Algoma Sports Medicine & Physical Injuries Clinic

# PAIN CLINIC
# PATIENT INTAKE FORM

## PAITNET INFORMATION

| | | |
|---|---|---|
| Name: | | Date of Birth: |
| Health Card# | Version Code: | Gender: ❑ Male ❑ Female |
| Address: | | Home Phone: |
| City: | Postal Code: | Cell Phone: |
| | | Work Phone: |

| |
|---|
| Who is your primary care provider (Physician/NP, etc.): |
| Insurance Provider: |

As a professional courtesy, we would like to keep your primary care provider up to date regarding your injury or treatment. Is it Ok to provide them with a consultation note and updates related to your injury?: ❑ YES ❑ NO

Who may we contact in case of an emergency? _____
Relationship: _____ Phone 1: _____ Phone 2: _____

Please list below all individuals with whom we may talk to about your health concerns:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

## MEDICAL HISTORY

| **Do you have any allergies?** (Medications, foods, environmental) | **Are you currently taking any medications** (prescription or over the counter, or supplements?) |
|---|---|
| | |

### Past and Present Medical History

| Condition | Past | Present | Condition | Past | Present |
|---|---|---|---|---|---|
| Weight Loss / Gain | ❑ | ❑ | Palpitations | ❑ | ❑ |
| Loss of Energy | ❑ | ❑ | High Cholesterol / Fat | ❑ | ❑ |
| Unusual Fatigue | ❑ | ❑ | Swollen Ankles | ❑ | ❑ |
| Headaches – Severe | ❑ | ❑ | Calf Pain (while walking) | ❑ | ❑ |
| Migraine | ❑ | ❑ | Varicose Veins / Phlebitis | ❑ | ❑ |
| Dizziness or Fainting | ❑ | ❑ | Loss of Appetite (Recent) | ❑ | ❑ |
| Decreased Hearing | ❑ | ❑ | Difficulty Swallowing | ❑ | ❑ |
| Ringing in Ears(s) | ❑ | ❑ | Indigestion or Heartburn | ❑ | ❑ |
| Failing Vision | ❑ | ❑ | Frequent Nose Bleeds | ❑ | ❑ |
| Blurred or Double Vision | ❑ | ❑ | Difficulty Sleeping | ❑ | ❑ |
| Eye Pain | ❑ | ❑ | Eczema | ❑ | ❑ |
| Frequent Ear Infections | ❑ | ❑ | Insomnia | ❑ | ❑ |
| Glaucoma | ❑ | ❑ | Peptic Ulcer | ❑ | ❑ |
| Cataracts | ❑ | ❑ | Abdominal Pains | ❑ | ❑ |
| Sinus Pain | ❑ | ❑ | Gall Bladder Troubles | ❑ | ❑ |
| Frequent Sore Throats | ❑ | ❑ | Jaundice / Hepatitis | ❑ | ❑ |
| Teeth/Gum Pain/Bleeding | ❑ | ❑ | Change in Bowel Habits | ❑ | ❑ |
| Hoarseness | ❑ | ❑ | Diarrhea | ❑ | ❑ |
| Chronic Cough | ❑ | ❑ | Constipation | ❑ | ❑ |
| Hay Fever | ❑ | ❑ | Bowel Polyps | ❑ | ❑ |
| Allergies | ❑ | ❑ | Crohn's or Colitis | ❑ | ❑ |
| Pneumonia / Pleurisy | ❑ | ❑ | Hernia | ❑ | ❑ |
| Bronchitis / Emphysema (COPD) | ❑ | ❑ | Hemorrhoids | ❑ | ❑ |
| Asthma / Wheezing | ❑ | ❑ | Frequent Urinary Tract Infections | ❑ | ❑ |
| Shortness of Breath | ❑ | ❑ | Anemia | ❑ | ❑ |
| Chest Pain or Tightness | ❑ | ❑ | Urinary – ❑Painful, ❑Bloody, ❑No Control | ❑ | ❑ |
| Heart Murmur | ❑ | ❑ | Decrease in force or flow of urine | ❑ | ❑ |
| Irregular Pulse | ❑ | ❑ | Kidney Stones | ❑ | ❑ |

