?
_____

_____

**Occupational History:**
O Working full-time O Working part-time O On medical leave O Disabled O Unemployed
What is your current occupation?
_____
Where do you work and how long have you been there?
_____
What duties do you perform?
_____
When did you last work?
_____

**Litigation**
Is Workers' Comp, disability, legal suit or an insurance settlement pending? O No O Yes, if yes, describe the current status of the litigation or settlement:
_____
_____

**DEMOGRAPHICS**

**Spoken Language:**

❑ English ❑ Spanish ❑ Vietnamese ❑ Non-English Other_____
❑ Declined

**Ethnicity:**

Are you Hispanic/Latino?

❑ Yes
❑ No
❑ Declined

**Race:**

❑ American Indian / Alaskan Native
❑ Asian
❑ Black/African American
❑ White
❑ Native Hawaiian / Other Pacific Islander
❑ Multiracial
❑ Other_____
❑ Declined

Gender Identity Values

- Identifies as Male
- Identifies as 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

Sexual Orientation Values

- Lesbian, gay, or homosexual
- Straight or heterosexual
- Bisexual
- Don't know
- Choose not to disclose

Patient Signature: _____Date:_____

Nurse's Signature: _____Date:_____