MountainStar
St. Mark's Hospital
Interventional Pain Center

PATIENT INTAKE FORM

Date________________________

Name____ DOB________________________

Phone Numbers (H)_____________________________ (C)___________________________ (W)___________________________

Referring Physician____

Primary Care Physician____

Please list any allergies you have to medications.

Medication	Reaction

Have you had reactions to latex, iodine, contrast dye, or shellfish?

If yes, please explain____

Please list all your current prescription and over-the-counter medications.

Medication	Dose/Route	Frequency

Please list all past surgeries.

Surgery	Date	Notes

MEDICAL HISTORY

Do you have, or have you had, any of the following?

Cardiovascular

- ☐ Anemia
- ☐ Heart Attack/MI (If yes, when? ________________)
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Heart Valve Disorder
- ☐ Peripheral Vascular Disease
- ☐ Stroke/TIA
- ☐ Blood Clots (If yes, when? ____________________)

Gastrointestinal

- ☐ GERD (Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Ulcers
- ☐ Constipation
- ☐ Pancreatitis

Urological

- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Dialysis
- ☐ Frequent UTI

Neurological

- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy

Psychological

- ☐ Depression
- ☐ Anxiety
- ☐ Claustrophobia
- ☐ Bipolar
- ☐ Schizophrenia

Head/Ears/Eyes/Nose/Throat

- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Thyroid Disorder
- ☐ Glaucoma

Respiratory

- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Chronic Joint Pains
- ☐ Back Pain
- ☐ Neck Pain

Other

- ☐ Cancer

  *What kind?*________________________________

  When? ________________________________

- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________
- ☐ ________________________________

SOCIAL HISTORY

Marital Status

(Check One) Single Never Married Married Separated Divorced Widowed Life Partner

Education

What Is Your Highest Level Of Education?

- ☐ Graduate/professional degree (What field? ________________________)
- ☐ Technical degree (What field? ___________________________)
- ☐ Some college
- ☐ High school diploma
- ☐ Other ___________________________________

Work History

(Check One) Full time Part time Unemployed Self employed Disabled Retired

Is your pain related to a work injury?

- ☐ No
- ☐ Yes

Have you stopped or modified your work because of your pain?

- ☐ No
- ☐ Yes

Do you drink alcohol?

- ☐ No
- ☐ Yes How much and how often____

Do you consume tobacco?

- ☐ No
- ☐ Yes (Check all that apply) Cigarettes Chewing Tobacco Pipe Cigars E-Cigs

Frequency ____

Do you have a prior or current history of prescription or street drug abuse?

- ☐ No
- ☐ Yes Please explain____

FAMILY HISTORY

Please list any significant health problems experienced by your immediate family members.

Parents____

____

Siblings____

____

Children____

____

PAIN HISTORY

When and how did the pain begin?

What other evaluations have you had for this problem (i.e. Neurologist, orthopedist, other pain clinics)?

Please list most recent diagnostic studies have you had done (i.e. Imaging, EMG)?

Study	Date	Facility

What therapies have you tried?

	Date	Helped	No change	Made it worse
Physical Therapy				
Chiropractic				
Massage				
Acupuncture				
Psychological				
Other				

Have you had injections for pain relief?

- ☐ No
- ☐ Yes If so, when and what type? ________________________________

Does your pain travel or radiate anywhere?

- ☐ No
- ☐ Yes If so, where?________________________________

Which statement best describes your pain?

- ☐ Always present, always the same
- ☐ Always present, intensity varies
- ☐ Usually present, but have short periods without pain
- ☐ Often present, but I am pain free most of the day
- ☐ Occasionally present, but occurring once to several times per day, lasting minutes to an hour
- ☐ Occasionally present for brief periods, seconds to minutes
- ☐ Rarely present, occurring every few days or weeks

What time of day is your pain worst?

- ☐ Morning on arising
- ☐ Later in the morning
- ☐ Afternoon
- ☐ Evening
- ☐ Bedtime
- ☐ Night (during usual sleeping hours)
- ☐ Pain is always the same
- ☐ Pain varies randomly

Do any of the following make your pain feel worse?

- ☐ Coughing, sneezing
- ☐ Sitting
- ☐ Standing
- ☐ Lying down
- ☐ Physical activity
- ☐ Weather (describe)________________________________
- ☐ Other (describe) ________________________________

Do any of the following make your pain feel better?

