fraserhealth

# CHRONIC PAIN CLINIC – INTAKE

## Jim Pattison Outpatient Care and Surgery Centre

Patient Reviewed



**Please answer questions on page 1 and 2 to help our team know you better.**

Last name: _____ First name: _____

Date (dd/mm/yyyy): _____ Personal Health Number (BC Services Card): _____

Person completing this form: ☐ Self ☐ Essential care partner (specify): _____

I need an interpreter: ☐ Yes ☐ No If yes, language: _____

☐ I would like appointment reminders, health information and other communications sent to me by email

Email: _____

**What are your goals for this program?**

For example: be more active, improve sleep, take part in specific activities.

_____

_____

_____

**What do you believe is causing your pain?**

_____

_____

**How long have you had pain?**

☐ Less than 6 months ☐ 6 to 12 months ☐ 1 to 3 years ☐ More than 3 years

**Are there other specialists or services you see for your pain?** ☐ Yes ☐ No

If yes, please tell us when, where and what treatments you had.

_____

_____

**In the last 12 months** have you had any tests, x-rays, MRI or CT scans related to your pain? ☐ Yes ☐ No

If yes, please specify: _____

**Please answer the following questions about your pain.**

| | | | Clinician Use Only | |
|---|---|---|---|---|
| Do you feel anxious? | ☐ Yes | ☐ No | GAD 7 | ☐ Yes |
| Do you feel depressed? | ☐ Yes | ☐ No | PHQ 9 | ☐ Yes |
| Do you feel afraid that activity will make your pain worse? | ☐ Yes | ☐ No | TSK | ☐ Yes |
| Do you think about your pain **all** the time? | ☐ Yes | ☐ No | PCS | ☐ Yes |

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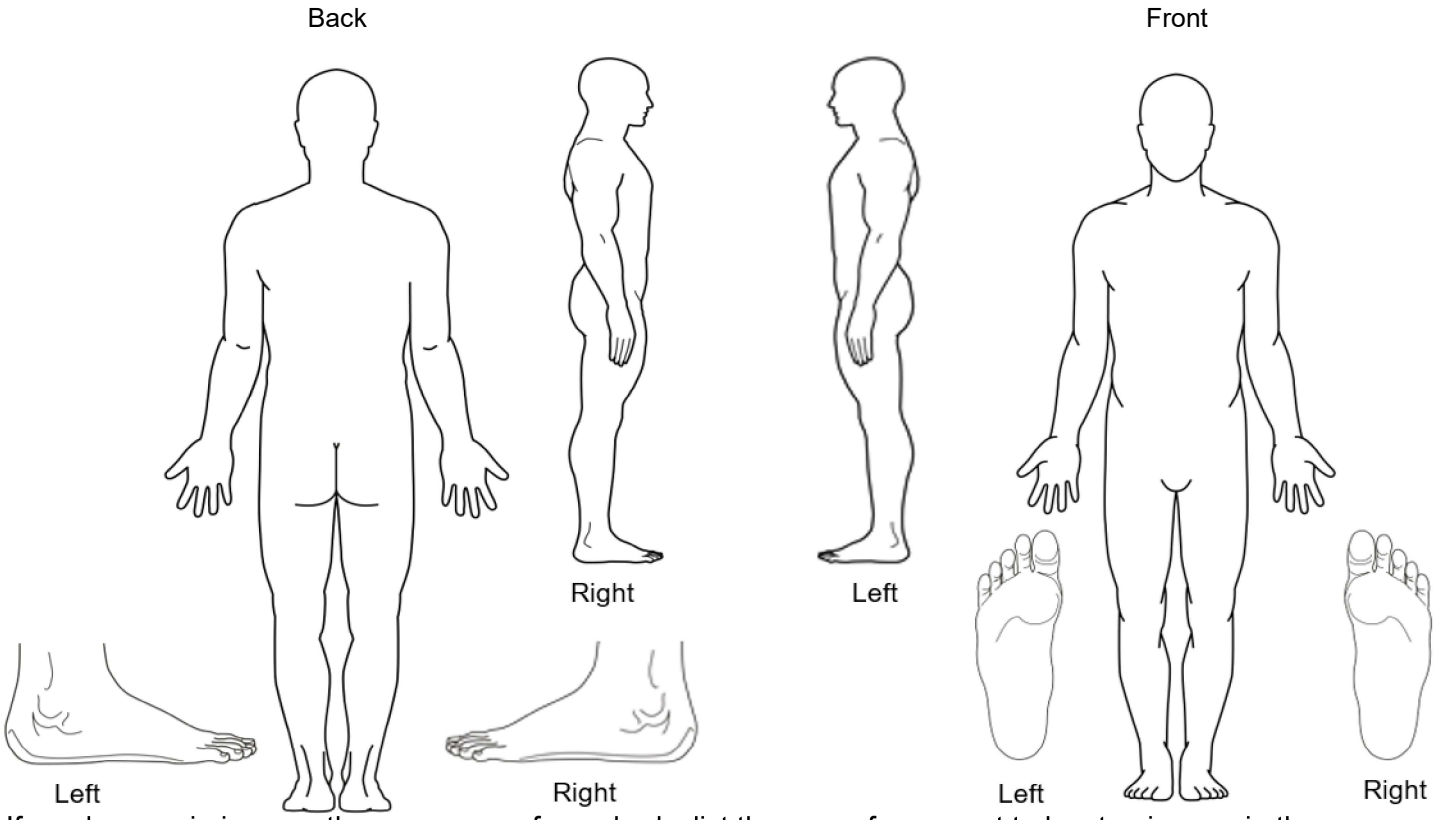
Mark with an **X** where you have pain.




If you have pain in more than one area of your body, list the areas from worst to least pain area in the spaces below.

1._____ 2. _____ 3. _____ 4. _____

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

No relief — Complete relief

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

| Select the number that describes how pain the past 24 hours has interfered with your: | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Has not affected** | | | | | | | | | | **Very affected** |
| | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| General activity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mood | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Walking Ability | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Normal Work (includes work outside the home and housework) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Relations with other people | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Enjoyment of life | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Total** **/ 70** | | | | | | | | | | | |