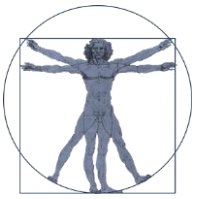


Center for Pain and Spine Care

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Name: _____ **DOB**: _____ **SSN:** _____-_____-_____

Sex: ☐M ☐F **Marital Status:** ☐S ☐M ☐W ☐D **Height:** _____ **Weight:** _____

Address: _____ **City/State:** _____ **Zip:** _____

Phone #: _____ **Cell #:** _____ **Email:** _____

Currently Employed: ☐ Yes ☐ No **Employer:** _____ **Occupation:** _____

Please circle for the following questions:

Race: White / Black / Hispanic / American Indian / Alaska Native / Asian / African American / Native Hawaiian /Other

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Other

Language: English / Spanish / Italian / French / German / Chinese / Arabic / Other

Emergency Contact: _____ **Relationship**: _____ **Phone #** _____

PCP: _____ **Phone:** _____ **Address:** _____

Referring MD: _____ **Phone:** _____ **Address:** _____

How did you hear about our office? Doctor/Attorney/Friend/Internet

Is your pain related to a work injury/ motor vehicle accident / other?

INSURANCE INFORMATION

(If your pain was caused by an accident please use that information as your primary insurance)

	Primary Insurance	Secondary Insurance
Company :		
Card Holder:	**Name:**	**Name:**
Card Holder:	**DOB:** **SSN:**	**DOB:** **SSN:**
Policy #		
Group#		

Date of Accident: _____ **Claim#:** _____

Attorney: _____ **Phone: #:** _____ **Fax #:** _____

Adjuster: _____ **Phone: #:** _____ **Fax #:** _____

Claim Rep: _____ **Phone: #:** _____ **Fax #:** _____

MEDICAL INTAKE FORM

NAME: _____ **DOB:** _____

MEDICAL HISTORY

General
- ☐ Cancer _____
- ☐ Diabetes _____

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

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

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

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

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

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

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

Others

_____

_____

_____

_____

_____

SURGICAL HISTORY

Please list any past surgeries:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

ALLERGIES

Medication Allergies: ☐ Yes ☐ No. **If Yes, please list Medications below:**

Medications	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Tropical Allergies:

☐ Latex ☐ Iodine

☐ Tape ☐ IV Contrast

Others:

_____

_____

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:

Current Medication Name	Dose	Frequency

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

Past Pain Medication Name	Dose	Frequency

FAMILY HISTORY

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

Diagnoses:	Mother	Father	Sister	Brother	Grandparents
Arthritis	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease/CAD	☐	☐	☐	☐	☐
Headaches/Migraines	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐
Liver Problems	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐

Others (Condition & Person): _____

☐ I have no significant family medical history

SOCIAL HISTORY

☐ 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 ☐ Daily use of alcohol ☐ History of alcoholism ☐ Current alcoholism ☐Never

Tobacco Use:☐ Current smoker ☐ Former smoker ☐ Never smoked ☐ Packs/day? ____ ☐ # of Years? _____

Illegal Drug Use: ☐ Denies any illegal drug use ☐ Currently uses illegal drugs _____

