

**REI Therapy Program™ Chronic Pain Intake Form Cover Sheet**

Please fax to: 505-466-6144 or mail to: REI Institute  
55 Lime Kiln Rd.  
Lamy, NM 87540

Date: \_\_\_\_\_

**Provider Name:** \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ email: \_\_\_\_\_

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**Client Name:** \_\_\_\_\_ Gender: M F D.O.B. \_\_\_\_\_

Client Diagnosis: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

**Ship to** (check one): Provider \_\_\_\_\_ Client contact: \_\_\_\_\_

**Payment information:**

\_\_\_\_\_ Enclosed is my check (payable to REI Institute).

\_\_\_\_\_ Please charge my credit card (circle type): Mastercard Visa Discover

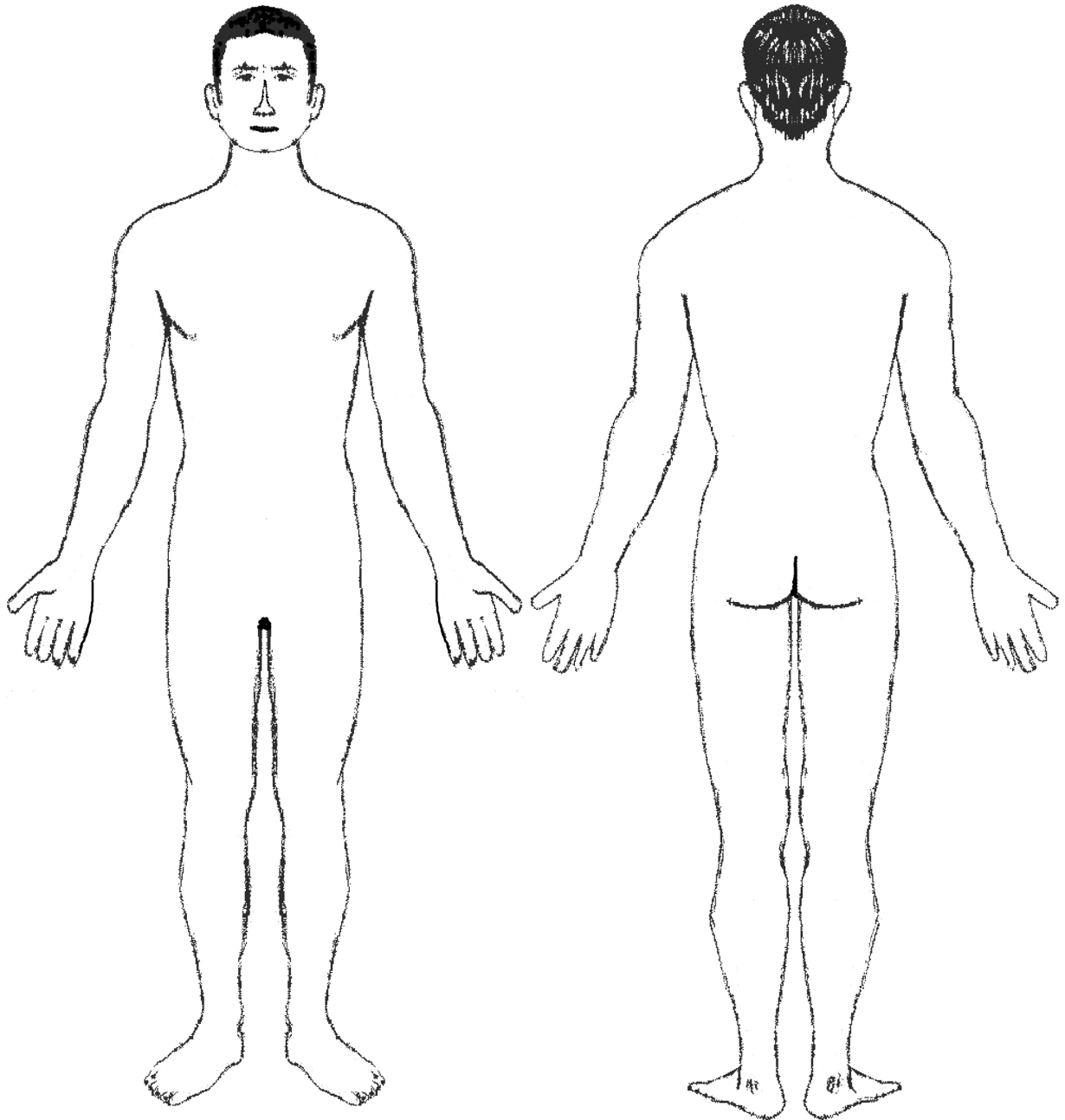
Card # \_\_\_\_\_ Expiration date: \_\_\_\_\_

