CARDIFF
PAIN & PERFORMANCE CLINIC

Patient Name: _____

Date of Birth: _____/_____/_____

Welcome to Cardiff Pain & Performance Clinic. Carefully complete all of the following questionnaires. The accuracy of your answers will help us better diagnose and treat you. Thank you for your patience with what may appear to be some duplication in questions in different areas. Each questionnaire has been carefully designed to identify your specific condition.

Patient Name: _____ **DOB:** _____/_____/_____

Consent to receive Emails: ☐

How old are you _____

Street Address: _____

City: _____ **Post Code:** _____

Phone: _____

E-mail address: _____

How did you hear about us? : _____

Check as many that apply to you about your reason for visiting us today:

❑ Headaches/Pain
❑ Sports improvement
❑ Movement issue
❑ Balance issues
❑ Head injury
❑ Neurological assessment
❑ Other: _____

❑ If injury occurred, when? _____

_____

❑ Another type of accident, trauma, or injury

_____

❑ Neurological problem or disease: (Please explain & include any prior diagnoses)

_____

❑ Diagnostics: (Please list previous diagnostic tests given for current complaints)

_____

CAUSES OF YOUR PAIN SYMPTOMS

Event(s) surrounding the onset of symptoms	Date	Pain Intensity Today Score out of 10:
_____	_____/_____/_____	
_____	_____/_____/_____	_____
_____	_____/_____/_____	

Quality of Life Rank. *Please rate your current quality of life.*

Poor **1** ◯ **2** ◯ **3** ◯ **4** ◯ **5** ◯ **6** ◯ **7** ◯ **8** ◯ **9** ◯ **10** ◯ Excellent

What are your 3 greatest concerns about your present state of health?

1. _____ 2. _____ 3. _____

What is the most important thing we can do for you?

_____

_____

Expectations.

What are you hoping to gain from your visit? What % relief or increase in function you feel would make treatment worthwhile?

❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

Brain Health Rank. *How well do you think your brain is functioning?*

Terribly **1** ◯ **2** ◯ **3** ◯ **4** ◯ **5** ◯ **6** ◯ **7** ◯ **8** ◯ **9** ◯ **10** ◯ Great

Have you seen anyone else for this condition? ☐ No. ☐ Yes. If yes, who? _____

Have you lost work days because of this condition? ☐ No. ☐ Yes. If yes, How Many? _____

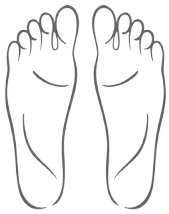
How long has this problem been present? ☐ Weeks _____ ☐ Months _____ ☐ Years _____

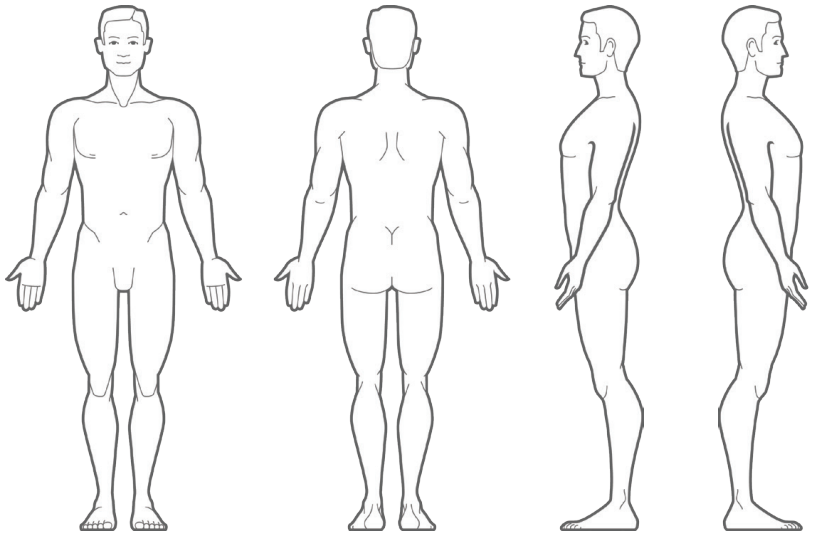
What do you think is causing your present condition? _____

Indicate any other symptoms you think may be important. _____

On the diagram, please mark the following symptoms, if you are experiencing them:

"//"	stabbing pain
"B"	for burning pain
"D"	for dull pain
"A"	for aching pain
"N"	on or in areas where you have numbness
"T"	in areas where you have tingling
"St"	in areas where you feel stiffness
"Sw"	in areas where you've had swelling
"C"	In areas where you have cramps
"W"	for weakness
"Tr"	for tremor





How have your symptoms progressed over time? _____

What aggravates your issues (Movement, time of day)? _____

What helps your issues? _____

How frequent is the issue present? _____

Is the issue worsening over time? _____

Personal Health History

Please answer the following questions as completely as possible.

