Foothill Center for Pain Management

[1505 WILSON TERRACE SUITE 240, GLENDALE CALIFORNIA 91206]

Name:_____ Date:_____

PHYSICAL INTAKE FORMS

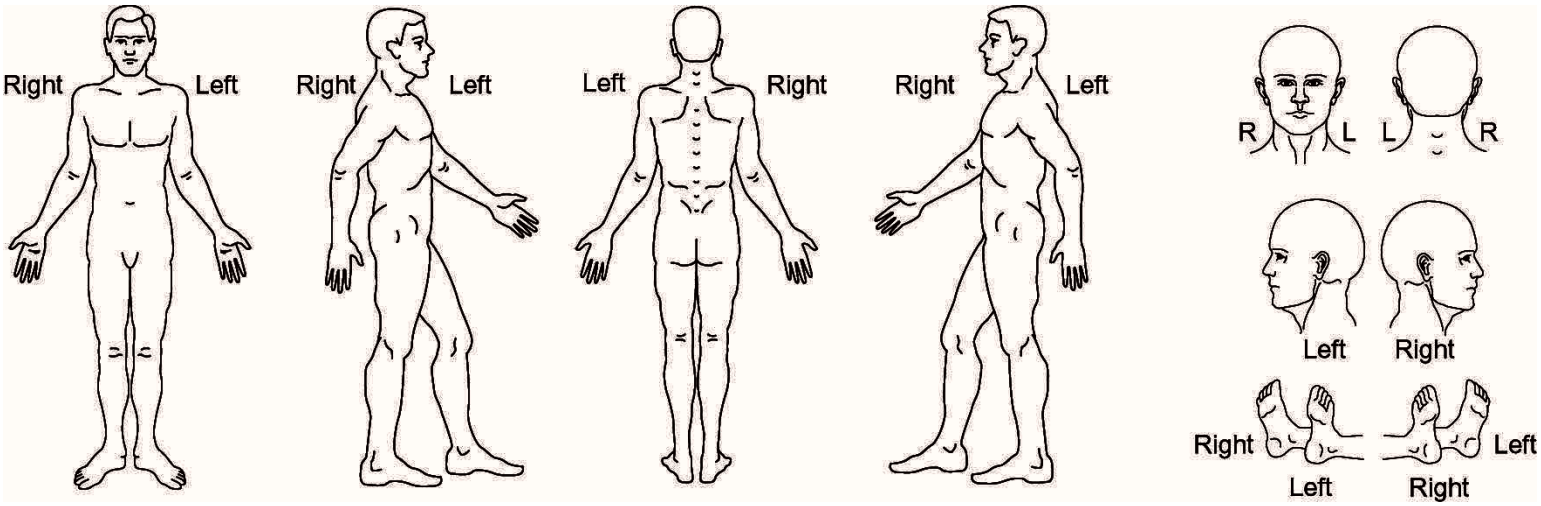
1. **List the body sites where you're experiencing pain.**

   Body site(s):_____

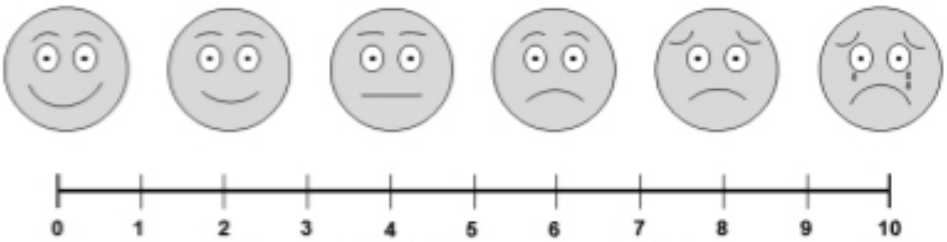
2. **Circle the words that best describe your pain:**

Aching	Sharp	Penetrating	Throbbing
Tender	Nagging	Shooting	Burning
Numb	Stabbing	Exhausting	Miserable
Unbearable	Gnawing	Tiring	Intermittent
Occasional	Frequent	Constant	Dull

3. **Locate and mark the areas of pain in the diagram below**



4. **Please rate your pain**



Your pain right now:_____

Worst pain this month:_____

Best pain this month:_____

5. Please answer the questions below.

Are you working? _____

Can you sleep through the night? _____

Are you able to enjoy time with your family/friends? _____

Are you depressed?_____

6. Please fill out your family history.

Relation	Medical Problems	Age of Death	Cause of Death
Father			
Mother			
Brothers #			
Sisters #			
Sons #			
Daughters #			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

7. Please fill out your social history

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Smoking:
- ☐ Never
- ☐ Now
- ☐ Past

How often do you use alcohol:
- ☐ None
- ☐ Rare
- ☐ Social
- ☐ Regular
- ☐ In past

Number of Children: _____

Caffeine: _____ drinks/day

Tobacco:
- ☐ Cigarettes _____/day
- ☐ Cigar
- ☐ Smokeless

Alcohol:
- ☐ None
- ☐ Current Alcoholic
- ☐ Past Alcoholism

Hobbies: _____

Exercise (Type and how often):_____

8. Please CHECK all that apply to your medical history

Cardiovascular
- ☐ Abnormal Heart Rhythm
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Heart Attack
- ☐ Peripheral Vascular Disease
- ☐ Heart Valve Disease

