

Patient Pain Index - Intake

Patient Name: _____ DOB: _____ Date: _____
E-mail: _____ Phone: _____

1. When or for how many weeks have you been experiencing your present problem? _____

2. Have you experienced similar pain in the past? No Yes If yes, when? _____

3. How did your pain begin? (Check all that apply)

- Suddenly Gradually Lifting Bending Accident
 No known cause Twisting Pulling After a fall Injury

4. Does the pain affect daily living (ADL)? (Check all that apply)

- Walking Standing/Sitting Household Activities Reduce Work Abilities Ability to Bend, Twist, Climb Stairs
 Sleeping Lifting/Carrying Personal Care(bathing/dressing) Range of motion limitations

5. Are your symptoms Worsening or Improving

6. On a numeric pain scale (0 = no pain, 10 = worst pain)

I rate my current pain: ___ / 10 I rate my pain at its best: ___ / 10 I rate my pain at its worst: ___ / 10

7. Pain Characteristics:

LOCATION

- Lumbar
 Gluteal (Buttocks)
 Radiating to Legs

TYPE

- Sharp
 Aching
 Burning
 Shooting
 Nerve Pain
 Numbness/Pins & Needles

FREQUENCY

- Constant
 Intermittent
 Activity-Related

8. Have you experienced any of the following? (Check all that apply)

- Excessive weight gain *(O99.210) obesity complication pregnancy* Fatigue *(O26.819)* New balance problems *(R26.81)*
 Loss of bladder control *(O26.89)* Difficulty walking *(R29.89)* Swelling (legs/arms) *(O12.00)*
 Center of gravity out of alignment *(M43.8X7) sagittal plane imbalance* Pain in the back, buttocks, hip or legs *(M54.40) lumbago with sciatica* Lower back pain *(M54.50)*
 Pain/ Burning/Stinging/Numbness/ Tingling/Weakness down the leg *(M54.10) radiculopathy* Large inward arch above buttocks and pendulous/distended abdomen *(M40.46) lordosis* Lower abdomen pain near hip and groin. Sharp stabbing or aching *(O26.899) round ligament pain*

9. Have you tried any of the below and if so for how many weeks? _____

- Over The Counter Medication Physical Therapy Acupuncture
 Ice/Heat application Stretches/Home Exercise Over The Counter Supports
 Chiropractic Treatment

10. Prior history of: (please upload any reports from any imaging such as Xray, CT and MRI)

- Back Pain Previous Back Surgery None
 Scoliosis Disc Pathology Herniation
 Fracture Spondylolisthesis Spinal Stenosis

Patient Signature: _____

RETURN COMPLETED INTAKE TO YOUR HEALTHCARE PROVIDER
HEALTHCARE PROVIDERS PLEASE FAX THIS FORM TO 813-354-4756 BE SURE TO KEEP A
COPY FOR YOUR RECORDS