



CHRONIC PAIN CLINIC – INTAKE

Jim Pattison Outpatient Care and Surgery Centre



Patient
Reviewed ✓

Form ID: PCXX106140C

Rev: February 11, 2025

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Please answer questions on page 1 and 2 to help our team know you better.

Last name: _____ First name: _____

Date (dd/mm/yyyy): _____ Personal Health Number (BC Services Card): _____

Person completing this form: ☐ Self ☐ Essential care partner (specify): _____

I need an interpreter: ☐ Yes ☐ No If yes, language: _____

☐ I would like appointment reminders, health information and other communications sent to me by email

Email: _____

What are your goals for this program?

For example: be more active, improve sleep, take part in specific activities.

What do you believe is causing your pain?

How long have you had pain?

☐ Less than 6 months ☐ 6 to 12 months ☐ 1 to 3 years ☐ More than 3 years

Are there other specialists or services you see for your pain? ☐ Yes ☐ No

If yes, please tell us when, where and what treatments you had.

In the last 12 months have you had any tests, x-rays, MRI or CT scans related to your pain? ☐ Yes ☐ No

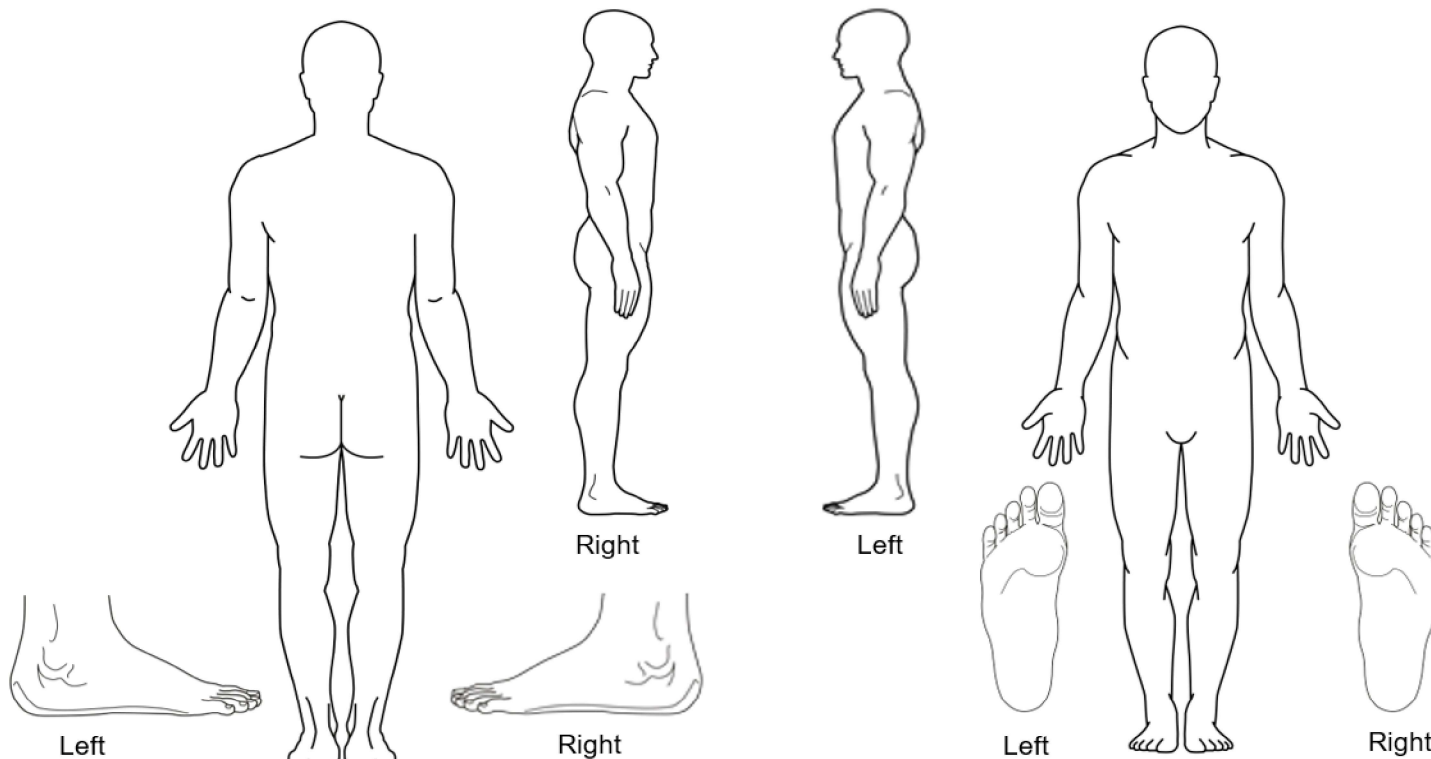
If yes, please specify: _____

Please answer the following questions about your pain.

			Clinician Use Only	
Do you feel anxious?	☐ Yes	☐ No	GAD 7	☐ Yes
Do you feel depressed?	☐ Yes	☐ No	PHQ 9	☐ Yes
Do you feel afraid that activity will make your pain worse?	☐ Yes	☐ No	TSK	☐ Yes
Do you think about your pain all the time?	☐ Yes	☐ No	PCS	☐ Yes

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Mark with an **X** where you have pain.



If you have pain in more than one area of your body, list the areas from worst to least pain area in the spaces below.

1. 2. 3. 4.

In the last 24 hours, how much relief have your pain treatments or medications provided? Please select the one percentage that shows most how much RELIEF you have received

No relief

Complete relief

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Select the number that describes how pain the past 24 hours has interfered with your:

	Has not affected							Very affected			
	0	1	2	3	4	5	6	7	8	9	10
General activity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mood	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walking Ability	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Normal Work (includes work outside the home and housework)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Relations with other people	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Enjoyment of life	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Total	/ 70										