Spa Bliss - New Patient Pain Intake Form

When did it start? ____

Was there a cause? ____

Characteristics: ____

Describe your problem: ____

How does it feel (pain or other symptoms) and how does it make you feel?

____

Does your problem occur at certain times? ______________________________

Intensity: ____

How bad is your problem?____

What impact does this problem have on your life?

What are you unable to do because of this problem, with respect to all aspects of your life: self-care, home, work, and leisure?

Using a scale, such as 0 to 10, 0 = at its best, 10 = at its worst how would you rank the problem

Please make a mark on the line below to indicate the level of discomfort you have today.

No Pain ____ **Worst Pain Ever**

0 1 2 3 4 5 6 7 8 9 10

Duration: ____

If certain activities cause you pain, how long does it last after you stop the activity?

____

Is it constant, or intermittent? ____

Aggravating factors: ____

What makes the problem worse? ____

What do you notice this problem to be associate with? ______________________

____

When do you typically feel the pain? ______________________________________

____

Do you have any associated symptoms?

None	Tingling	Numbness	Arm/Leg Weakness
Back/neck pain	Joint pain	Joint swelling	Muscle cramps/pain
Shortness of breath	Fatigue	Fever	

Alleviating factors:

What makes the problem better?____

What do you do for exercise? ____

Do you use a cane or walker? ____

What treatments have you had for this problem?

______ Massage ____ Chiropractic ___ Acupuncture ____ Physical Therapy

______ Behavioral Therapy ____ Injections _____ Surgery