☐ Formerly used illegal drugs (not currently using) _____

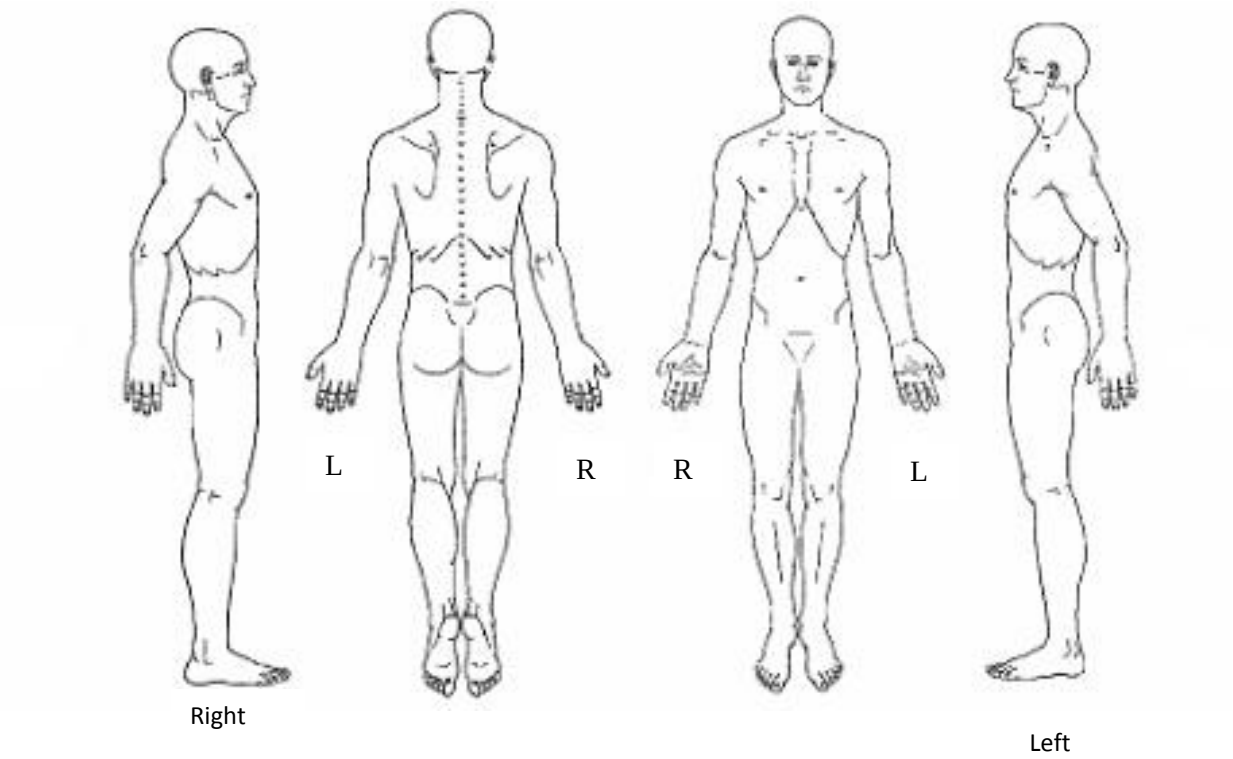
Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

PAIN HISTORY

Reason for your visit today (Chief Complaint)? _____

Does this pain radiate? Yes / No. If Yes, where? _____

INSTRUCTIONS: Please mark the areas on your body where you feel your PAIN. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



ONSET OF SYMPTOMS

Approximately when did this pain begin? _____

What caused your current pain? _____

How did your current pain begin? ☐ Gradually ☐ Suddenly

Has your pain changed since it began? ☐ Improved ☐ Worsened ☐ 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 ☐ Bedtime ☐ Middle of the night ☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

Please rate your pain on a scale of 1 to 10, 10 being the worst pain:

WORST _____ BEST _____ NOW_____

Please mark how the activities below change your pain level: ☑

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

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

_____

_____

ASSOCIATED SYMPTOMS

Do you have Numbness/Tingling? Yes / No. **If Yes, Where?** _____

Weakness in the arm/leg: Yes / No _____ **Balance Problems:** Yes / No _____

Bladder Incontinence: Yes / No _____ **Uncontrolled Bowel :** Yes / No _____

Joint Swelling/Stiffness: Yes / No _____ **Fever/Chills :** Yes / No _____

Additional Comments: _____

Please mark all treatments you have used to relief pain: ☑

Activity	Increases	Decreases	No Change
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐

Other: _____

INTERVENTIONAL PAIN TREATMENT HISTORY

Please mark all treatments you have received for pain relief: ☑

☐ Epidural Steroid Injection – Cervical/Thoracic/Lumbar _____ Relieved Pain? Yes / No
☐ Joint Injection – Joint(s) _____ Relieved Pain? Yes / No
☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar Relieved Pain? Yes / No
☐ MILD (Minimally Invasive Lumbar Decompression) _____ Relieved Pain? Yes / No
☐ Nerve Blocks – Area/Nerve(s) _____ Relieved Pain? Yes / No
☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar Relieved Pain? Yes / No
☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____ Relieved Pain? Yes / No
☐ Trigger Point Injections – Where? _____ Relieved Pain? Yes / No
☐ Vertebroplasty/Kyphoplasty – Level(s) _____ Relieved Pain? Yes / No
☐ Other _____ Relieved Pain? Yes / No

DIAGNOSTIC TESTS AND IMAGING

Please 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

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 _____

Name(s): _____