Pulmonary
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Sleep Apnea
- ☐ TB

Gastrointestinal
- ☐ Gall Stones
- ☐ Cirrhosis
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Ulcerative Colitis

Renal/Kidney
- ☐ Acute Renal Failure
- ☐ Benign Prostatic Hypertrophy
- ☐ Chronic Renal Failure
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Frequent Bladder Infections

Musculoskeletal/Connective Tissue
- ☐ Chronic Pain
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus Erythematosis

Endocrine
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Osteoporosis

OB/GYN
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Currently Pregnant

Neurological
- ☐ Alzheimer's Disease
- ☐ ADD/ADHD
- ☐ Cerebral Palsy
- ☐ Stroke
- ☐ Dementia
- ☐ Degenerative Disc Disease
- ☐ Headaches
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Sensory Neuropathy
- ☐ Seizures
- ☐ TIAS

Hematologic
- ☐ Iron Deficiency Anemia
- ☐ Sickle Cell Disease
- ☐ Thallasemia

Cancer
- ☐ Bone
- ☐ Brain
- ☐ Breast
- ☐ Colon
- ☐ Hepatic/Liver
- ☐ Leukemia
- ☐ Lung
- ☐ Lymphoma
- ☐ Melanoma
- ☐ Pancreatic
- ☐ Prostate
- ☐ Renal/Kidney
- ☐ Skin
- ☐ Testicular
- ☐ Thyroid

Other
- ☐ Cataract
- ☐ Glaucoma
- ☐ Over weight

Psychiatric
- ☐ Anxiety
- ☐ Anorexia Nervosa
- ☐ Bipolar Disorder
- ☐ Bulimia
- ☐ Depression
- ☐ Obsessive Compulsive
- ☐ Schizophrenia
- ☐ Panic Attack

9. Other medical problems or things we should know about your health.

_____

_____

_____

_____

10. Please CHECK Past Surgical History

Cardiac Surgery — **Date/ Details**
- ☐ Bypass (_____ vessels)
- ☐ Heart Valve Replacement
- ☐ PTCA (Angioplasty)
- ☐ Stent
- ☐ Pacemaker

Gastrointestinal
- ☐ Cholecystectomy (gallbladder)
- ☐ Gastric Bypass
- ☐ Appendectomy
- ☐ Hernia

Renal/Kidney
- ☐ Renal Surgery
- ☐ Prostate Resection
- ☐ Bladder Surgery

Endocrine
- ☐ Thyroidectomy

OB/GYN
- ☐ Hysterectomy
- ☐C-Section (number ___)

Other Surgeries — **Date/Details**
- ☐ Tonsillectomy
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Cataract
- ☐ Biopsy
- ☐ Fracture
- ☐ Major Trauma

Orthopedic
- ☐ Joint Replacement
- ☐ Arthroscopic
- ☐ Back Surgery
  Type:_____
  Level:_____
- ☐ Other

11. Please CHECK your Current Symptoms

General
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Weight Change

Eyes
- ☐ Blurred Vision
- ☐ Light Sensitivity

Ears/Nose/Throat
- ☐ Hearing Problems
- ☐ Nose Bleeds
- ☐ Bleeding Gums
- ☐ Dentures Present

Cardiovascular
- ☐ Chest Pain
- ☐ Leg Pain w/ walking
- ☐ Dizziness
- ☐ Shortness of Breath
- ☐ Palpitations
- ☐ Swollen Feet/Ankles
- ☐ Rapid Heart Rate
- ☐ Varicose Veins

Respiratory
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Chest Wall Pain
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Indigestion
- ☐ Poor Appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nauseas
- ☐ Vomiting

Genitourinary
- ☐ Impotence
- ☐ Nighttime urination
- ☐ Frequent Urination
- ☐ Change in urine stream

Musculoskeletal
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Joint Stiffness
- ☐ Arm or Leg Pain
- ☐ Muscle aches

Skin
- ☐ Dry Skin
- ☐ Jaundice
- ☐ Color Change
- ☐ Temperature Change

Neurological
- ☐ Difficulty walking
- ☐ Headaches
- ☐ Memory Loss
- ☐ Numbness
- ☐ Seizures
- ☐ Tremor
- ☐ Vertigo
- ☐ Weakness

Hematologic
- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Blood Transfusions

Endocrine
- ☐ Enlarging hands/feet
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Increased thirst
- ☐ Increased hunger
- ☐ Sweating excessive

Allergic/ Immunologic
- ☐ Allergies
- ☐ Hay fever
- ☐ Frequent colds
- ☐ HIV exposure
- ☐ Chemical Sensitivity

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Mood Swings
- ☐ Poor Concentration

☐ Trouble Sleeping
☐ Suicidal thoughts

12. Please list Medication Allergies

Medication :_____ **Reaction:**_____

Medication:_____ **Reaction:**_____

Medication:_____ **Reaction:**_____

Medication:_____ **Reaction:**_____

Medication:_____ **Reaction:**_____

13. Please list your Current Medication

Name	Dosage	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

If there are more medication (s) please attach a separate sheet with the additional information