Signature: \_\_\_\_\_ Name on card: \_\_\_\_\_

Please briefly describe the client for whom the REI Therapy Program will be made (personality and symptoms):

## REI Therapy Program Questionnaire Part I - Adults with Chronic Pain

On the chart below please indicate the location of your pain and the level in that area (on a scale of 0-10 with 0 being no pain and 10 being unbearable pain). If your pain level varies, please use a range (such as 3-7) and describe the situation(s) that cause this variance on question 5 on the next page. Also note the type of pain that exists in each location on question 4 (sharp, throbbing, radiating, dull, numbing, etc.).



## **REI Therapy Program Questionnaire Part II - Adults with Chronic Pain**

1. Please describe when your pain began:

2. Please list any medications you are taking (including time of day and dosage):

3. Please describe other therapies you're done or have done in the past (herbs, acupuncture, massage, vitamins, homeopathics, relaxation techniques, pain clinic, etc.):

4. Please describe the type of pain you experience in each location (sharp, throbbing, radiating, dull, numbing, etc.):

5. Please describe how your pain levels differ throughout the day (time of day, types of activities):

6. Please explain how your pain has impacted your life:

## REI Therapy Program Questionnaire Part III - Adults with Chronic Pain

Client's name: \_\_\_\_\_

Person completing form: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Please select a rating for each of the following questions. Refer to behavior for the past 3 months. For each item, decide whether the behavior is relevant and to what degree.

0= not relevant

1= slightly relevant

2= pretty relevant

3= very relevant

Don't think too hard about the answer -- your first reaction is usually the right one.

|  | not relevant | slightly relevant | pretty relevant | very relevant |
|--|--------------|-------------------|-----------------|---------------|
| 1. Wakes frequently at night               | 0            | 1                 | 2               | 3             |
| 2. Impulsive, acts without thinking        | 0            | 1                 | 2               | 3             |
| 3. Avoids eye contact                      | 0            | 1                 | 2               | 3             |
| 4. Anxious                                 | 0            | 1                 | 2               | 3             |
| 5. Slow to wake-up after sleep             | 0            | 1                 | 2               | 3             |
| 6. Is easily distracted                    | 0            | 1                 | 2               | 3             |
| 7. Has trouble falling asleep              | 0            | 1                 | 2               | 3             |
| 8. Resists physical contact                | 0            | 1                 | 2               | 3             |
| 9. Irritable or whiny                      | 0            | 1                 | 2               | 3             |
| 10. Bothered by certain sounds             | 0            | 1                 | 2               | 3             |
| 11. Repetitive body movements              | 0            | 1                 | 2               | 3             |
| 12. Has trouble staying on task            | 0            | 1                 | 2               | 3             |
| 13. Has poor appetite, doesn't want to eat | 0            | 1                 | 2               | 3             |
| 14. Headaches                              | 0            | 1                 | 2               | 3             |
| 15. Mood changes often                     | 0            | 1                 | 2               | 3             |
| 16. Seems unhappy most of time             | 0            | 1                 | 2               | 3             |
| 17. Worries excessively                    | 0            | 1                 | 2               | 3             |
| 18. Doesn't finish things                  | 0            | 1                 | 2               | 3             |
| 19. Has to have own way                    | 0            | 1                 | 2               | 3             |
| 20. Becomes frustrated easily              | 0            | 1                 | 2               | 3             |