MEDICAL HISTORY CONTINUED

| Condition | Past | Present |
|---|---|---|
| STD's / Genital Warts | ❑ | ❑ |
| Urethral Discharge | ❑ | ❑ |
| Circulatory Problems | ❑ | ❑ |
| Bruise Easily | ❑ | ❑ |
| Cancer (Type: _____) | ❑ | ❑ |
| Diabetes | ❑ | ❑ |
| Excessive Thrust | ❑ | ❑ |
| Thyroid Disease | ❑ | ❑ |
| Seizures / Convulsions | ❑ | ❑ |
| Stroke | ❑ | ❑ |
| Tremor/Hands Shaking | ❑ | ❑ |
| Muscle Weakness | ❑ | ❑ |
| Numbness / Tingling Sensations | ❑ | ❑ |
| Arthritis / Rheumatism | ❑ | ❑ |
| Back Pain – Frequent | ❑ | ❑ |
| Bone Fracture/Joint Injury | ❑ | ❑ |
| Gout | ❑ | ❑ |
| Osteoporosis | ❑ | ❑ |
| Foot Pain | ❑ | ❑ |
| Cold/Numb Feet | ❑ | ❑ |
| Rashes | ❑ | ❑ |
| Hives | ❑ | ❑ |
| Psoriasis | ❑ | ❑ |
| Drug Abuse | ❑ | ❑ |
| Depression | ❑ | ❑ |
| Nervousness | ❑ | ❑ |
| Memory Loss | ❑ | ❑ |
| Phobias | ❑ | ❑ |

| Condition | Past | Present |
|---|---|---|
| Moodiness | ❑ | ❑ |
| Stress – Excessive | ❑ | ❑ |
| Mental Illness | ❑ | ❑ |
| Chicken Pox | ❑ | ❑ |
| Polio | ❑ | ❑ |
| Mumps | ❑ | ❑ |
| Measles | ❑ | ❑ |
| Rheumatic Fever | ❑ | ❑ |
| Tuberculosis | ❑ | ❑ |
| Exposure to blood/bodily fluids | ❑ | ❑ |
| Blood Transfusions | ❑ | ❑ |
| Sexual Problems | ❑ | ❑ |
| **Women Only** | | |
| Last Menstrual Period (Date: _____) | | |
| Was the flow ❑Regular, ❑Irregular, ❑Pain/Cramps | | |
| Are you currently Pregnant: ❑Yes ❑No | | |
| Number of Pregnancies: _____ | | |
| Number of Abortions: _____ | | |
| Number of Miscarriages: _____ | | |
| Number of Live Births: _____ | | |
| Are you currently on Birth Control | ❑ | ❑ |
| Method: _____ | | |
| Date of last mammogram: _____ | | |
| History of Communicable Diseases? (I.e. HIV, Hep B, etc. Please specify: | ❑ | ❑ |

## Family Medical History

(please specify relationship)

| Condition | |
|---|---|
| Glaucoma | ❑ |
| Thyroid Problems | ❑ |
| Hay Fever | ❑ |
| Asthma | ❑ |
| Anaemia | ❑ |
| Bleeds Easily | ❑ |
| Osteoporosis | ❑ |
| Stroke | ❑ |
| Diabetes | ❑ |
| Heart Disease | ❑ |
| Depression | ❑ |
| High/Low Blood Pressure | ❑ |

| Condition | |
|---|---|
| High Cholesterol | ❑ |
| Alcoholism | ❑ |
| Genetic Disease | ❑ |
| Migraine | ❑ |
| Epilepsy | ❑ |
| Psoriasis | ❑ |
| Arthritis | ❑ |
| Mental Illness | ❑ |
| Eczema | ❑ |
| Cancer (Type) | ❑ |
| Atherosclerosis | ❑ |
| Other: | ❑ |

## Habits and Health Access

(please specify relationship)

Do you Smoke Cigarettes? _____/day # Years _____
Alcohol: Drinks/week: _____
Street Drugs: _____
Caffeine Drinks: _____
Sleep Pattern: ❑ satisfactory ❑ occasionally disturbed
❑ Mostly disturbed

Last Routine Physical (Date): _____
Last Blood Test (Date): _____
Last Urine Test (Date): _____
Last Eye Exam (Date): _____
Last Dental Exam (Date): _____
Last Pap (Women) (Date): _____
Last Prostate/Rectal(Date): _____
Last Electrocardiogram (Date): _____

## Hospitalizations and Surgeries

(Please indicate the year and reason – not including normal pregnancies)

**Hospitalizations**

| Year | Illness / Injury |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Surgeries**

| Year | Illness / Injury |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**INJURY INFORMATION**

