



## *Mediators to Movement & Meaning*

CHRONIC PAIN CLINIC

### GENERAL INTAKE

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email: \_\_\_\_\_

Emerg. Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

Referred by: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

### WAIVER

I hereby grant m Group the authority to release any medical information pertinent to my assessment and treatments, to my family physician and/or referring physician, as well as to the agency(s) who will be paying for these services. Potential agencies include: WSIB, Insurance Companies, Lawyers and Employers.

I also hereby allow m Group to access to current/previously ordered medical diagnostic evaluations, including x-rays, blood work, CT/MRI results, etc., from any other facilities.

A photocopy of this authorization may be accepted with the same authority as the original.

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_



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C H R O N I C P A I N C L I N I C

*'Mediators to Movement & Meaning'* or **m**Group, is a group of health care practitioners who have come together to deliver the most comprehensive pain management program in the world. Pain is the unpleasant feelings a person has or a symptom of some hurt or disorder suffered by a person. It can be of a mental emotional origin or a somatic sensation felt in the physical body. It can also be a combination of these. Chronic pain is pain that is ongoing and appears to be permanent, long-lasting or frequently occurring. It is pain that persists after an injury has healed or a disease is over.

Here at **m**Group, we treat the person who has the pain first and the pain the person has second. Our program is geared to learn about a person's life so that we can integrate and adapt the science and medicine of healing to the person not the other way around. Because of this, our initial intake is very detailed, so please bear with us regarding all of the questionnaires and forms as it is the only way we can catch up on your life, to help us understand and hopefully teach you how to manage and/or heal your pain.

Thank you for your time, patience and opportunity to help you on your journey to a better quality of life.

Sincerely and in Health,

Dr. Chris Mazzuchin



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### PERSONALITY PROFILE

(try to respond with the first thing that comes to mind, and no response is alright too)

Write a factual statement \_\_\_\_\_

Write a fictional statement \_\_\_\_\_

What is your favourite room in your house/residence ? \_\_\_\_\_

What is the most important activity in your day ?

What is your favourite animal ? \_\_\_\_\_

... plant ? \_\_\_\_\_

...mineral ? \_\_\_\_\_

... food ? \_\_\_\_\_

... beverage/drink? \_\_\_\_\_

What is one of your favourite movies (or scenes) ? \_\_\_\_\_

Who is one of your favourite celebrities ? \_\_\_\_\_

Write down a number. \_\_\_\_\_... and a letter in the alphabet \_\_\_\_\_

What is your favourite music or song to listen to ? \_\_\_\_\_

What is your favourite article of clothing ? \_\_\_\_\_

What do you first notice about people ? \_\_\_\_\_

What comes to mind when you read the word love ? \_\_\_\_\_

What would you change about the world ? \_\_\_\_\_

What do you typically do when you are unhappy ? \_\_\_\_\_

Circle an emotion: ANGER SADNESS JOY WORRY FEAR GUILT ENVY

FRUSTRATED IRRITABLE DISAPPOINTMENT SHAME

Quickly sketch a picture of your current state of mind. (remember anything you draw is acceptable)



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## TRIAGE QUESTIONS

### PHYSICAL

	STRONGLY AGREE,	MAYBE,	NO
1. Can you touch your pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is most of your pain helped by pharmaceutical interventions only?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does moving help your pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your pain move?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Can your pain be affected by temperature?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your sleep change because of the pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the pain resulting in difficulty with actions during intimacy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your pain change during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Can you still manage to get through your day, despite the pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you need or have used a gait aid like a cane, walker, brace, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. If you have had surgery, did it help at all with your pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. When the pain gets worse does it radiate elsewhere?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the pain cause numbness and tingling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do certain positions help or hinder your pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Has physical treatments like physio, chiro or massage help the pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### MENTAL

1. Do you feel any pain in any other place other than your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is some, (not all) of your pain helped by pharmaceutical interventions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do people's actions/behaviour bother your pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do stressful situations amplify your pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have just anger or just sadness, (not both) with your pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your pain affect your finances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your pain affect the majority of your daily activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the pain cause you to nap often?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the pain causing "performance" issues during intimacy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you notice your pain all day long?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your pain discourage you about the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does your pain cause you to be more critical of others and things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you more irritable because of the pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you feel more nervous since the pain started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have an increased fear of dying now because of the pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Has your pain interfered with your ability to communicate to others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Did your pain start small and grow bigger over time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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## EMOTIONAL

- |   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
| 1. Does your pain affect your heart?                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do people bother you and your pain?                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does expressing yourself help your pain?                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have anger and sadness with your pain?                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your pain impact your relationship with others?         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is the pain resulting in a reduction in desire for intimacy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your pain cause you to cry more than usual?             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has your appetite changed because of the pain?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does the pain cause numbness but not tingling?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does your pain cause you to feel light headed or dizzy?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Does music help your pain?                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have difficulty concentrating or paying attention?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does your pain affect your memory?                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are you moodier than usual, do you have mood swings?        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you feel crippled by your pain?                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## SPIRITUAL

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
| 1. Has your pain stopped your desire for living?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do peoples 'intentions' bother your pain?                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does praying or meditating help your pain?                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel you cannot be helped?                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has your pain caused you to lose some of your faith?        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does your pain affect how you see the world?                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has your pain affected your support network?                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your pain prompt thoughts about suicide?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you a more spiritual person now because of your pain?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is your belief in your ability to heal your pain doubted?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you lost a sense of initiative or drive?              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you go to church less or even more now due to the pain? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does this pain have a personality?                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you dream less or more since the pain began?            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have extraordinary experiences now due to the pain? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## OTHER:

- |   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
| Would you be interested in naturopathic medicine?         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Would you be interested in chiropractic treatments?       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Would you be interested in reiki/energy healing sessions? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Would you be interested in massage therapy?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Would you be interested in osteopathy treatments?         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |