

New Patient Intake Form

Name _____ Age _____ Date _____

Height _____ Weight _____ Occupation _____

Best Number to Reach _____ Pharmacy Name and Number _____

Referring Physician _____ Primary Care Physician _____

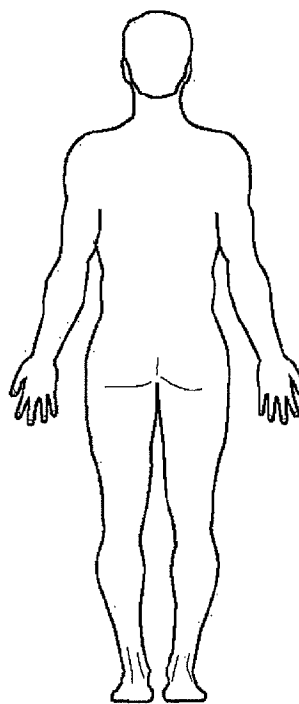
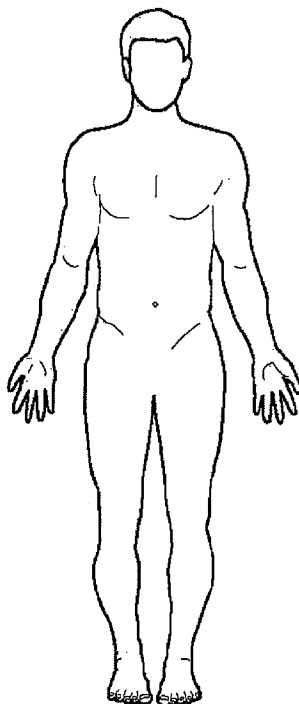
1. Chief Pain Complaint: _____
2. When and how did it begin? _____
3. Does your pain radiate anywhere? _____
4. Please mark the area(s) in the diagrams below where you are having pain:

Front

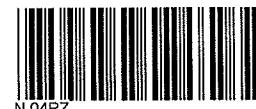
Right Side

Back

Left Side



5. On a scale from 0-10, with 0 being no pain and 10 being the worst pain imaginable, what number describes your pain: At its best: _____ At its worst: _____ Right at this moment: _____
6. How often does the pain occur? Continuously Several times a day Intermittent Occasionally
Less than daily
7. When is your pain worse? Morning Afternoon Evening All the Time No Usual Pattern
8. How has the pain intensity changed since it began? Better Worse No Change



9. Select one or more items below to describe your pain (circle all that apply): Aching Burning Cramping
 Dull Electric Shock Sharp Shooting Stabbing Throbbing Deep Numb Tingling
 Other _____
10. Please circle the ones your pain interferes with (circle all that apply): General Activity Mood
 Walking Ability Normal Work Relation With Other People Sleep Enjoyment of Life
11. What makes the pain worse? (circle all that apply): Standing Sitting Walking Movement Lying Down
 Bending Forward Arching Backward Coughing Sneezing Using Bathroom Other _____
12. What makes the pain better? (circle all that apply): Standing Sitting Walking Movement Lying Down
 Bending Forward Arching Backward Coughing Sneezing Using Bathroom Other _____
13. What tests have been done and when? (circle all that apply & give dates):
 X-ray _____ MRI _____ CT _____ EMG _____ Bone Scan _____ Other _____
14. Do you have any of the following symptoms associated with your pain?
 Numbness/Tingling If yes, where? _____
 Weakness If yes, where? _____
 Bowel/Bladder Incontinence If yes, when did it start? _____
15. List the names of other doctors or specialists you have seen for your pain or who have treated your pain:

16. Please check all procedures or modalities you have tried to manage or treat your pain:

Did it help?	Did it help?
Acupuncture _____	Massage _____
Biofeedback _____	Meditation _____
Chiropractor _____	Nerve Blocks _____
Epidural _____	Physical Therapy _____
Facet Block _____	Psychotherapy _____
Ice/Heat _____	Surgery _____
Medications _____	TENS _____
Other _____	

17. Are you involved in any litigation or lawsuit regarding your pain? Yes No

18. Are you seeking Workers' Compensation as a result of your pain? Yes No

19. Medical Illnesses (circle all that apply):

- | | |
|--|--|
| Diabetes -diet, medication, insulin | Heart -angina, heart attack, irregular heart beat, pacemaker, heart failure |
| Thyroid -Hypothyroidism, hyperthyroidism | Lung - asthma, emphysema, COPD |
| Liver -Hepatitis, cirrhosis | Stomach - ulcer, GERD/reflux |
| Psychiatric -depression, anxiety, suicide | Kidney -stones, failure, dialysis |
| High Blood Pressure | Neurologic -stroke, seizure, neuropathy |
| High Cholesterol | Arthritis -rheumatoid, fibromyalgia |
| Cancer -Type _____ | Infection -HIV, AIDS |
| Other _____ | |

20. Prior Surgeries (please list type & date):

21. Allergies: _____

22. Current Non-Pain Medications (name and current dose please):

Do you take any of the following blood thinners? (circle all that apply):
Aspirin Coumadin Plavix Heparin Aggrenox Pletal Lovenox Ticlid

23. Current Pain Medications:

24. Previous Pain Medications:

25. Social History: Single Married Divorced Children
Use tobacco? Amount _____ Use alcohol? Amount _____
Use illegal drugs? Type _____ Been treated for alcohol or drug addiction? YES NO



26. Family History (circle all that apply):

Cancer Who? _____ **Diabetes** Who? _____
Heart Disease Who? _____ **Stroke** Who? _____
Depression/Suicide Who? _____ **Alcohol/Drug Abuse** Who? _____

27. Review of Systems (circle all that apply):

General: Weight changes, fatigue, appetite change, fever, sleep disturbance
Skin: Bruising, rashes, plaques, color change, lesions, dryness
Head/Eyes: Headache, blurry vision, glaucoma
ENT: Ears ringing, sinusitis, sore throat, nasal congestion, hoarseness
Respiratory: Chronic cough, shortness of breath, wheezing
Cardiovascular: Chest pain, palpitations, fainting, leg swelling, leg cramps, aneurysms
Hematology: Anemia, easy bruising/bleeding
GI: Heartburn, nausea, constipation, diarrhea, ulcer, reflux
Urinary: Blood in urine, painful urination frequency, urgency, loss of bladder control
Musculoskeletal: Joint pain, arthritis, spasm, cramps, joint swelling, redness, stiffness
Neurological: Stroke, seizures, weakness, numbness, blackout, memory loss
Psychological: Depression, mania, anxiety, sleep problems, suicidal ideation
Endocrine: Thyroid problems, heat/cold intolerance, nervousness, diabetes

I, the undersigned, have completed this form. The information that I have provided is true and accurate to the best of my knowledge.

X _____
Patient/Legal Guardian Signature Date

X _____
Person signing on patient's behalf/relationship Reason patient is unable to sign

For Nurses Only:
BP _____ HR _____ T _____ Taken by _____ Date _____ Time _____

Form Reviewed by Physician _____ Date _____ Time _____