Date of Injury: _____

Was this a workplace injury? ❑ YES ❑ NO

WISB Claim? ❑ YES ❑ NO
Claim# _____

Please describe your injury/illness: _____
_____

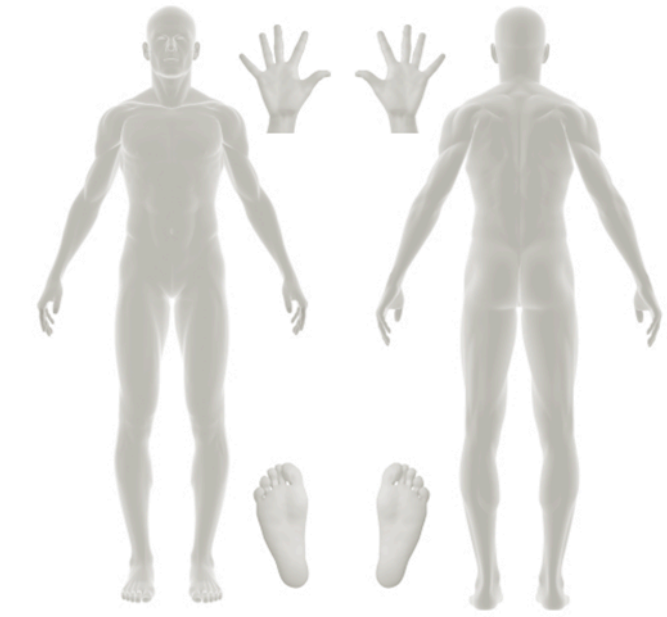
Please describe how it happened: _____
_____

Has the injury got ❑ Better or ❑ Worse since it occurred

On a Scale of 0-10, with 10 being the worst pain you have ever experienced, what would the pain on average be? _____
Currently be? _____

Would you describe the pain as: ❑ constant ❑ dull ❑ sharp ❑ throbbing ❑ tight ❑ burning ❑ tingling

Is there anything that makes it feel better? _____
Is there anything that makes it feel worse? _____
Have you received care from anyone yet for this injury? _____
Has it helped? _____



On the diagram, please mark with an "X" where the injury is, and where you are feeling the most pain. You may also mark on this diagram any pain that is radiating around by using the following:

S = Sharp/Stabbing Pain
B = Burning Pain
N = Numbness
P = Pins and Needles

Check the words that best describe the pain

| | | |
|---|---|---|
| ❑ Tingling | ❑ Cramping | ❑ Exausting |
| ❑ Radiating | ❑ Boring | ❑ Continuous |
| ❑ Sheeting | ❑ Heavy | ❑ Penetrating |
| ❑ Stabbing | ❑ Tender | ❑ Nagging |
| ❑ Burning | ❑ Splitting | ❑ Exerueiating |
| ❑ Deep | ❑ Piercing | ❑ Unbearable |
| ❑ Numb | ❑ Aching | ❑ Throbbing |
| ❑ Laneinating | ❑ Cutting | ❑ Gnawing |
| ❑ Teraing | ❑ Sharp | |

Are you doing anything to help with the pain?

- ❑ Warm Compress
- ❑ Cold Compress
- ❑ Relaxation Techniques
- ❑ Distraction
- ❑ Biofeedback
- ❑ Hypnosis

| MEDICATION HISTORY | |
|---|---|
| Are you currently taking any pain medications? | If so, how long does it take for the pain to return? |
| List (name, dose and frequency) | ❑ 1 hour<br>❑ 2 hours<br>❑ 3 hours<br>❑ 4 hours<br>❑ 5-12 hours<br>❑ More than 12 hours<br>❑ Do not take any pain medications |
| I prefer to take pain medications: | I take my pain medications (in a 24 hour period) |
| ❑ On a regular basis<br>❑ Only when necessary<br>❑ I do not take pain medications | ❑ Not every day<br>❑ 1-2 times a day<br>❑ 3- 4 times a day<br>❑ 5- 6 times a day<br>❑ 6+ times a day |
| Do you feel you need a stronger type of pain medication? | Do you feel that you need to take more of the pain medication then your provider prescribed? |
| ❑ YES ❑ NO<br>Why?<br>_____<br>_____ | ❑ YES ❑ NO ❑ Not Sure<br>Why?<br>_____<br>_____ |
| Are you concerned that you use too much pain medication? | Are you having any side effects caused by your pain medication |
| ❑ YES ❑ NO ❑ Not Sure<br>Why?<br>_____<br>_____ | ❑ YES ❑ NO ❑ Not Sure<br>Explain:<br>_____<br>_____ |
| Do you feel you need more information about your pain medication? | Is there anything you are taking/doing for pain that your provider has not provided you? |
| ❑ YES ❑ NO ❑ Not Sure<br>Is there something specific you are concerned about?<br>_____<br>_____ | |

