ccnm
CANADIAN COLLEGE OF NATUROPATHIC MEDICINE

# Pain Management and Sports Medicine Adult Intake Form

**Name** _____ **Date** _____
**Date of birth** _____
**Sex** M F Ht: _____ Wt: _____ BIA: _____

**Address**

_____
_____
_____

**Phone**

_____ h
_____ w
_____ other

May we leave messages relating to your visits? Y N
Which phone number?
_____

**Emergency contact:**
Name _____ Phone _____

Referred by _____

**How did you hear about our Clinic? Please check one of the following:**

- ☐ **Media/TV Article**
- ☐ **Corporate Health/Wellness Event**
- ☐ **CCNM staff**
- ☐ **CCNM patient**
- ☐ **Friend/non-CCNM**
- ☐ **Family/non-CCNM**
- ☐ **CCNM Information Session**
- ☐ **Other** _____
- ☐ **TTC Advertising**
- ☐ **Newsletter Delivery to Residence**
- ☐ **Human Nature Radio Show**
- ☐ **CCNM Open House**
- ☐ **CCNM student**
- ☐ **RSNC Patient**
- ☐ **Satellite Clinic Patient**
- ☐ **CCNM website**

**Referred by** _____

**Referred to** _____

**Other health care providers:**

| 1. | 2. | 3. |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| (_____)_____ | (_____)_____ | (_____)_____ |

**What are your health concerns, in order of importance to you?**

1. _____

2. _____
3. _____
4. _____
5. _____

**If you are female, are you currently pregnant?** Yes No (Please circle one)

**Medical History**

**Please describe your general state of health briefly?**

| |
|---|
| |

**Please check the following conditions which apply to you. If a choice is given, please circle the appropriate one.**

| | |
|---|---|
| Alcoholism or substance abuse | Lung disease |
| Anemia or sickle cell | Mental trouble/depression/anxiety |
| Arthritis/joint disease | Pneumonia |
| Blood clots/phlebitis | Radiation or chemotherapy |
| Cancer (type) _____ | Rheumatic Fever |
| Diabetes | Seizures, Epilepsy |
| Digestive (type) _____ | Serious Injury or Accident _____ |
| Bleeding easily | Sexually Transmitted Disease _____ |
| Frequent Sinusitis | Skin Disease _____ |
| Gall Bladder Trouble | Stroke |
| Hay Fever, Allergy, Eczema | Thyroid Disease |
| Hearing Loss | Tuberculosis |
| Heart Attack. Heart Disease, Heart Failure | Urinary Difficulties (infection, etc.) |
| Heart Murmur | Vision Problems |
| Headaches | Other _____ |
| High Blood Pressure | Other _____ |
| High Cholesterol | Other _____ |

History of Infertility

Liver Disease, Hepatitis, etc.

Kidney Infection/Stones

**Please indicate any serious conditions, illnesses or injuries, and any hospitalizations, along with approximate dates**

_____

_____

_____

_____

**Do you have any allergies (medicines, environmental, etc.)?**

_____

_____

**Prescription Medications/Supplements** – please list on the table below all medications you are taking.

| **Name of medication or product, and strength** | **How often do you take this medication?** | **How much do you take for each dose?** | **When did you start taking this medication?** | **Why or for what medical condition are you taking this medication?** | **When did you stop taking this medication, and why?** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Please list past prescription medications.**

_____

_____

_____

_____

**How many times have you been treated with antibiotics?** _____

**Do you frequently use any of the following? (circle)**

Aspirin Laxatives Antacids Diet pills Birth control: pills/implants/injections

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often _____

**Please indicate what immunizations you have had**

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis A

☐ Tetanus booster; when? _____ ☐ Flu ☐ Hepatitis B

☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Smallpox

Other _____

Please indicate if any caused adverse reactions:

_____

**Do you get regular screening tests done by another doctor?** (Pap, blood tests, etc.)? Y / N

**<u>Women Only</u>**

**Reproductive History**

Age at 1st menstrual period _____ First day of most recent menstrual period _____

Usual Flow: Heavy _____ Moderate _____ Light _____ Length of period in days _____

Number of days between periods _____ Clots in menstrual flow ____ Colour of flow _____

Do you have (please circle): Painful periods, missed periods, spotting between periods, vaginal bleeding, unusual discharge/infection, recurring vaginal infections

If you have gone through menopause, have you had any post menopausal bleeding? _____

Date of last Pap _____ History of abnormal Pap? _____

Number of: Pregnancies _____ Live Births ____ Abortions _____ Miscarriages _____

Have you experienced complications during pregnancy/delivery/other problems?

