Chronic Pain and Mental Health Intake Form

Personal Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Medical Information

Primary Pain Diagnosis

Duration of Pain (e.g., months/years)

Location(s) of Pain

Average Pain Intensity (0-10)

Current Medications

Mental Health

Any past or current mental health diagnoses

Are you currently receiving mental health treatment?

Anxiety Level (0-10)

Mood/Emotional State

Support System (family, friends, etc.)

Additional Information

What would you like to achieve from treatment?

Other Concerns or Comments