PAIN INVENTORY

1. When does the pain usually begin? _____
2. How long does it usually last? _____
3. How often does it occur? _____
   Is there any side effects (depression, headaches, etc)? _____
4. Have you tried Chiropractic? _____ Was it helpful? _____
5. Have you tried Physiotherapy? _____ Was it helpful? _____
6. Have you had any x-rays, MRIs,etc yet? _____

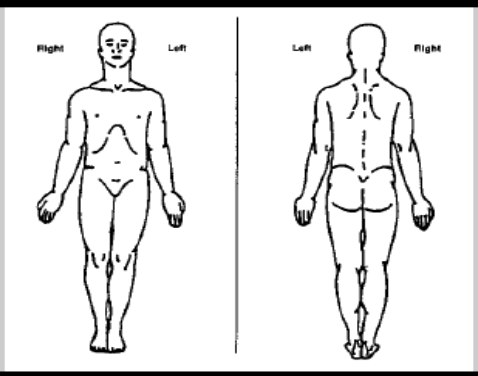
Is there anything else we should know about your injury/pain?

BRIEF PAIN INVENTORY

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.




3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as bad as you can imagine |

4. Please rate your pain by circling the one nuimber that best describes your pain at its least in the last 24 hours.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as bad as you can imagine |

5. Please rate your pain by circling the one number that best describes your pain on the average.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as bad as you can imagine |

6. Please rate your pain by circling the one number that tells how much pain you have right now.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as bad as you can imagine |

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

| 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
|---|---|---|---|---|---|---|---|---|---|---|
| No Relief | | | | | | | | | | Complete Relief |

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

**A. General Activity**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

**B. Mood**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

**C. Walking Ability**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

**D. Normal Work (includes both work outside the home and housework)**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

**E. Relations with other people**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

**F. Sleep**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

**G. Enjoyment of life**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

CONSENT FORM

In this document "I", "my", "me" and "you" refer to the patient
"Health Care Provider" refers to any clinician employed or student employed or under the fellowship of our clinicians with Algoma Sports Medicine and Physical Injuries Clinic

**Medical History and Consent to Assessment**

I certify that the information contained in this patient intake form is accurate, complete and true.

I hereby request and consent to the performance of the required physical examinations and tests be completed in order to diagnose my condition. I understand that the health care provider will attempt to explain the procedures, and will attempt to provide appropriate privacy measures throughout the evaluation of my injury or illness.

**Treatment Consent**

Algoma Sports Medicines health care providers are trained to assess and treat many different conditions related to sports injuries. Our health care providers are trained in various manual and sports medicine techniques through various organizations in North America, and Europe as part of their medical training. This necessitates hands on techniques when diagnosing and treating various areas of the body. The treatment hypothesis and supportive research entails utilizing whole body muscle balance approach. The health care provider providing care for you will attempt to explain to you each time what they are doing, and you should advise the practitioner if there is any component of the examination or treatment that you are not comfortable with (i.e. feeling a muscle, ribs, body positioning, etc.).

The use of manual therapy is a very safe and effective treatment for many sports injuries. There is a probable 1 to 3 in a million chance of catastrophic vascular problems (stroke) with cervical manipulation. The health care provider will inform you that they would like to perform cervical manipulation, and if you wish not to have this technique performed, please advise the health care provider.

Manual therapy also carries a small probability of causing a compression fracture in the spine in predisposed individuals with spinal cancers, severe osteoporosis, bony problems, bleeding disorders, or severe degenerative diseases. All of the above can utilize very gentle manual therapy. The most common side effects are pain for a couple of days if the treatment is not aggressive, strain/sprain syndromes can also occur in 1% of cases.

**Privacy Consent**

This office may share my health information with other agencies/persons in accordance with current legislation and office policy. I also understand that if desired, someone can be in the room with me while being assessed and treated. Please note that the door may be open at all times during the history, physical or treatment.

By signing below I understand that my consent may be withdrawn at any time, except for actions already taken, I release the health care provider providing any assessment or treatment, the facility, directors, officers, and successors from any liabilities, claims, and causes of action, known or unknown, contingent or fixed, that may result from the treatment and/or assessment. I agree not to file a lawsuit or other action to assert a claim.

Signature: _____ Date: _____

Witness: _____ Date: _____