**<u>Contraceptive History</u>**

What type of contraception are you taking? _____

Problems with the current method? _____

Sexual preference: heterosexual ____ homosexual ____ bisexual ____

**Men Only**

Do you have: Prostate problems ___ Testicular cancer ___ Vasectomy ___ Sexual dysfunction ___?

Sexual Preference: heterosexual ____ homosexual ____ bisexual ____

**Diet**

**Do you have any food allergies or intolerances? Please list.**

_____

_____

_____

**Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?**

_____

_____

**Describe a typical day's diet**

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

**Family History**

**Indicate if a close relative (parent, child, and sibling) has had any of the following:**

| | Who? | | Who? |
|---|---|---|---|
| Allergies | | Kidney disease | |
| Asthma | | Liver Disease | |
| Cardiovascular disease | | Lung Disease | |
| Cyst | | Other mental illness | |
| Cancer | | Seizures | |
| Diabetes | | Stroke | |
| Digestive | | Thyroid disease | |
| Depression | | Tuberculosis | |
| Drug abuse/alcoholism | | Ulcers | |
| Easy Bleeding | | Other | |
| High Blood Pressure | | Other | |
| Headaches | | Other | |

☐ I don't know my family medical history

**Environment**

Occupation _____

Hobbies _____

Living Environment _____

**Are you exposed to significant tobacco smoke (work, home, etc.)?** Y / N

**Are you frequently exposed to animals (work, pets, etc.)?** Y / N

**How is your home heated?** _____

**Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.**

_____

_____

_____

_____

**How would you describe the emotional climate of your home?**

_____

_____

**How stressful is your work, or other aspects of your life? How well do you handle these stresses?**

_____

_____

_____

_____

**Is there anything that you feel is important that has not been covered?**

_____

_____

_____

_____

**Do you exercise regularly? Y / N what do you do for exercise, how much, how often?**

_____

_____

_____

_____

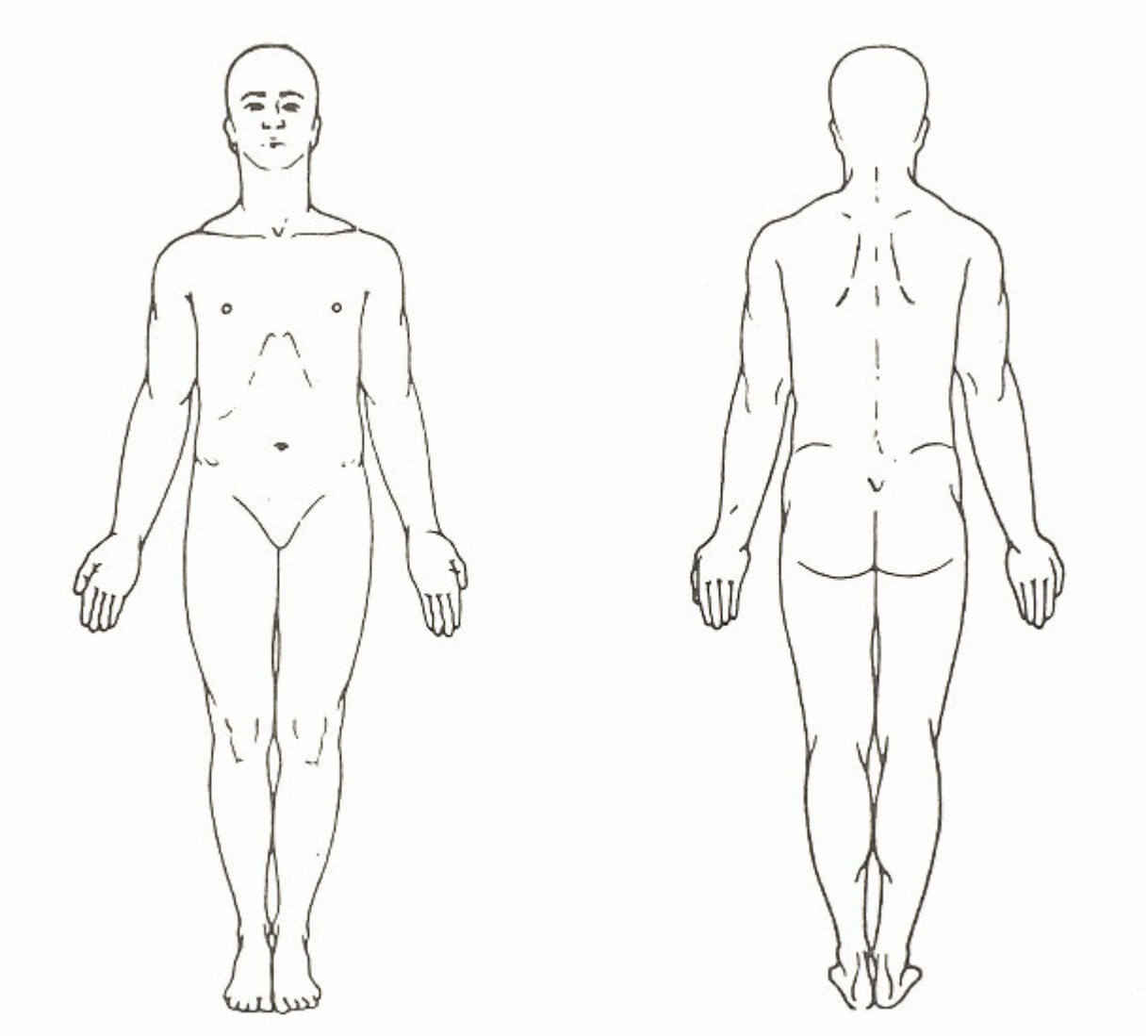
