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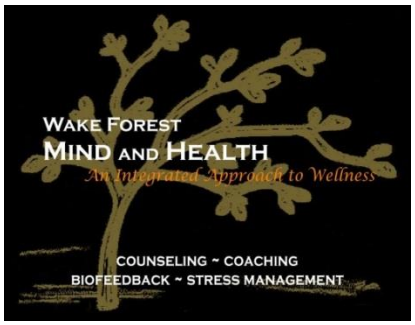


Adult / Adolescent Pain Management and Biofeedback Intake Form

Today's Date: _____

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

Ethnicity: ☐ Asian ☐ Hispanic / Latino ☐ African-American ☐ Caucasian Other: _____

RELATIONSHIP STATUS:

☐ Single ☐ Dating ☐ Partnered / Significant Other ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Duration of Relationship: _____ Number of Children: _____ Children Still Residing in the Home: _____

STUDENT / EMPLOYMENT STATUS:

☐ Full-Time Employed ☐ Part-Time Employed ☐ Homemaker / Caretaker ☐ Legally Disabled

☐ Unemployed ☐ Retired ☐ Full-Time Student ☐ Part-Time Student ☐ Active Volunteer

Length of Employment: _____ Retirement / Unemployment Date: _____

School and Grade or Major / Degree: _____

Employer Name and Position: _____

PHYSICIAN INFORMATION:

Referring Physician: _____ Phone: _____

Address: _____ City:_____ State: _____ Zip Code: _____

Primary Care Physician (PCP): _____ Phone: _____

Address: _____ City:_____ State: _____ Zip Code: _____

CONTACT INFORMATION:

Mailing Address:
_____
_____
_____

Physical Address (If Different):
_____
_____
_____

May I send mail to the above mailing address? ☐ Yes ☐ No

Telephone Numbers / Email Address (Please provide only numbers at which you give me permission to call you):

Home: _____ May I leave a message? ☐ Yes ☐ No
Work: _____ May I leave a message? ☐ Yes ☐ No
Cell: _____ May I leave a message? ☐ Yes ☐ No
Email*: _____ May I email you? ☐ Yes ☐ No
*Please be aware that email might not be confidential.

Name of Parent / Guardian or Contact Person in Case of Emergency: _____

Telephone #: _____ **Relationship:** _____

MENTAL HEALTH HISTORY:

1. Are you currently receiving psychotherapy elsewhere? ☐ Yes ☐ No
2. Have you ever had psychotherapy in the past? ☐ Yes ☐ No
3. If yes, previous therapist's name to either question above: _____

   When? _____ Duration of treatment: _____

   Focus of treatment / presenting issue: _____
4. May I contact your primary care / referring physician to coordinate care**?** ☐ Yes ☐ No
5. In the past year, have you experienced any significant life changes, stressors, loss / grief, crisis, or trauma? ☐ Yes ☐ No

   If yes, please describe: _____
6. Have you ever experienced or are currently experiencing any of the following? ☐ Yes ☐ No

   ☐ Depression / feeling down / apathy
   ☐ Bipolar disorder / extreme mood swings
   ☐ Anxiety disorder / panic attacks (most recent occurrence): _____
   ☐ Phobias (phobia triggers): _____
   ☐ Sleep disturbance (e.g., difficulty falling or staying asleep, sleeping too much / too little, restlessness, etc.)
   ☐ Schizophrenia / hallucinations (auditory / visual)
   ☐ Unexplained memory lapses
   ☐ Alcohol / prescription medication / recreational drug abuse
   ☐ Frequent body complaints (e.g., achiness, persistent pain, migraine / tension headaches)
   ☐ Eating disorder (previous or current treatment): _____
   ☐ Body image issues
   ☐ Repetitive thoughts or behaviors (e.g., obsessions, rituals, etc.)
   ☐ Problems with concentration, focus, learning disability
   ☐ Trauma history / crisis
   ☐ Homicidal thoughts / acts of aggression
   ☐ Suicidal thoughts / attempts (last attempt / hospitalization): _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family experienced difficulties with any of the following? ☐ Yes ☐ No

