Procedure Visit Intake Form

IMPORTANT: Please complete all sections of this form. Do not leave any unanswered items. If the question does not apply, you may put "N/A".

Personal Information

Full Name

First Name	Middle Name	Last Name

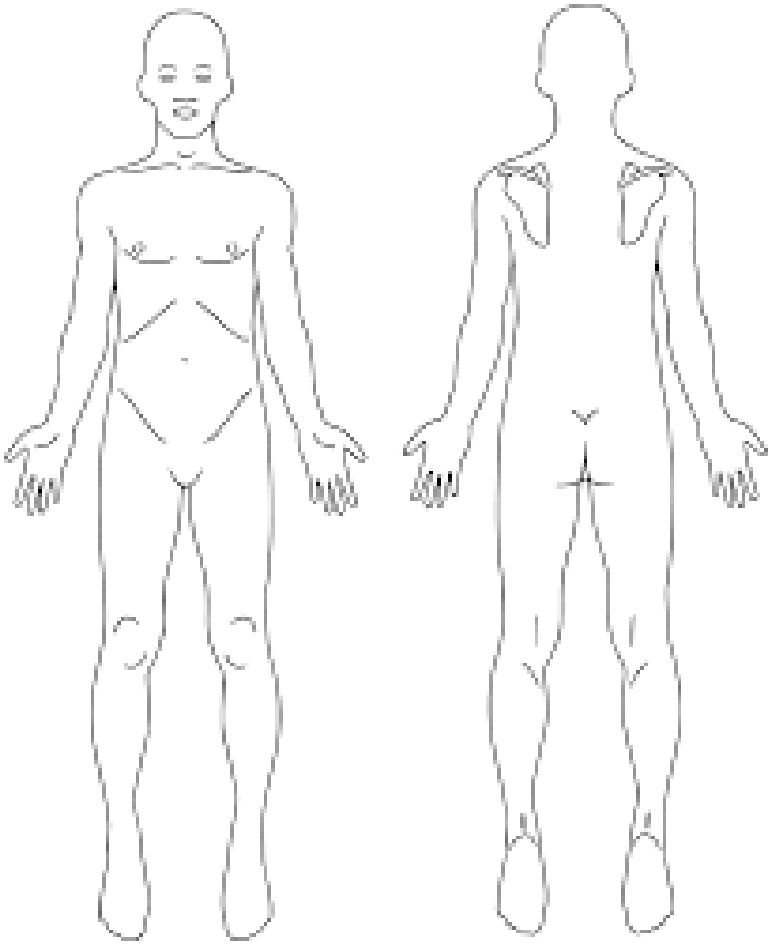
Date of Birth

Today's Date

Referring Provider
Contact Number

Location of your pain today

You may also help us visualize the location of your pain by shading the body part in the image provided below.



Pain radiates into:

- ☐ Right leg
- ☐ Right arm
- ☐ Left leg
- ☐ Left arm
- ☐ Pain does not radiate
- ☐ Other: _____

Quality of pain:

- ☐ Aching
- ☐ Cramping
- ☐ Numbness
- ☐ Hot/Burning
- ☐ Tingling/Pins and Needles
- ☐ Throbbing
- ☐ Shock-like
- ☐ Shooting
- ☐ Spasming
- ☐ Dull
- ☐ Tiring/Exhausting
- ☐ Stabbing/Sharp
- ☐ Squeezing
- ☐ No Pain
- ☐ Other: _____

