fraserhealth

JPOCSC Pain Intake Form
Draft 2024 January

PATIENT TO COMPLETE
PAGES 1 & 2

Name Label

RESET FORM

Date Form Completed: _____ Name: _____

CONFIDENTIALITY (Regarding your information)
All personal information concerning Fraser Health clients is confidential and only to be used by individuals who require access to it in order to provide direct service to the person to whom the information belongs to.

Do you consent to the Pain Program contacting you by email? ◯ Yes ◯ No
If so, please provide your email: _____
(You will receive educational information, appointment reminders, and other important communication)

Person providing the information on this form:
◯ Self ◯ Other (please state relationship) ☐ Interpreter (needed for appointments)
Relationship: _____ Language Spoken: _____

Do you have specific goals you would like to achieve as you start this program?
(Eg. Be more active, improve sleep, engage in specific activities, etec.)

_____

_____

What do you believe is causing or has caused your pain?

_____

_____

How long have you had pain?
◯ Less than 6 months ◯ 6 to 12 months ◯ 1 to 3 years ◯ more than 3 years

Have you previously attended a pain clinic or seen a pain specialist? ◯ Yes ◯ No
If yes, please provide details (who, when where and what treaments):

_____

_____

Are there other specialists or services you see for your pain condition? ◯ Yes ◯ No
If yes, please provide details (who, when where and what treaments):

_____

_____

Have you had any tests, X-rays, MRI or CT scans related to your pain in <u>the last 12 months</u>? ◯ Yes ◯ No
If yes, please specify:

_____

Please answer the following statements:	YES	NO
Do you feel anxious? If yes, please attach a filled out GAD7 form.	◯	◯
Do you feel depressed? If yes, please attach a filled out PHQ9 form.	◯	◯
Do you feel afraid that activity will make your pain worse? If yes, please attach a filled out TSK form.	◯	◯
Do you think about your pain ALL the time? If yes, please attach a filled out PCS form.	◯	◯

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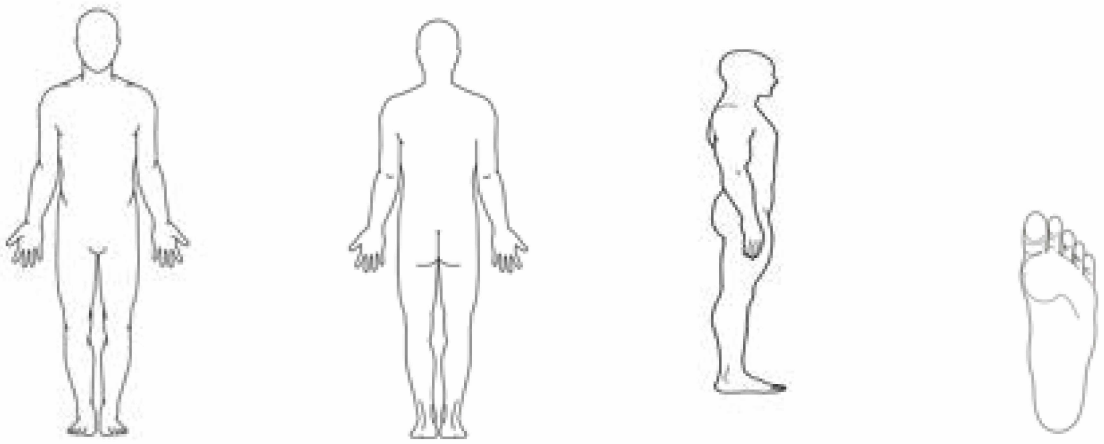
MARK WITH AN X WHERE YOU HAVE PAIN:



If you have pain in more than one area of your body list the areas from worst to least pain area			
1.	2.	3.	4.

In the last 24 hours, how much relief have your pain treatments or medications provided? Please circle 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 Interfered										Totally Interfered
	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: 0