

St. Mark's Hospital

Interventional Pain Clinic

PATIENT INTAKE FORM

Name: Rachel Lynch

DOB: 1979-07-06

Phone Numbers (H): +1-452-850-4965 (C): +1-812-242-8971 (W): None

Referring Physician: Dr. Calvin Smith

Primary Care Physician: Dr. Holly Porter

Please list any allergies you have to medications.

Medication	Reaction
N/A	N/A

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
N/A	N/A	N/A

Please list all past surgeries.

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

N/A	N/A	N/A

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?

☐ 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
N/A	N/A	N/A

What therapies have you tried?

	Date	Helped	No change	Made it worse
Physical Therapy	2025-08-21			
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
2. Fax to 877-642-3374.
3. Deliver to 1250 E 3900 S Suite #30 | Salt Lake City, UT 84124