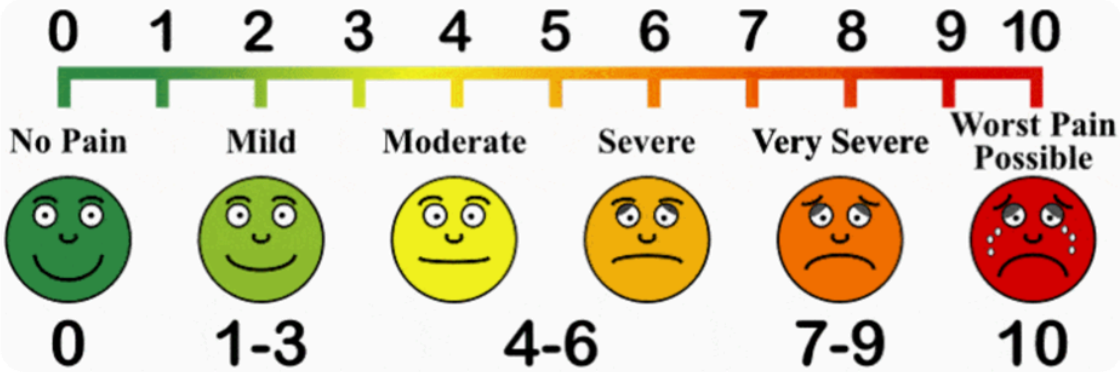
The following describes the pain frequency:

- ☐ Constant
- ☐ Intermittent (comes & goes)
- ☐ Changes in severity but always present
- ☐ No Pain

The pain is worse in:

- ☐ Mornings
- ☐ During the day
- ☐ Evenings
- ☐ Nights
- ☐ Middle of the night
- ☐ No Pain

On a scale of 0-10, **0 being no pain** and **10 being the worst pain** you can imagine.



Worst Pain (0 as no pain and 10 as the worst pain imaginable):

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

Pain Level Today (0 as no pain and 10 as worst pain imaginable):

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

Modalities currently used to treat the pain:

- ☐ Injections for pain
- ☐ Manipulation
- ☐ Home exercises
- ☐ Exercises in physical therapy
- ☐ Pain medications
- ☐ Muscle relaxant pills
- ☐ Aspirin/Anti-inflammatory pills
- ☐ Heat/Ice
- ☐ Cognitive-behavioral therapy
- ☐ Chiropractic care
- ☐ Acupuncture
- ☐ Aquatic therapy
- ☐ Dry Needling
- ☐ Massage therapy
- ☐ Nothing
- ☐ Other: _____

Factors that reduce the pain:

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Injections for Pain
- ☐ Manipulation
- ☐ Home exercises
- ☐ Exercises in physical therapy
- ☐ Pain pills
- ☐ Muscle relaxant pills
- ☐ Aspirin/Anti-inflammatory pills
- ☐ Heat / Ice
- ☐ Nothing
- ☐ Other: _____

Activities that make the pain worse:

- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Driving
- ☐ Standing
- ☐ Walking
- ☐ Bending forward
- ☐ Bending backward
- ☐ Coughing
- ☐ Sneezing
- ☐ Reaching
- ☐ Lifting
- ☐ Nothing
- ☐ Other: _____

Activities that pain continues to interfere with despite current treatment/s:

- ☐ Walking
- ☐ Standing
- ☐ Sitting
- ☐ Bathing
- ☐ Getting dressed
- ☐ Cleaning
- ☐ Cooking
- ☐ Lawn Care
- ☐ Laundry
- ☐ Sitting at Work
- ☐ Walking at Work
- ☐ Standing at Work
- ☐ School
- ☐ Home duties
- ☐ Child Care
- ☐ Dining outside
- ☐ Sports
- ☐ Nothing
- ☐ Other: _____

Have you visited the emergency room since your last visit?

- ☐ Yes
- ☐ No

Date and name of the facility:

Have you had MRI Scan for this pain?

- ☐ Yes
- ☐ No

Date and name of the facility where MRI was performed:

Have you had CT scan for this pain?

- ☐ Yes
- ☐ No

Date and name of the facility where CT scan was performed:

Have you had X-ray for this pain?

- ☐ Yes
- ☐ No

Date and name of the facility where X-ray was performed:

Have you had any operations or procedures since your last visit?

- ☐ Yes
- ☐ No

Please describe briefly:

Have you been diagnosed with any new medical problems since your last visit?

- ☐ Yes
- ☐ No

Please describe briefly: