Today's Date_____

Welcome to United Pain Center

We are so glad that you are here! Please complete this intake paperwork thoroughly and accurately, to help our medical team get to know you and provide the best possible care. If you have any questions, please ask our front desk staff, or call 951.303.3718. We look forward to working with you in addressing your chronic pain concerns. **ALSO, PLEASE BRING PHOTO ID, INSURANCE CARDS AND CD/DVD COPIES OF ANY RELEVANT IMAGING (I.E., RECENT MRI).**

PATIENT INFORMATION

Patient Name_____ DOB_____ Age_____ Sex_____

Street Address_____ State_____ Zip_____

Home Phone_____ Mobile _____ Work_____

Email Address_____ Social Security Number_____

Referring Physician_____ Primary Care Physician_____

Emergency Contact_____ Relationship to Patient_____ Phone_____

Marital Status_____ Employer_____ Occupation_____

Are you on disability? YES NO Last Worked_____ Are you presently involved in a lawsuit? YES NO

If yes, please list your attorney's name and contact number_____

INSURANCE INFORMATION

Primary Insurance Company_____ Policy Holder_____

Policy Number_____ Group Number_____ Relationship to Holder_____

Secondary Insurance Company_____ Policy Holder_____

Policy Number_____ Group Number_____ Relationship to Holder_____

RIVERSIDE COUNTY
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Instructions: Below is a list of problems that people may have in response to a very stressful experience. Please read each problem and circle the number that indicates how much you have been bothered by that problem.

PCL-5 In the **past month**, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings, such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4
PCL-5 (14 August 2013) www.ptsd.va.gov	Total Score				

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GAD-7 Over the **last two weeks**, how often were you bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Developed by Drs. Spitzer, Williams, Kroenke, et al, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, or distribute.	Total Score			

PHQ-9 Over the **last two weeks**, how often were you bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
Developed by Drs. Spitzer, Williams, Kroenke, et al, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, or distribute.	Total Score			

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?

☐ **Not Difficult at All** ☐ **Somewhat Difficult** ☐ **Very Difficult** ☐ **Extremely Difficult**

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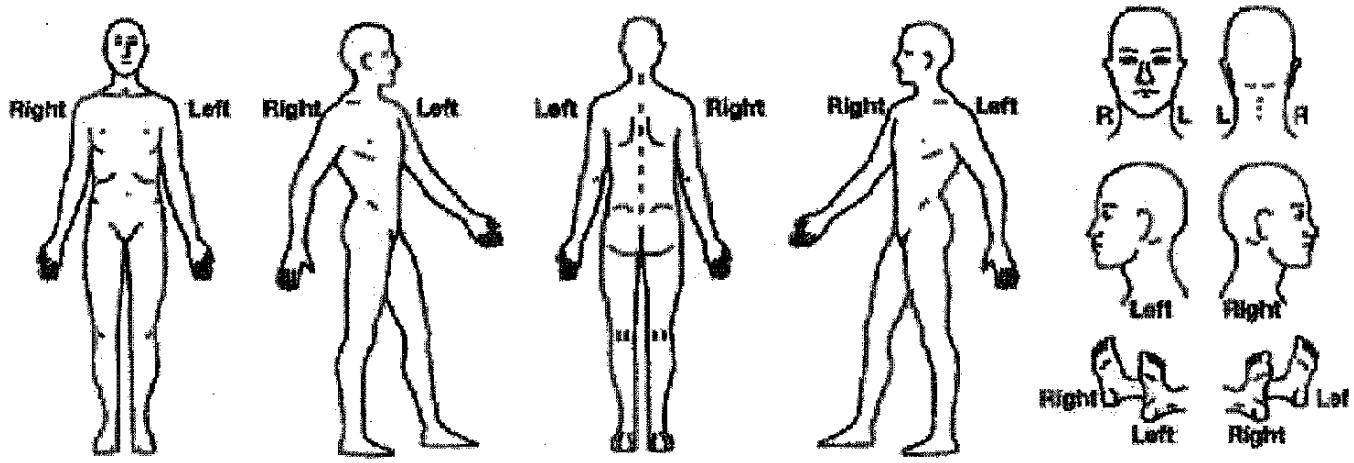
TSK 11 This is a list of phrases other patients have used to express how they view their condition. Please circle the number which describes how you feel about each statement.	**Strongly Disagree**	**Somewhat Disagree**	**Somewhat Agree**	**Strongly Agree**
1. I'm afraid I might injure myself if I exercise.	**1**	**2**	**3**	**4**
2. If I were to try to overcome it, my pain would increase.	**1**	**2**	**3**	**4**
3. My body is telling me I have something dangerously wrong.	**1**	**2**	**3**	**4**
4. People aren't taking my medical condition seriously enough.	**1**	**2**	**3**	**4**
5. My accident/problem has put my body at risk for the rest of my life.	**1**	**2**	**3**	**4**
6. Pain always means I have injured my body.	**1**	**2**	**3**	**4**
7. Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening.	**1**	**2**	**3**	**4**
8. I wouldn't have this much pain if there wasn't something potentially dangerous going on in my body.	**1**	**2**	**3**	**4**
9. Pain lets me know when to stop exercising so that I don't injure myself.	**1**	**2**	**3**	**4**
10. I can't do all the things normal people do because it's too easy for me to get injured.	**1**	**2**	**3**	**4**
11. No one should have to exercise when s/he is in pain.	**1**	**2**	**3**	**4**
Woby et al. (2005), Psychometric properties of the TSK-11: A shortened version of the Tampa Scale for Kinesiophobia. Used with permission.	Total Score			



What pain problem(s) brought you to United Pain Center?_____

Is your pain due to an injury (home, work, vehicle)? _____

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If not, what caused the pain (surgery, illness, no obvious cause)?_____

_____

What treatments have you tried?_____

_____

What words best describe your pain?_____

What makes the pain **better** or **worse**?_____

How has your life been affected?_____

_____

Do you have specific treatment goals?_____

_____

MEDICAL HISTORY

Medical History_____

_____

Surgical History_____

_____

Current Medications_____

_____

_____

Allergies_____

Exercise (type, frequency, duration)_____

Average Hours of Sleep/Night_____

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Current or Prior Substance Use			
Tobacco ☐	Alcohol ☐	Caffeine ☐	Barbiturates ☐
Marijuana ☐	Prescription Rx ☐	Cocaine ☐	Heroin ☐
Steroids ☐	Supplements ☐	Amphetamines ☐	Other ☐

Please elaborate on any of the above_____

_____

Your Family's Medical History	Yes	No		Yes	No		Yes	No
Diabetes			Arthritis			Depression		
High Blood Pressure			Headaches			Anxiety		
Cancer			Back Pain			Alcoholism		
Cancer			Fibromyalgia			Drug Abuse		

M = Mother
F = Father
MGF = Maternal Grandfather
PGM = Paternal Grandmother
Sib = Sibling (Brother/Sister)
C = Child(ren)