|  |   |   |   |   |
|--|---|---|---|---|
| 21. Eats excessively or would like to                          | 0 | 1 | 2 | 3 |
| 22. Often has stomach aches                                    | 0 | 1 | 2 | 3 |
| 23. Afraid of new things, places or people                     | 0 | 1 | 2 | 3 |
| 24. Controlling, needs to run things                           | 0 | 1 | 2 | 3 |
| 25. Eats limited diet, only likes certain foods                | 0 | 1 | 2 | 3 |
| 26. Inactive, listless   | 0 | 1 | 2 | 3 |
| 27. Hard to reach, preoccupied                                 | 0 | 1 | 2 | 3 |
| 28. Seeks isolation  | 0 | 1 | 2 | 3 |
| 29. Moves around aimlessly                                     | 0 | 1 | 2 | 3 |
| 30. Bothered by clothes against skin                           | 0 | 1 | 2 | 3 |
| 31. Clumsy, uncoordinated                                      | 0 | 1 | 2 | 3 |
| 32. Forgets things   | 0 | 1 | 2 | 3 |
| 33. Moody  | 0 | 1 | 2 | 3 |
| 34. Stares into space, seems in own world                      | 0 | 1 | 2 | 3 |
| 35. Hears things others don't                                  | 0 | 1 | 2 | 3 |
| 36. Has recurring obsessive thoughts                           | 0 | 1 | 2 | 3 |
| 37. Has uncontrollable body movements                          | 0 | 1 | 2 | 3 |
| 38. Lacks motivation   | 0 | 1 | 2 | 3 |
| 39. Craves pressure against body                               | 0 | 1 | 2 | 3 |
| 40. Easily overwhelmed by noisy environments                   | 0 | 1 | 2 | 3 |
| 41. Easily startled  | 0 | 1 | 2 | 3 |
| 42. Easily bored   | 0 | 1 | 2 | 3 |
| 43. Quick temper/easily angered                                | 0 | 1 | 2 | 3 |
| 44. Has fear or panics for no observable reason                | 0 | 1 | 2 | 3 |
| 45. Very sensitive to other's feelings                         | 0 | 1 | 2 | 3 |
| 46. Sees things others don't (shadows, colors, objects moving) | 0 | 1 | 2 | 3 |
| 47. Has poor balance   | 0 | 1 | 2 | 3 |
| 48. Sleeps too much (or would like to if given the chance)     | 0 | 1 | 2 | 3 |
| 49. Has feelings of hopelessness, helplessness, negativity     | 0 | 1 | 2 | 3 |

|   |   |   |   |   |
|---|---|---|---|---|
| 50. Fixates on thought, activity or object  | 0 | 1 | 2 | 3 |
| 51. Talks loudly  | 0 | 1 | 2 | 3 |
| 52. Low self-esteem   | 0 | 1 | 2 | 3 |
| 53. Has difficulty telling which direction a sound came from  | 0 | 1 | 2 | 3 |
| 54. Verbally abusive toward others  | 0 | 1 | 2 | 3 |
| 55. Engages in ritualistic behaviors (needs to things a certain way all the time)                         | 0 | 1 | 2 | 3 |
| 56. Has negative outlook on life  | 0 | 1 | 2 | 3 |
| 57. Abuses alcohol or drugs   | 0 | 1 | 2 | 3 |
| 58. Often has ringing in ears   | 0 | 1 | 2 | 3 |
| 59. Recoils to touch (tactically defensive)   | 0 | 1 | 2 | 3 |
| 60. Doesn't seem to know where he/she is in space / bumps into things and people frequently               | 0 | 1 | 2 | 3 |
| 61. Has difficulty making decisions   | 0 | 1 | 2 | 3 |
| 62. Has thoughts of harming self (including suicide)  | 0 | 1 | 2 | 3 |
| 63. Is argumentative/oppositional   | 0 | 1 | 2 | 3 |
| 64. Often seems tired, sluggish, slow moving  | 0 | 1 | 2 | 3 |
| 65. Has repeated negative thoughts  | 0 | 1 | 2 | 3 |
| 66. Has periods of confusion  | 0 | 1 | 2 | 3 |
| 67. Has extreme cyclic changes in mood (very high to very low)  | 0 | 1 | 2 | 3 |
| 68. Frequently experiences déjà vu (feelings of experiencing the same thing before when he/she never has) | 0 | 1 | 2 | 3 |
| 69. Dislikes change   | 0 | 1 | 2 | 3 |
| 70. Fearful of specific things (snakes, spiders, heights, people)   | 0 | 1 | 2 | 3 |
| 71. Experiences frequent changes in sleep patterns  | 0 | 1 | 2 | 3 |
| 72. Thinks in terms of "black and white" has trouble seeing nuances in situations                         | 0 | 1 | 2 | 3 |
| 73. Has difficulty understanding/identifying own feelings   | 0 | 1 | 2 | 3 |
| 74. Bothered by/sensitive to lights   | 0 | 1 | 2 | 3 |
| 75. Has/had eating disorder   | 0 | 1 | 2 | 3 |