SXM SYMPTOM MEDICINE
Pain Medicine, Palliative Care, Anesthesia

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tel: 888.796.6331 fax: 888.796.6330

PATIENT ASSESSMENT INTAKE NOTES

Welcome to Symptom Medicine. You have been referred to SXM by your physician for a medical evaluation. We are a full spectrum pain and symptom management clinic, specializing in anesthesia, pain medicine, palliative care, symptom management and hospice. . Please review important information regarding your privacy rights, self determination and patient rights. More information is available in the clinic on request. For additional information about SXM, email us www.symtommedicine.com or visit info@symtommedicine.com

Return the completed form in its entirety, and return it via fax or mail. Enter N/A if a question does not apply to your current medical condition or complaint.

PATIENT DEMOGRAPHICS

Name:	AKA	Patient Representative
DOB Age	Male/Female	Marital Status
Address	Tel.	Mobile
Living Arrangements	Primary Language	Interrupter
Referring Physician	Tel.	Fax
PCP	Tel.	Fax
Pharmacy	Tel.	Fax
Patient Representatives	Relationship	Tel.
Emergency Contact	Relationship	Tel.

WORK HISTORY

Current or Former Employer	Address	Phone
Occupation	Title	Hours Work Per Week
Type of Modified Work	Off Work Due to Illness	Off Work Due to Injury
How Long Off Work?	Retired	Disabled
Workman's Compensation Carrier	Date of Injury	Body Part Injured
Prior Workman's Compensation Claim	Date of Injury	Body Part Injured

SERVICES REQUESTED

Services Requested	Patient Self Determination			Circle Your Complaints
New Pain Problem	DNR/DNI	Yes	No	Anxiety Agitation Confusion Depression
Cancer Pain &Symptoms	POLST FORM	Yes	No	Pain Edema Dementia Breathlessness
Chronic Pain Management	Advanced Directives	Yes	No	Reduced Mobility Psychological support
Hospice Patient	DPOA	Yes	No	Shortness Of Breath Poor Appetite Ascites
Medication and Prescriptions	Health Care Proxy	Yes	No	Pressure Sores Weakness Constipation
Pain Procedure/Injection	Patient Representative	Y Es	N	Disability Coping Counseling Vomiting
Symptom Management				Support Nausea Diarrhea Muscle pain
Other				Anorexia Insomnia Cough Nerve pain

PATIENT ASSESSMENT INTAKE NOTES

HISTORY OF PAIN and SYMPTOMS

When did your symptoms start (date)?

When did your pain begin (date)?

Where is location of your pain?

Are you in a lawsuit for your pain or symptoms?

What is the cause of your pain or symptoms?

☐ Sport Injury ☐ Fall ☐ Work Injury ☐ Car Accident ☐ Chemotherapy ☐ Radiation ☐ Unknown Cause

☐ Illness _____ ☐ Surgery _____ ☐ Treatment _____ ☐Other_____

How did your pain and/or symptoms first start?

☐ Suddenly ☐ Gradually ☐ Slow and Gradual ☐Ever Increasing ☐ Comes and Goes

Describe the timing of your pain and symptoms:

☐ Constant ☐ Intermittent ☐ Unpredictable ☐ Predictable Describe:

Mark all that describe your pain and symptoms

☐ Pricking ☐ Aching ☐ Burning ☐ Throbbing ☐ Sharp Stabbing ☐ Numbness Tingling ☐ Pins Needles

☐ Dull ☐ Cramping ☐ Aching ☐ Other

Has your pain and symptom interrupted with any of the following?

☐ Sleep ☐ Driving ☐ Shopping ☐ Family ☐ Social ☐ Working ☐ Recreational Activities ☐ Appetite

☐ Sexual Activity ☐ Exercise ☐ Physical Activity ☐ Household Activities ☐ Relationships

QUALITY OF LIFE

Rank the Severity	None			Poor		Moderate			Good		Excellent
Fatigue Low Energy	0	1	2	3	4	5	6	7	8	9	10
Concentration	0	1	2	3	4	5	6	7	8	9	10
Sleep Disturbances	0	1	2	3	4	5	6	7	8	9	10
Agitation	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10
Appetite	0	1	2	3	4	5	6	7	8	9	10
Anger Hostility	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10
Coping ability	0	1	2	3	4	5	6	7	8	9	10
Relationships	0	1	2	3	4	5	6	7	8	9	10
Support	0	1	2	3	4	5	6	7	8	9	10
Exercise & Activity	0	1	2	3	4	5	6	7	8	9	10
Control	0	1	2	3	4	5	6	7	8	9	10
Dignity	0	1	2	3	4	5	6	7	8	9	10
Independence	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

