Pain Assessment Intake Form

Please describe your pain: *

Where is your pain originating from in your body? Does your pain travel anywhere else? *

What do you think is causing your pain? *

How long have you been experiencing your pain? *: _____

Is the pain occasional? If so, how often? *

- ◯ Yes
- ◯ No

Is the pain continuous? *

- ◯ Yes
- ◯ No

Have you recently experienced a:

- ☐ Motor vehicle accident
- ☐ Worker's injury
- ☐ Sports injury
- ☐ Surgery
- ☐ Other trauma

What words best describe your pain? *

- ☐ Aching
- ☐ Burning
- ☐ Throbbing
- ☐ Electric shock
- ☐ Gnawing
- ☐ Hot
- ☐ Squeezing
- ☐ Tingling
- ☐ Cramping
- ☐ Shooting
- ☐ Pressure
- ☐ Numbing
- ☐ Deep aching
- ☐ Itching
- ☐ Stabbing
- ☐ Other

Do you have any other symptoms in addition to pain? *

- ◯ Yes
- ◯ No

If applicable, please select all other symptoms that you're experiencing:

- ☐ Sleep problems
- ☐ Itching
- ☐ Vomiting
- ☐ Loss of appetite
- ☐ Confusion
- ☐ Fear
- ☐ Other
- ☐ Nausea
- ☐ Irritability
- ☐ Weakness
- ☐ Constipation
- ☐ Difficulty urinating
- ☐ Anxiety

Does your pain disturb any of the following? *

- [ ] Sleep
- [ ] Concentration
- [ ] Eating
- [ ] Energy
- [ ] Self-care
- [ ] Mood
- [ ] Walking
- [ ] Relationships
- [ ] Housework
- [ ] Enjoyment of life
- [ ] Work
- [ ] Recreation

Do you have a history of depression? *

- ◯ Yes
- ◯ No

Does the pain make you feel depressed? *

- ◯ Yes
- ◯ No

What have you tried to treat the pain? *

- [ ] Medications
- [ ] Other treatment
- [ ] This is my first time treating the pain

Do you have any medical problems/conditions?

- [ ] Peptic ulcer disease
- [ ] High blood pressure
- [ ] Edema/swelling of legs
- [ ] Kidney disease
- [ ] Cancer
- [ ] Other

Do you have any allergies? *

- ◯ Yes
- ◯ No

If yes, write your allergy