

# St. Mark's Hospital

Interventional Pain Clinic

## PATIENT INTAKE FORM

Name: Michael Frazier  
Phone Numbers (H): 9008308701 (C): 780-541-0032 (W): None  
Referring Physician: Dr. Bonnie Atkinson  
Primary Care Physician: Dr. Tyler Armstrong

DOB: 1960-10-24

Please list any allergies you have to medications.

Medication	Reaction
Rosuvastatin	Swelling

Have you had reactions to latex, iodine, contrast dye, or shellfish? If yes, please explain: N/A

Please list all medications you're currently taking.

Medication	Dose/Route	Frequency
Albuterol	2 puffs	Every 4-6 hours as needed

Please list all past surgeries.

Surgery	Date	Notes
---------	------	-------

Gallbladder Removal	2005-06-18	Successful outcome, patient stable.

## MEDICAL HISTORY

Do you have, or have you had, any of the following?

### Cardiovascular

- ☐ Anemia
- ☐ Heart Attack/MI (If yes, when? N/A)
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Heart Valve Disorder
- ☐ Peripheral Vascular Disease
- ☐ Stroke/TIA
- ☐ Blood Clots (If yes, when? N/A)

### Gastrointestinal

- ☐ GERD (Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Ulcers
- ☐ Constipation
- ☐ Pancreatitis

### Urological

- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Dialysis
- ☐ Frequent UTI

### Neurological

- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy

### Psychological

- ☐ Depression

☐ Anxiety

☐ Claustrophobia

☐ Bipolar

☐ Schizophrenia

### Head/Ears/Eyes/Nose/Throat

☐ Headaches

☐ Migraines

☐ Head Injury

☐ Thyroid Disorder

☐ Glaucoma

### Respiratory

☐ Asthma

☐ Bronchitis/Pneumonia

☐ Emphysema/COPD

### Musculoskeletal/Rheumatologic

☐ Osteoarthritis

☐ Rheumatoid Arthritis

☐ Lupus

☐ Osteoporosis

☐ Chronic Joint Pains

☐ Back Pain

☐ Neck Pain

### Other

☐ Cancer

*What kind? N/A*

*When? N/A*

## SOCIAL HISTORY

### Marital Status

(Check One)

☐ Single

☐ Never Married

☐ Married

☐ Separated

☐ Divorced

☐ Widowed

☐ Life Partner

## Education

What Is Your Highest Level Of Education?

☐ Graduate/professional degree (What field? N/A)

☐ Technical degree (What field? N/A)

☐ Some college

☐ High school diploma

☐ Other N/A

## Work History

(Check One)

☐ Full time   ☐ Part time   ☐ Unemployed   ☐ Self employed   ☐ Disabled   ☐ Retired

Is your pain related to a work injury?

☐ No

☐ Yes

Have you stopped or modified your work because of your pain?

☐ No

☐ Yes

Do you drink alcohol?

☐ No

☐ Yes

How much and how often? N/A

Do you consume tobacco?

☐ No

☐ Yes

(Check all that apply)

☐ Cigarettes   ☐ Chewing Tobacco   ☐ Pipe   ☐ Cigars   ☐ E-Cigs

Frequency N/A

Do you have a prior or current history of prescription or street drug abuse?

☐ No

☐ Yes

Please explain N/A

## FAMILY HISTORY

Please list any significant health problems experienced by your immediate family members.

Parents

N/A

Siblings

N/A

Children

N/A

PAIN HISTORY

When and how did the pain begin?

N/A

What other evaluations have you had for this problem (i.e. Neurologist, orthopedist, other pain clinics)?

N/A

Please list most recent diagnostic studies have you had done (i.e. Imaging, EMG)?

Study	Date	Facility
MRI Brain	2025-04-26	Saint Mary Hospital
ECG	2025-11-02	Community Health Labs

What therapies have you tried?

	Date	Helped	No change	Made it worse
Physical Therapy	2025-05-20			
Chiropractic	N/A			
Massage	N/A			
Acupuncture	N/A			
Psychological	N/A			
Other	N/A			

Have you had injections for pain relief?

F No

F Yes

If so, when and what type? N/A

Does your pain travel or radiate anywhere?

F No

F Yes

If so, where? N/A

Which statement best describes your pain?

F Always present, always the same

F Always present, intensity varies

F Usually present, but have short periods without pain

F Often present, but I am pain free most of the day

F Occasionally present, but occurring once to several times per day, lasting minutes to an hour

F Occasionally present for brief periods, seconds to minutes

F Rarely present, occurring every few days or weeks

What time of day is your pain worst?

F Morning on arising

F Later in the morning

F Afternoon

F Evening

F Bedtime

F Night (during usual sleeping hours)

F Pain is always the same

F Pain varies randomly

Do any of the following make your pain feel worse?

F Coughing, sneezing

F Sitting

F Standing

F Lying down

F Physical activity

F Weather (describe) N/A

F Other (describe) N/A

Do any of the following make your pain feel better?

F Relaxation

F Sitting

F Standing

F Lying down

F Walking

F Medications

F Heat

F Alcoholic beverages

F Other (describe) N/A

F Nothing makes it feel better

Please circle the number of your pain on the scale below.

	No Pain		Low		Moderate		Intense		Unbearable	
NOW	1	2	3	4	5	6	7	8	9	10
LEAST in the past month	1	2	3	4	5	6	7	8	9	10
MOST in the past month	1	2	3	4	5	6	7	8	9	10

Please indicate the location and type of pain on the drawing below using the symbols listed.

000 Pins and needles

FRONT

BACK

XX Burning

///// Stabbing

== Numbness

^^^ Aching

Please complete this form and turn it into the Interventional Pain Clinic

1. Email to [paincliniccontact@mountainstarhealth.com](mailto:paincliniccontact@mountainstarhealth.com)
2. Fax to 877-642-3374.

3. Deliver to 1250 E 3900 S Suite #30 | Salt Lake City, UT 84124