Name_____ Initials _____

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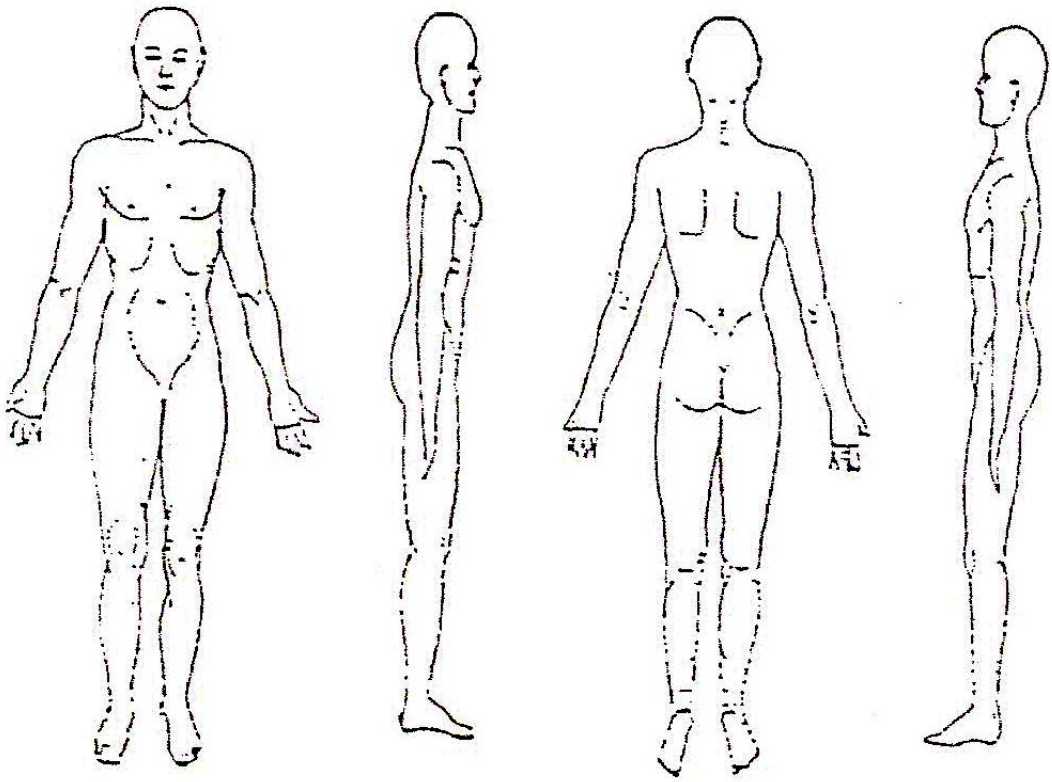
PATIENT ASSESSMENT INTAKE NOTES

PAIN and SYMPTOM DIAGRAM

Mark the body diagram with the following:

1. Location -- **X**= exact spot where pain or symptoms started **#**= where pain radiates to
2. Severity-- **W** = severe **Z** = moderate
3. Character or Type- **N**= nerve, i.e. numbness & tingling **M** = muscle, i.e. cramping, spasms **B** = burning **I** =itching **R** =rash **S** = sores **E** = swelling
4. Feels inside, deep or internal **– I** = inside
5. Feels outside, superficial or external **– O** = outside



PAIN SCALE

Rank Your Pain	No Pain					Moderate					Severe Pain
Average for Past Week	0	1	2	3	4	5	6	7	8	9	10
Average Since Started	0	1	2	3	4	5	6	7	8	9	10
Level When 1st Started	0	1	2	3	4	5	6	7	8	9	10
Level with Rest	0	1	2	3	4	5	6	7	8	9	10
Level With Medications	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

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CURRENT SYMPTOMS SCALE

Rank the Severity	None					Moderate					Severe
Shortness Of Breath	0	1	2	3	4	5	6	7	8	9	10
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Agitation	0	1	2	3	4	5	6	7	8	9	10
Fatigue Low Energy	0	1	2	3	4	5	6	7	8	9	10
Diarrhea	0	1	2	3	4	5	6	7	8	9	10
Nausea Vomiting	0	1	2	3	4	5	6	7	8	9	10
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Medication side effects	0	1	2	3	4	5	6	7	8	9	10
Treatment Side Effects	0	1	2	3	4	5	6	7	8	9	10
Skin problems (rash, sores)	0	1	2	3	4	5	6	7	8	9	10
Difficulty Swallowing	0	1	2	3	4	5	6	7	8	9	10
Constipation	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

MAKES PAIN and SYMPTOMS BETTER

What Makes It Better?	No Change (No help)					Moderate Improvement					No Pain (Best)
Lying	0	1	2	3	4	5	6	7	8	9	10
Sitting	0	1	2	3	4	5	6	7	8	9	10
Stretching/ Massage	0	1	2	3	4	5	6	7	8	9	10
Heat	0	1	2	3	4	5	6	7	8	9	10
Ice	0	1	2	3	4	5	6	7	8	9	10
Medication	0	1	2	3	4	5	6	7	8	9	10
Treatment	0	1	2	3	4	5	6	7	8	9	10
Activity or Exercise	0	1	2	3	4	5	6	7	8	9	10
Alcohol	0	1	2	3	4	5	6	7	8	9	10
Distraction	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