List all operations and surgeries you may have had, with dates *(month/year)*

_____

_____

List any major illness you have had, with dates *(month/year)*

_____

_____

Have you ever had concussion or whiplash? If so, how long for and when?

_____

_____

Have you ever broken any bones or had any fractures or other impact injuries?

_____

_____

_____

Is there a family history of any conditions, is so what? _____

Is there anything else we have not covered, or anything you wish to disclose?

The following questions help us determine levels of stress. Please answer as completely as possible.

Please indicate your familial status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partnered

How many children do you have? ❑ None ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ Other: ___

Do you have a job? _____ How many hours a week? _____

Describe your work environment: _____

Describe your home life: _____

What is your highest level of education? _____

What are your hobbies? _____

Please answer the following questions as completely as possible. *Social history*

Has quality of life changed? ☐ No ☐ Yes. Explain? _____

Do you exercise? ☐ No ☐ Yes. What type and how often? _____

Do you currently use any tobacco products? ☐ No ☐ Yes. What kind, how often and how long? _____

Do you drink alcoholic beverages? ☐ No ☐ Yes. How much per week? _____

Do you drink caffeinated beverages? ☐ No ☐ Yes. What type, how often, and how long? _____

Do you currently use recreational drugs? ☐ No ☐ Yes. What kind, how long, and for how long? _____

Do you have any special dietary restrictions? ☐ No ☐ Yes. What type? _____

Quality of Sleep. *Please rate your current quality of sleep.*

Poor **1** ◯ **2** ◯ **3** ◯ **4** ◯ **5** ◯ **6** ◯ **7** ◯ **8** ◯ **9** ◯ **10** ◯ Excellent

Can you fall asleep? ☐ No ☐ Yes. How long? _____

Nightmares/Vivid dreams? ☐ No ☐ Yes.

Are you able to stay asleep? ☐ No ☐ Yes. How many times do you wake up? _____

Night sweats? ☐ No ☐ Yes.

Restless leg at night? ☐ No ☐ Yes.

Energy levels:

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

Focus/Concentration levels:

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

Review of Systems & Medical History

1. Does anything trigger your symptoms such as ❑ exercise ❑ sleep ❑ posture ❑ environment? _____

2. Do your symptoms get worse with physical or mental activity? ☐No ☐Yes _____

3. Are you currently experiencing any of the following symptoms, now or recently?

❑ Chest pain ❑ Pale skin ❑ Neck Pain ❑ Shortness of breath

❑ Light-Headedness ❑ Swelling in your left arm ❑ Blackouts ❑ Left arm pain

❑ Jaw pain ❑ Excessive sweating without exertion

4. Please check off any of the below symptoms that you are experiencing now or recently.

❑ Nausea ❑ Difficulty with Swallowing ❑ Vomiting ❑ Dizziness or vertigo

❑ Abnormal sweating ❑ Difficulty with speaking ❑ Double vision ❑ Numbness

❑ feeling unsteady ❑ Blurred vision ❑ Balance problems ❑ Headache

5. Have you noticed any of the following?

❑ Recent fever ❑ Change in appetite ❑ Memory issues ❑ Unexplained weight loss

❑ Drowsiness ❑ Brain Fog ❑ Confusion ❑ Sensitivity Light

❑ Pressure in head ❑ Sensitivity to Sound ❑ Recent fatigue ❑ Unexplained weight gain

❑ More Emotional

Are there any emotional traumas, past or present that you feel have relevance to your presentation *You may describe any other concerns in person if you prefer:*

Please mark below any of the conditions that apply to you, past or present.