- ☐ Depression
- ☐ Bipolar disorder / extreme mood swings
- ☐ Anxiety disorder / pain attacks
- ☐ Phobias (phobia triggers): _____
- ☐ Sleep disturbance (e.g., difficulty falling or staying asleep, sleeping too much / too little, restlessness, etc.)
- ☐ Schizophrenia / hallucinations (auditory / visual)
- ☐ Unexplained memory lapses
- ☐ Alcohol / prescription medication / recreational drug abuse
- ☐ Frequent body complaints (e.g., achiness, persistent pain, migraine / tension headaches)
- ☐ Eating disorder
- ☐ Body image issues
- ☐ Repetitive thoughts or behaviors (e.g., obsessions, rituals, etc.)
- ☐ Problems with concentration, focus, learning disability
- ☐ Trauma history / crisis
- ☐ Homicidal thoughts / acts of aggression
- ☐ Suicide attempts / completion (family member): _____

REASON FOR SEEKING COUNSELING / BIOFEEDBACK:

What is the reason you are seeking counseling or biofeedback?

_____

_____

_____

_____

_____

What would you like to gain from counseling or biofeedback? What are your goals?

_____

_____

_____

_____

_____

What activities / roles / responsibilities do you hope to resume or participate more in?

_____

_____

_____

_____

_____

MEDICAL AND HEALTH HISTORY

Name: _____ Date: _____

1. Where is your pain located / what is your medical diagnosis? _____

2. How did your pain / medical condition start?

☐ After a work related injury	Date: _____	Workman's comp? ☐ Yes ☐ No
☐ After an auto accident	Date: _____	Pending litigation? ☐ Yes ☐ No
☐ After an injury	Date: _____	Pending litigation? ☐ Yes ☐ No

☐ Developed slowly over time
☐ Other: _____

3. Please check the kinds of doctors or specialists you have seen about your pain / medical condition:

☐ Orthopedic
☐ Neurologist
☐ Neurosurgeon
☐ Physical medicine
☐ Gynecologist
☐ Pain management / anesthesiologist
☐ Cardiologist
☐ Dermatologist
☐ Endocrinologist
☐ Gastroenterologist
☐ Internal medicine
☐ General surgeon
☐ Oncologist
☐ Hand surgeon
☐ Psychiatrist
☐ Plastic surgeon
☐ Urologist
☐ Rheumatologist
☐ Other: _____

4. What tests have been done to try to diagnose your pain / medical condition?

☐ X-rays
☐ MRI scan
☐ CT scan
☐ Myelogram
☐ Bone Scan
☐ Blood work
☐ Ultrasound
☐ Other: _____

Findings: (if known): _____

5. What other treatments have you tried to help this pain?

☐ Physical therapy
☐ TENS unit
☐ Injections or nerve blocks
☐ Stress management
☐ Interdisciplinary pain program
☐ Biofeedback
☐ Hypnosis
☐ Acupuncture
☐ Chiropractic
☐ Other: _____

6. Do you regularly participate in any of the following?

☐ Cardio exercise / stretching / strengthening
☐ Massage
☐ Tai Chi
☐ Relaxation / biofeedback exercises
☐ Self-hypnosis
☐ Other: _____

7. Please check either "Yes" or "No" to any of these which apply to you:

	Yes	**No**
Do you consume a lot of caffeine daily?	☐	☐
Do you currently smoke?	☐	☐
Do you currently drink alcohol on a regular basis?	☐	☐
Currently under a lot of stress?	☐	☐
Current family problems?	☐	☐

8. Please check and circle all that currently apply:

- ☐ Irritability / quick temper / mood swings
- ☐ Nervousness / restlessness (daytime / nighttime)
- ☐ Insomnia / frequent wakening / too much sleep
- ☐ Disturbing dreams / nightmares
- ☐ Daytime drowsiness
- ☐ Sedation from prescription medication
- ☐ Migraine / tension headaches
- ☐ Lightheadedness / dizziness
- ☐ Poor focus / concentration
- ☐ Confusion / disorientation
- ☐ Poor memory / forgetfulness
- ☐ Trouble working / loss of productivity
- ☐ Difficulty driving
- ☐ Increased / decreased appetite
- ☐ Unplanned weight loss / gain
- ☐ Bowel / bladder problems, incontinence, or pain
- ☐ Abdominal pain / constipation / diarrhea / IBS
- ☐ Nausea / vomiting
- ☐ Difficulty breathing / asthma / lung pain
- ☐ Chest pain / tightness
- ☐ Abnormal heart beat / arrhythmia
- ☐ Rash / eczema / psoriasis / easy bruising
- ☐ Muscle weakness / fatigue
- ☐ Numbness / tingling sensation / nerve pain
- ☐ Decreased sexual interest
- ☐ Other: _____

