

# St. Mark's Hospital

*Interventional Pain Clinic*

## PATIENT INTAKE FORM

Name: Michael Frazier

DOB: 1960-10-24

Phone Numbers (H): 9008308701 (C): 780-541-0032 (W): None

Referring Physician: Dr. Bonnie Atkinson

Primary Care Physician: Dr. Tyler Armstrong

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

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

### Gastrointestinal

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

### Urological

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

### Neurological

- F Multiple Sclerosis
- F Peripheral Neuropathy

### Psychological

- F Depression

F Anxiety

F Claustrophobia

F Bipolar

F Schizophrenia

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

- F Headaches
- F Migraines
- F Head Injury
- F Thyroid Disorder
- F Glaucoma

### Respiratory

- F Asthma
- F Bronchitis/Pneumonia
- F Emphysema/COPD

### Musculoskeletal/Rheumatologic

- F Osteoarthritis
- F Rheumatoid Arthritis
- F Lupus
- F Osteoporosis
- F Chronic Joint Pains
- F Back Pain
- F Neck Pain

### Other

F 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?

- F Graduate/professional degree (What field? N/A)
- F Technical degree (What field? N/A)
- F Some college
- F High school diploma
- F Other N/A

## **Work History**

(Check One)

Full time Part time Unemployed Self employed Disabled Retired

Is your pain related to a work injury?

- F No
- F Yes

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

- F No
- F Yes

Do you drink alcohol?

- F No
- F Yes

How much and how often? N/A

Do you consume tobacco?

- F No
- F 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?

- F No
- F 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