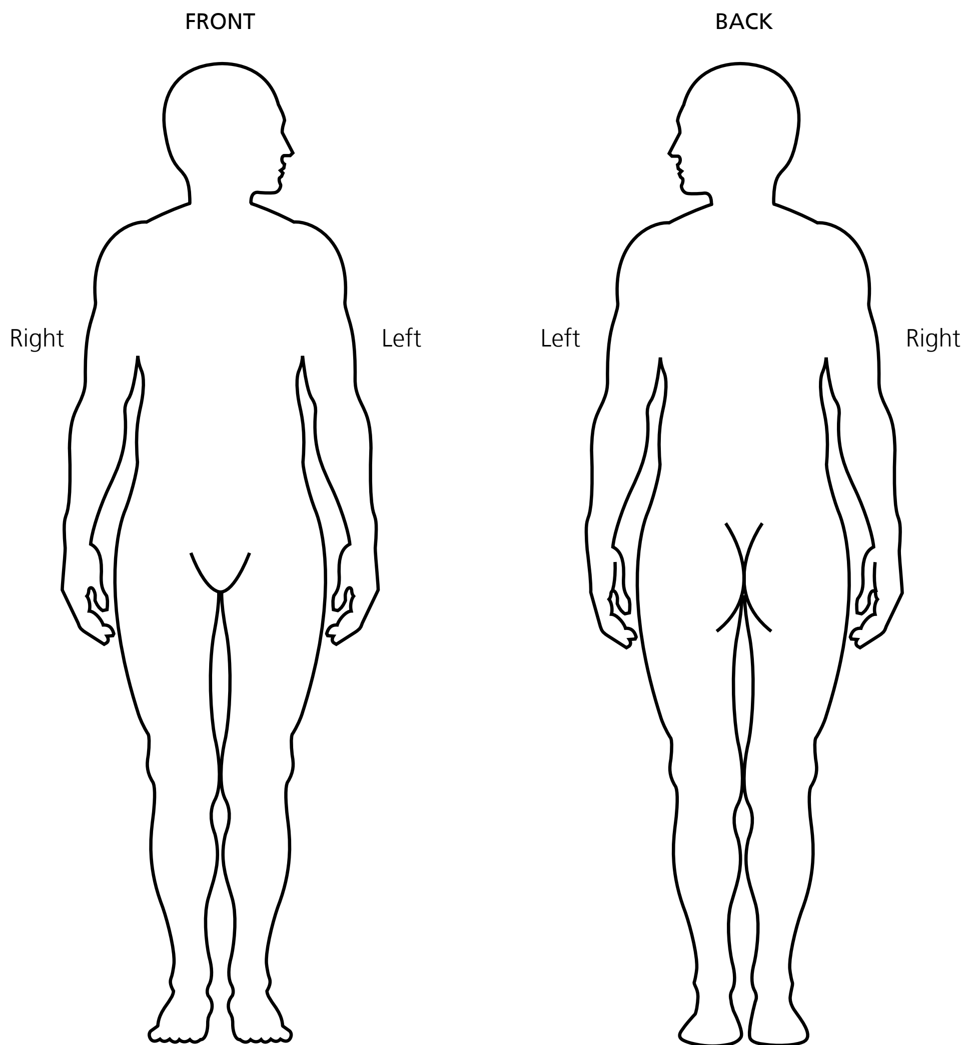
- ☐ Relaxation
- ☐ Sitting
- ☐ Standing
- ☐ Lying down
- ☐ Walking
- ☐ Medications
- ☐ Heat
- ☐ Alcoholic beverages
- ☐ Other (describe) ________________________________
- ☐ Nothing makes it feel better

Please circle the number of your pain on the scale below.

	No Pain		Low		Moderate		Intense		Unbearable	
NOW	1	2	3	4	5	6	7	8	9	10
LEAST in the past month	1	2	3	4	5	6	7	8	9	10
MOST in the past month	1	2	3	4	5	6	7	8	9	10

Please indicate the location and type of pain on the drawing below using the symbols listed.

000 Pins and needles
XX Burning
///// Stabbing
== Numbness
^^^ Aching



Please complete this form and turn it into the Intervention Pain Clinic

1. Email to painclinic contact@mountainstarhealth.com
2. Fax to 877-642-3374.
3. Deliver to 1250 E 3900 S Suite #30 | Salt Lake City, UT 84124