DAILY LIFE QUESTIONNAIRE

1. In general, would you say your overall health is?

   1. __ Excellent 2. __Very good 3. __Good 4. __ Fair 5. __ Poor

The following items are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, rate each one using the following scale.

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, riding a bike, playing golf, etc.

   1. ___ Yes, limited a lot 2. ___ Yes, limited a little 3. ___ No, not at all

3. Climbing <u>several</u> flights of stairs.

   1. ___ Yes, limited a lot 2. ___ Yes, limited a little 3. ___ No, not at all

During the <u>past 4 weeks</u> have you had any one of the following problems with your work or other regular daily activities <u>as a result of your physical health?</u>

4. Accomplished less that you would like? 1. __ Yes 2.__ No

5. Were limited in the kind of work or other activities? 1. __ Yes 2.__ No

Overall during the <u>past 4 weeks</u> have you had any of the following problems with your work or other regularly daily activities <u>as a result of any emotional problems</u> (such as feeling anxious or tense?)

6. Accomplished less than you would like? 1. __ Yes 2. __ No

7. Did not do work as carefully as usual? 1. __ Yes 2. __ No

8. Overall, during the <u>past 4 weeks</u> how much did pain interfere with your normal work (including both inside and outside the home and housework):

   1. __ Not at all 2. __ A little bit 3. __ Moderately 4. __ Quite a bit 5. __ Extremely

Now please rate how things have been during the <u>past 4 weeks</u>. For each question please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:

		1. All	**2. Most**	**3. A good bit**	**4. A little**	**5. None**
				……OF THE TIME……		
9.	Have you felt calm and peaceful?	___	___	___	___	___
10.	Did you have a lot of energy?	___	___	___	___	___
11.	Have you felt downhearted and blue?	___	___	___	___	___

12. During the past 4 weeks, how much of the time has your <u>physical or emotional problems</u> interfered with your social activities (e.g., visiting with friends, relatives, etc).

   1. __ All of the time 2. __ Most of the time 3. __ A good bit of the time 4. __ A little 5. __ None

COPING TECHNIQUES FOR MANAGING PAIN / MEDICAL CONDITION

In the <u>last 7 days</u> on how many days did you do the following to manage your pain / medical condition?

1.	Distract self by getting active in something else	1 2 3 4 5 6 7
2.	Relaxation tapes, self-hypnosis, biofeedback for at least 15 minutes	1 2 3 4 5 6 7
3.	Stretching program (at least for 10 minutes)	1 2 3 4 5 6 7
4.	Exercise (for at least 30 minutes, e.g., walking, back strengthening)	1 2 3 4 5 6 7

5. How helpful were these or other techniques (other than medicine) in managing your pain?

Not helpful ` **Very helpful**

1 2 3 4 5 6 7 8 9 10

ABBREVIATED MPI QUESTIONNAIRE

Please circle a number that describes how that specific question applies to you.

1. What is your level of pain at the present moment?
   0 1 2 3 4 5 6
   No pain Very intense pain

2. On average, how severe has your pain been in the past week?
   0 1 2 3 4 5 6
   Not at all Extremely severe

3. How much has pain changed the amount of satisfaction or enjoyment you get from taking part in social and recreational activities?
   0 1 2 3 4 5 6
   No change Extreme change

4. How much has pain changed your ability to participate in social and recreational activities?
   0 1 2 3 4 5 6
   No change Extreme change

