FUNCTIONAL
PAIN MANAGEMENT

Functional Pain Management Intake Form

Have you been referred for or are you interested in Functional Pain Management	Yes	No	————————
How does your spouse/partner respond when you are very active (for example, exercising)?	Encouragingly	Frustrated	Neutral
Does your spouse/partner understand how your pain affects you?	Yes	No	Not sure
Have you had pain longer than 6 months?	Yes	No	------------------
Over the last several months, have you been continually worried or anxious about a number of events or activities in your daily life?	Yes	No	------------------
On average do you sleep less than 6 hours?	Yes	No	Sometimes
How would you rate your quality of sleep?	Poor	Fair	Good
Do you ever snore while sleeping?	Yes	No	Unsure
Do you regularly have at least 3 locations of pain?	Yes	No	------------------
Do you regularly (most days) eat fruits and vegetables?	Yes	No	------------------
Do you regularly (multiple days/week) eat fast food?	Yes	No	------------------
Do you smoke cigarettes, cigars, or e-cigarettes?	Yes	No	------------------
Do you normally drink more than 1 alcoholic beverage per day?	Yes	No	------------------
Do you normally drink greater than 2 caffeinated beverages/day?	Yes	No	------------------
In the past 6 months have you used any illicit drugs?	Yes	No	------------------
Have you experienced any traumas that you re-experience (nightmares, flashbacks, etc.)?	Yes	No	------------------

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Do you have pain that is a result of a motor vehicle accident or occupational injury?	Yes ♡	No	Unsure
During the past month, have you often been bothered by feeling down, depressed or hopeless?	Yes ♢	No	------------------
During the past month, have you often been bothered by little interest or pleasure in doing things?	Yes ♢	No	------------------
What is your favorite song?			

Please circle if you've ever been diagnosed with or believe you may have any of the following. ☆

Restless Leg Syndrome

Chronic Fatigue Syndrome

Fibromyalgia

Temporomandibular Joint Disorder

Migraine or tension headaches

Irritable Bowel Syndrome

Multiple Chemical Sensitivities

Neck injury (including whiplash)

Anxiety or panic attacks

Depression

For office use only
⬚ Spouse Response Inventory   Brief Resilience Survey   △ Generalized Anxiety Disorder -7
▸ Pittsburgh Sleep Quality Index   ■ Test Mallampati score   ☆ Central Sensitization Inventory
A
◯ Remind provider to discuss nutrition   ♢ Center for Epidemiologic Studies Depression Scale (both must be answered yes to give CES-D)   ♡ Injustice Experience Questionnaire