MAKE S PAIN and SYMPTOMS WORSE

What Makes It Worse?	No Symptoms or Pain					Moderate					Severe Symptoms or pain
Walking	0	1	2	3	4	5	6	7	8	9	10
Lifting	0	1	2	3	4	5	6	7	8	9	10
Sitting or Driving	0	1	2	3	4	5	6	7	8	9	10
Bending or Twisting	0	1	2	3	4	5	6	7	8	9	10
Activity or Exercise	0	1	2	3	4	5	6	7	8	9	10
Temperature Changes	0	1	2	3	4	5	6	7	8	9	10
Treatment	0	1	2	3	4	5	6	7	8	9	10
Medications	0	1	2	3	4	5	6	7	8	9	10
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Weather	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

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MEDICAL PROBLEMS

Current Medical Problems	Date Started	Current Medical Problems	Date Started
1.		6	
2		7	
3		8	
4		9	
5		10	D

PRIOR SURGERIES

Prior Surgeries	Date	Prior Surgeries	Date
1		5	
2		6	
3		7	
4		8	D

PRIOR TREATMENTS

List Past Pain Treatment (S)	Date Done	Describe	Helpful? Yes or NO
Surgery			
Nerve Block			
Epidural Steroid Injection			
Physical Therapy			
Occupational Therapy			
Biofeedback/Relaxation			
Psychological Support			
Acupuncture			
Pool Therapy			
Muscle Injections/ Trigger Point			

Hardware & Devices

Assistant Device	Date Started		Body Implants and Hardware	Date Placed
Wheelchair			Heart Pace Maker	
Cane			Interthecal Pump	
Walker			Spinal Cord Stimulator	
Crutches			Prosthesis (Joint Replacement, Rods)	
			Heart Stents	

DIAGNOSTIC TESTS

	Where Completed	Date Done	Body Part	Reason Test Done
X-Rays				
CAT Scan				
MRI				
EMG/Nerve Conduction Study				
Myelogram				
Bone Scan				
Radiation Treatment				

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	Name Of Medication	Mo/Year Started	Dose	Pills Day	Number of Times a Day	Helpful Yes of No?	Side Effects** Yes or No?
Medication							

	Pain Medication Tried In Past	

ALLERGIES & SIDE EFFECTS	Allergies and Recation (include Medications, Foods, dyes, Environmental)	
	Side Effects of Medications (use above references**)	

SOCIAL HISTORY	Living Situation	
	Marital Status	
	Children's Ages	
	Education Completed in School	
	Military Branch	
	Felony Conviction and Reason	
	Disability And Why	
	Psychiatric Care	
	Workers Compensation	
	Lawyer	

ETOH TOBACCO ILLICITS	Tobacco	Packs per Day	For	Years
	Alcohol	Drinks Per Day	For	Years
	Recreational Drugs	List All Types		
	Rehabilitation For Drugs	Dates Of Treatment		
	Rehabilitation For ETOH	Dates Of Treatment		
	Do you drink to Decrease Pain	How Many Per Day		
	Do you Use Drugs to Decrease Pain			

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PATIENT ASSESSMENT INTAKE NOTES

		You	Family			You	Family			You	Family	
PERSONAL and FAMILY MEDICAL HISTORY	Weight Loss				Weight Gain				Loss of Appetite			
	Depression				Anxiety				Fatigue			
	Psychological Problems				Difficult Concentrating				Sleep Problem Hours Sleep Per Night			
	Nervousness				Difficulty with Memory				Neurological Problems			
	Suicide Attempts				Dentures				Hoarse Voice			
	Trouble Swallowing				Hearing Loss				Vision Changes			
	Heart Disease				Heart Attack				Swollen Feet and Legs			
	High Blood Pressure				Stroke CVA				Palpations Fast Heart			
	Chest Pain				Cough				Asthma			
	Shortness of Breath				Pneumonia				Pulmonary Embolism			
	TB Tubercuolosis				Coughing Blood				Stomach Problems			
	Vomiting blood				Black Stools				Liver Disease			
	Hepatitis				Bowel Problems				Poor Bladder Control			
	Kidney Stones				Difficulty Urination				Sexual Dysfunction			
	Menstrual Problems				Vaginal Bleeding				Constipation			
	Diarrhea				Nausea or Vomiting				Cold Intolerance			
	Diabetes				Thyroid Problems				Drug Rehabilitation			
	Heat Intolerance											
	Ringing in the Ears				Fainting				Headache Migraines			
	Weakness				Epilepsy				Seizures Last Seizure			
	Paralysis				Broken Bones				Arthritis			
	Muscle Cramps				Neck Pain				Back Pain			
	Bruising				Nose Bleeds				Anemia			
	Bleeding Disorders				Cancer and Type:				Rash			
	Past Work Injuries				Auto Accidents				Disability			
	Alcohol Detox				Hereditary Disease							

DOCTORS and HEALTH CARE PROVIDERS	Name of Provider	Specialty	Tel.	Treatment

Signature	Date	Name	Relationship
For Office Received		Ins Confirmed	Appt Date
PCP/Ref Letter Sent		Payment Received	Appt Confirmed W/ Pt

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