5. During the past week, how tense or anxious have you been?
   0 1 2 3 4 5 6
   Not at all Extremely tense

6. During the past week, how irritable have you been?
   0 1 2 3 4 5 6
   Not at all Extremely irritable

7. During the past week, how well do you feel you have been able to deal with your problems?
   0 1 2 3 4 5 6
   Not at all Extremely well

8. During the past week, how successful were you in coping with stressful situations in your life?
   0 1 2 3 4 5 6
   Not at all Extremely successful

9. During the past week, how discouraged or hopeless have you felt?
   0 1 2 3 4 5 6
   Not at all Very hopeless

10. During the past week, how interested have you been in other people or activities?
    0 1 2 3 4 5 6
    Very interested Very poor interest

Within the past month, Monday through Friday:

- How many hours a day resting or reclining due to your pain or medical problem between 8:00 AM and 8:00 PM? _____
- How many hours a day are you active or productive a day between 8:00 AM and 8:00 PM? _____

Medical Problems

Active Problems / Health Concerns / Medical Diagnoses	Date of Onset

Surgical Procedures
(Last 10 Years Only)

Type of Surgery	Date of Surgery

Allergies

Drug / Food	Reaction

Current Medications Prescribed for Medical Conditions, Pain, Sleep Disturbance, Psychiatric Issues, Etc.

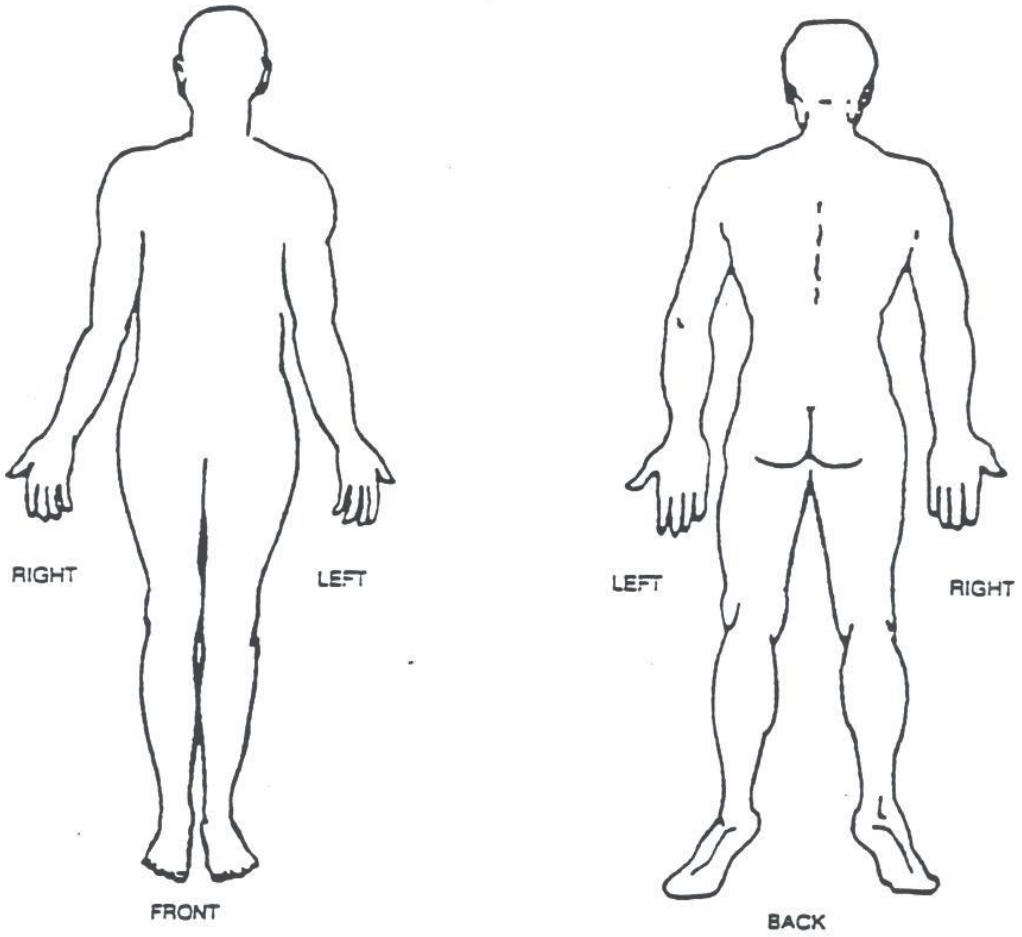
Medication	Dose	Start Date	Frequency	Reason for Taking	Prescribing Doctor

BODY MAP / SITES OF DISCOMFORT

Mark the area on your body where you feel the described sensations:

^^^^^^ Aching
OOOO Numbness
-------- Pins & Needles

XXXX Burning
//////// Stabbing



On a scale of 0 to 10, please circle how intense your pain or discomfort is at the present moment.