_____

_____

**Pain Questionnaire - Part One**

**Where Is Your Pain?**

Please mark, on the drawings below, the areas where you feel pain. Put **E** if external, or **I** if internal, near the areas, which you mark. Put **EI** if both external and internal.



## Part Two - What Does Your Pain Feel Like?

Some of the words below describe you *present* pain. Circle **ONLY** those words that best describe it. Leave out any category that is not suitable. Use only a single word in each appropriate category – the one that applies best.

| | | | |
|---|---|---|---|
| 1<br>Throbbing | 2<br>Shooting | 3<br>Stabbing | 4<br>Sharp |
| 5<br>Gnawing | 6<br>Tugging | 7<br>Burning | 8<br>Tingling |
| 9<br>Dull | 10<br>Tender | 11<br>Itchy | 12<br>Aching |
| 13<br>Radiating | 14<br>Numb | 15<br>Cold | 16<br>Unbearable |

## Part Three – How Does Your Pain Change With Time?

1. Which word or words would you use to describe the **pattern** of your pain?

| 1 | 2 | 3 |
|---|---|---|
| Continuous | Intermittent | Brief |

2. What kinds of thing(s) relieve your pain?

3. What kinds of thing(s) increase your pain?

4. Please rate how your injury has affected your day to day function by placing a check mark in the appropriate spaces.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Pain | Severe | ☐ | In Bed Severe | ☐ | Non-Active | ☐ | None At All | ☐ |
| Physical mobility | Severe | ☐ | In Bed Severe | ☐ | Non-Active | ☐ | None At All | ☐ |
| Stiffness | Severe | ☐ | In Bed Severe | ☐ | Non-Active | ☐ | None At All | ☐ |
| Social Interaction | Severe | ☐ | In Bed Severe | ☐ | Non-Active | ☐ | None At All | ☐ |
| Concentration | Severe | ☐ | In Bed Severe | ☐ | Non-Active | ☐ | None At All | ☐ |

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