ONE STOP MEDICAL CARE

Pain Management
New Patient Intake Form

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk if you have any question on how to complete any section on this form.

Patient Information

Today's date: ______________________________

Your name: ______________________________ Date of Birth: ________________ Age: __________

Referring Physician: ________________________ Primary Care Physician: ______________________________

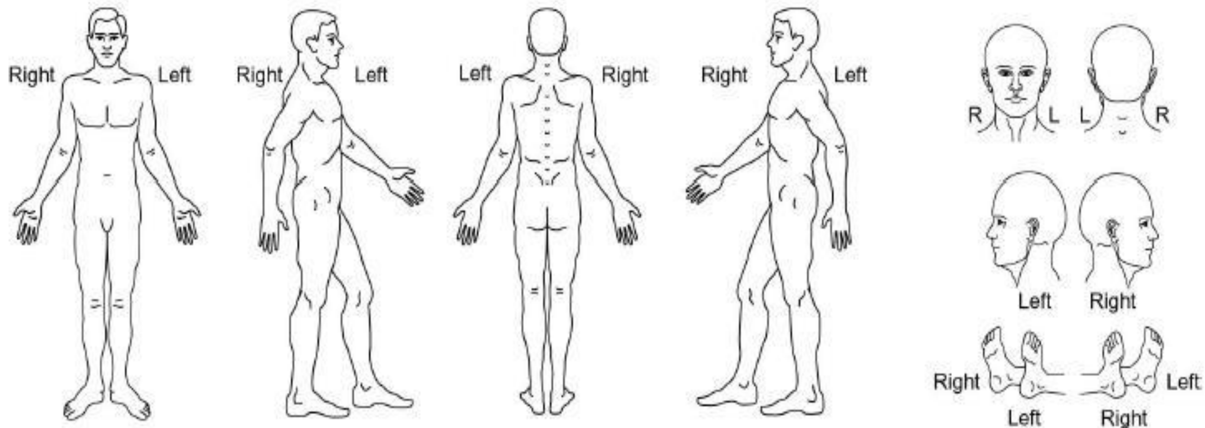
Pain History

Chief Complaint (Reason for your visit today)? ____

Does this pain radiate? If so where? ____

Please list any additional areas of pain: ____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately when did this pain begin? ____

What caused your current pain episode? ____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing

☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness

When is your pain at its worst?

☐ Mornings ☐Daytime ☐ Evenings ☐ Middle of the night

☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present

☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now______________ The Best It Gets______________ The Worst It Gets______________

Mark the effect each of the following have on your pain level - ☑

	Increases	Decreases	No Change
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

What other factors worsen or affect your pain which is not mentioned above?

____

____

Associated Symptoms

	NO	Yes	Comments
Numbness/Tingling	☐	☐	Where? ______________
Weakness in the arm/leg	☐	☐	______________
Balance Problems	☐	☐	______________
Bladder Incontinence	☐	☐	______________
Bowel Incontinence	☐	☐	______________
Joint Swelling/Stiffness	☐	☐	______________
Fevers/chills	☐	☐	______________

Please mark all of the following treatments you have used for pain relief: ☑

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐

Other ____

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) ____

☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ MILD (Minimally Invasive Lumbar Decompression) - ______________________________

☐ Nerve Blocks – Area/Nerve(s) - ____

☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant ______________________________

☐ Trigger Point Injections – Where? ____

☐ Vertebroplasty/Kyphoplasty – Level(s) ______________________________________

☐ Other - ____

Which of these procedures listed above have helped with your pain? ______________________

____

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

☐MRI of the: ____ Date: __________________

☐X-Ray of the: ____ Date: __________________

☐CT Scan of the: ______________________________________ Date: __________________

☐EMG/NCV study of the: ______________________________ Date: __________________

☐Other Diagnostic Testing: ____________________________ Date: __________________

☐ I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/Psychologist

☐ Chiropractor ☐ Orthopedic Surgeon ☐ Rheumatologist

☐ Internist ☐ Physical Therapist ☐ Neurologist

☐ Other ____

Past Medical History

Please list the names of other Pain Physicians you have seen in the past?________________________________

____

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ☐ Cancer – Type ___________________
- ☐ Diabetes – Type_________________

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders

Gastrointestinal
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ Constipation

Urological
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis

Neuropsychological
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder

Head/Ears/Eyes/Nose/Throat
- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Other Diagnosed Conditions
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) ______________________________ Date? __________

2) ______________________________ Date? __________

3) ______________________________ Date? __________

4) ______________________________ Date? __________

5) ______________________________ Date? __________

☐ I have **NEVER** had any surgical procedures performed.

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other __________

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

Medication Name	**Dose**	**Frequency**
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

Please list all past pain medications that you have been on at any point for your current pain complaints?

Medication Name	**Dose**	**Frequency**
1)		
2)		
3)		
4)		
5)		

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name	Allergic Reaction
1) ____________________	____________________
2) ____________________	____________________
3) ____________________	____________________
4) ____________________	____________________
5) ____________________	____________________

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐Arthritis ☐Cancer ☐Diabetes

☐Headaches/Migraines ☐High Blood Pressure ☐Kidney Problems

☐Liver Problems ☐Osteoporosis ☐Rheumatoid arthritis

☐Seizures ☐ Stroke

☐Other Medical Problems: ____________________

☐ I have no significant family medical history

Social History

Occupation: ____________ When was the last time you worked? ____________

Who is in your current household? ____________________

Are there any stairs in your current home? ____________ If so how many? ________

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use:

☐ Social Use ☐ History of alcoholism ☐ Current alcoholism ☐Never

☐ Daily use of alcohol

Tobacco Use:

☐ Current user ☐ Former user ☐ Never used

☐ Packs per day? _______ ☐ How many years? _______ ☐ Quit Date: _______

Illegal Drug Use:

☐ Denies any illegal drug use ☐ Currently uses illegal drugs

☐ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional:	☐ Chills	☐Difficulty sleeping	☐ Easy bruising
	☐ Night Sweats	☐Fatigue	☐ Fevers
	☐ Insomnia	☐ Low sex drive	☐ Tremors
	☐ Unexplained Weight Gain		☐ Weakness
	☐ Unexplained Weight Loss		

Eyes:	☐ Recent Visual changes		

Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems
	☐ Nosebleeds	☐ Sinus problems	

Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots
	☐ Fainting	☐ Palpitations	☐ Swelling in feet
	☐ Shortness of breath during sleep		

Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath

Gastrointestinal:	☐ Constipation	☐ Acid Reflux	☐Abdominal Cramps
	☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia

Musculoskeletal:	☐ Back Pain	☐ Joint Pains	☐ Joint Stiffness
	☐ Joint Swelling	☐ muscle spasms	☐ Neck Pain

Genitourinary/Nephrology:	☐ Flank Pain	☐ Blood in Urine	☐ Painful Urination
	☐ Decreased Urine Flow/Frequency/Volume		

Neurological:	☐ Dizziness	☐ Headaches	☐ Tremors
	☐ Numbness/Tingling		☐ Seizures

Psychiatric:	☐ Depressed Mood	☐ Feeling Anxious	☐ Stress Problems
	☐ Suicidal Thoughts	☐ Suicidal Planning	
	☐ Thoughts of Harming Others		

☐ All other review of systems negative ☐ Reviewer ______________________