0-----1-----2-----3-----4-----5------6-----7-----8-----9-----10

Date of last complete physical: _____

How many times in the past 12 months have you visited the ER / ED for your pain or medical problem? _____

AUTHORIZATION OF PAYMENT OF SERVICES / INSURANCE INFORMATION

Credit Card Information and Authorization for Payment:

I,_____, authorize Katherine E. Walker, PhD, LPC, NCC, BCIA-C to charge the below-referenced credit card when I have not cancelled my scheduled appointment within 24 hours or fail to show for my scheduled appointment time. I understand that this also includes any appointment that is considered a client no-show or for any balance due that is owed due to my insurance company not covering services.

Type of Card:

MASTERCARD VISA DISCOVER AMERICAN EXPRESS

Account Holder Name Listed on Credit Card: _____

Credit Card Number (Please Include Dashes): _____

Credit Card Expiration Date: _____

Credit Card Security Code (3-Digits on Back of Debit, MasterCard, or Visa; 4-Digit on Front of American Express):

_____

Complete Billing Address for This Credit Card:

_____

_____

_____

_____ _____

Authorized Card Holder Signature Date

Insurance Information:

Insurance Carrier: _____ Plan Name: _____

Insured's Name: _____ Insured's ID Number: _____

Group ID Number: _____ Insured's Date of Birth: _____

Insured's Employer Name: _____

Insured's Address if Different from Client: _____

Please remember that I will be considered an out-of-network provider should you wish to use your insurance for reimbursement of payment for services. Let me know if you would like to submit claims to your insurance company and I will provide you with the information you will need to include on your member reimbursement claim.

Referral / Marketing Survey

To best help me accurately account for how clients initially find my professional services and to thank referral sources who directed you to me, please take a moment and check the box for which of the following best describes how you were initially referred to me. Additionally, please write in the name of the individual, medical or mental health practice name, or local business in the line provided if applicable.

- ☐ Referral by private health insurance such as supplemental health insurance provided by employer.
- ☐ Referral by employee assistance program, employee health, HR department, or supervisor / manager.
- ☐ Referral by a medical professional (include medical professional's name and practice name):

  _____

- ☐ Referral by another mental health professional (include mental health professional's name and practice name):

  _____

- ☐ Referral by someone who is seeing me or did see me for professional services (include individual's name):

  _____

- ☐ Posting of my business card or practice flyer in a local business (include name of business):

  _____

Online search engine listing or online general business directory listing:

- ☐ Best of the Web
- ☐ Bing
- ☐ Google
- ☐ Local
- ☐ Localeze
- ☐ Manta
- ☐ Mapquest
- ☐ Super Pages
- ☐ Yahoo
- ☐ Yellow Book
- ☐ Yellowbot
- ☐ Yelp
- ☐ YP / Yellow Pages

Online therapist directory listing:

- ☐ All Therapist
- ☐ Biofeedback Certification International Alliance
- ☐ Bio-Medical
- ☐ Good Therapy
- ☐ LGBT Center of Raleigh
- ☐ Marriage Counseling Guide
- ☐ National Board for Certified Counselors
- ☐ Network Therapy
- ☐ Psychology Today
- ☐ Sound Mindz
- ☐ Therapy Tribe
- ☐ Theravive

Social media website:

- ☐ Blogger
- ☐ Facebook
- ☐ Google+
- ☐ LinkedIn
- ☐ Twitter

Local print advertising:

- ☐ 919 Magazine – Wake Forest Edition
- ☐ The Wake Weekly

~ Thank You! ~