	Past	Present
Osteoporosis	☐	☐
Dislocated bones	☐	☐
Fractured bones	☐	☐
Bone infection (osteomyelitis)	☐	☐
Herniated disc	☐	☐
Scoliosis or other spinal curvature	☐	☐
Osteoarthritis or DJD	☐	☐
Rheumatoid arthritis	☐	☐
Other arthritis	☐	☐
Gout	☐	☐
Mental or emotional disorder	☐	☐
Learning disability	☐	☐
Glaucoma	☐	☐
Heart palpitations (heart racing)	☐	☐
Swelling in legs or feet	☐	☐
Congestive heart failure	☐	☐
Chronic/frequent cough	☐	☐
COPD	☐	☐
Coughing up blood	☐	☐
Colon problems	☐	☐
Gall bladder trouble	☐	☐
Liver disease	☐	☐
Stomach/duodenal ulcer	☐	☐
Cirrhosis	☐	☐
Change in hat size	☐	☐
Acne	☐	☐
Hypertension	☐	☐
Seizures	☐	☐
Trouble concentrating	☐	☐
Paralysis	☐	☐
Twitching muscles	☐	☐
ADD or ADHD	☐	☐
Macular degeneration	☐	☐
Ringing in ears	☐	☐
Sinus problems	☐	☐
Mouth sores	☐	☐
Irregular heart beats	☐	☐
Experience passing out	☐	☐
Skipped heart beats	☐	☐
Congenital heart disease	☐	☐
Shortness of breath with activity	☐	☐
Short of breath at rest	☐	☐
Polyps	☐	☐
Diverticulitis	☐	☐
Change in nails	☐	☐
Eczema	☐	☐
Dermatitis	☐	☐
Pain in your face	☐	☐
Temporal arteritis	☐	☐
Fainting spells	☐	☐

	Past	Present
Blurred vision	☐	☐
Double vision	☐	☐
Muscle cramping	☐	☐
Tremors (shaking)	☐	☐
Dyslexia	☐	☐
Sleep apnea	☐	☐
Cataracts	☐	☐
Arrhythmia	☐	☐
Heart murmur	☐	☐
Atherosclerosis/arteriosclerosis	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Gastric ulcers	☐	☐
Celiac Disease (Sprue)	☐	☐
Irritable bowel syndrome	☐	☐
Night sweats	☐	☐
Psoriasis	☐	☐
Skin cancer	☐	☐
Loss of consciousness	☐	☐
Concussions	☐	☐
Weak muscles of face	☐	☐
Bed wetting	☐	☐
Retinopathy	☐	☐
High cholesterol	☐	☐
Scarlet fever	☐	☐
Rheumatic fever	☐	☐
Emphysema	☐	☐
Bronchitis	☐	☐
Hepatitis	☐	☐
Chrohn's disease	☐	☐
Diabetes	☐	☐
Hyperthyroidism	☐	☐
Hypothyroidism	☐	☐
Shingles	☐	☐
Herpes	☐	☐
Warts	☐	☐
Psychological issues	☐	☐
Depression	☐	☐
Prostate problems	☐	☐
Erectile dysfunction	☐	☐
Discharge from urethra	☐	☐
Bleeding disorder	☐	☐
Anemia	☐	☐
Anxiety	☐	☐
Phobias	☐	☐
Breast discharge	☐	☐
Breast lumps/soreness	☐	☐
Vascular disease	☐	☐
Varicose veins	☐	☐
Auto immune disease	☐	☐

	Past	Present
Panic attacks	☐	☐
PTSD	☐	☐
OCD	☐	☐
Kidney problems or disease	☐	☐
Difficulty urinating	☐	☐
Feelings of urgency to urinate	☐	☐
Leg pain with walking	☐	☐
Blood clots/phlebitis	☐	☐
Frequent colds or flus	☐	☐
Alcoholism	☐	☐
Cancer	☐	☐
Feelings of suicide	☐	☐
Infrequent urination	☐	☐
Blood in urine	☐	☐
Painful urination	☐	☐
Awaken to urinate	☐	☐
Bladder infections	☐	☐
Venous insufficiency	☐	☐
HIV/AIDS	☐	☐
Other *(please describe)*	☐	☐

Patient Authorisation

Thank you for taking the time to fill out this Intake form. This information is important to help us obtain an accurate clinical picture in order to inform an appropriate diagnosis and treatment plan. Please sign below to authorize that this information has been read and filled out completely and accurately to the best of your ability. The information is strictly confidential and our privacy policy can be found at www.cardiffpainandperformance.com/privacy

_____ _____

Patient's (or guardian's) signature Date

Please sign below to consent to the examination process:

_____ _____

Patient's (or guardian's) signature Date

Please sign below to consent to receiving treatment:

_____ _____

Patient's (or guardian's) signature Date

Notes.

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