The Pain Center, LLC

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PATIENT INTAKE FORM

To your first visit, please bring this form, your health insurance card, medication card, photo identification and a list of all medications. Thank you

Name: _____ Age: _____ Sex: _____ Date: _____

Pharmacy: _____ Email: _____

Do you want to access your medical records electronically? Yes or No

Do you take any blood thinners (ie: aspirin, clopidogrel (Plavix), warfarin (Coumadin), etc)? Yes or No

Who prescribes this & office phone number _____

Where is your pain located?

_____

_____

_____

How long have you had this pain? _____

Did one event cause the pain? Yes or No If yes, what? _____

Date of accident/injury, if applicable _____

Any lawsuits/liability claims related to accident/injury? Yes or No

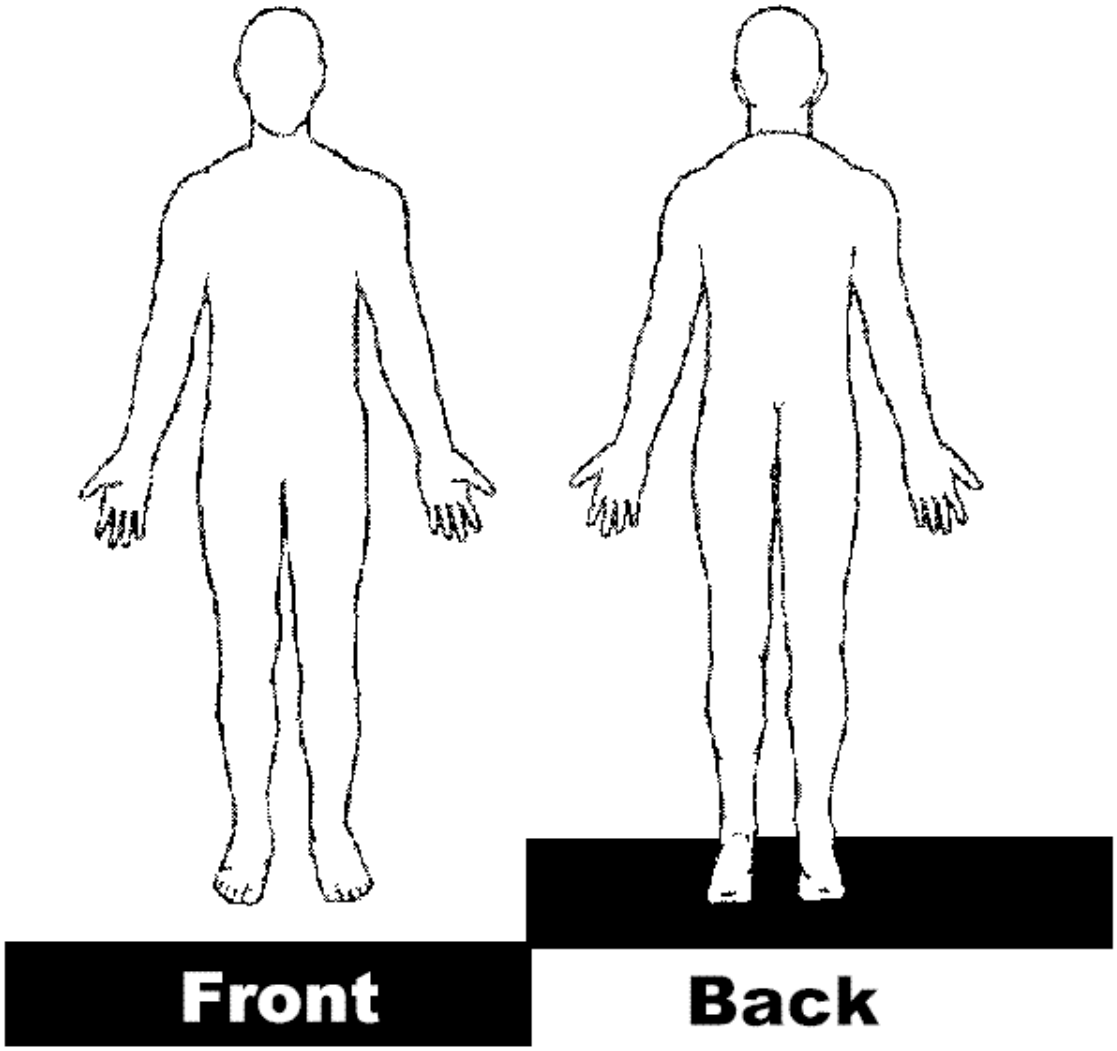
Do you have a lawyer? Yes or No

Quality of Pain:

( ) Aching	( ) Shooting	( ) Non-Descriptive
( ) Burning	( ) Variable	
( ) Sharp	( ) Throbbing	
( ) Dull	( ) Pins and Needles	

Is the pain Constant or Intermittent? _____

Location of pain: Please mark the area with a circle or X



Neurological Changes: ( ) Weakness _____ Constant or Intermittent

( ) Numbness _____ Constant or Intermittent

( ) Other _____ Constant or Intermittent

Frequent Stumbling? Yes or No

Frequent Falls? Yes or No

Since pain began, is it Better, Worse, or Same? _____

What makes the pain better? _____

What makes the pain worse? ( ) Lying Down ( ) Travel ( ) Sitting ( ) Straightening Up

( ) Lifting ( ) Bending ( ) Walking

( ) Cough/Sneeze ( ) Turning ( ) Mental Stress

( ) Standing ( ) Twisting ( ) Any Activity

Do you hurt more in the Morning or Night or are they Equal? _____

What is your pain score (0-10): Now _____ Best level _____ Worst level _____ Average _____

Does pain prevent you from falling asleep? Yes or No

Do you have trouble sleeping? Yes or No Total number of hours sleep per night _____

Do you awaken frequently at night? Yes or No How many times a night? _____

Years of Education Completed: ( ) <5 years ( ) 6-9 years ( ) 10-12 years ( ) >12 years

Have you tried any of the following medications? Please list.

NSAIDs (i.e.: ibuprofen, meloxicam) _____

Muscle Relaxers _____

Narcotics _____

Benzodiazepines (i.e.: Xanax, valium) _____

Antidepressants _____

Other _____

Lyrica (pregabalin) or Neurontin (gabapentin) _____

Have you tried any of the following? If so, please list when, how long treatment was tried, & if it was helpful.

Chiropractor_____

Tens _____

Psychiatric/Counseling _____

Physical Therapy _____

Injections/Interventions/Procedures _____

Have you been seen by another pain physician? Yes or No If you have, who? _____

_____

Have you had any of the following tests? If so, please list approximate date & facility where done. List what area of the body this was done on (ie: neck, low back).

CT _____

MRI _____

X-ray _____

EMG/NCV (electromyography/nerve conduction) _____

Other _____

Medication Allergies: _____

Do you have or have you ever had any of the following:

- Lung Disorder: _____

  Asthma ( ) COPD ( ) Do you use oxygen? Yes or No

- Bleeding Problem or Blood Disorder: _____

- Endocrine Disorder: _____

  Diabetes ( ) Type? I or II Do you use insulin? Yes or No

  Thyroid ( ) Low or High

- Heart Problems: _____

  ( ) Valve Disease ( ) Heart Attack

  ( ) Coronary Artery Disease ( ) Congestive Heart Failure

  ( ) High Blood Pressure

- Neurological Disorder: _____

  ( ) Seizure ( ) Stroke (CVA) ( ) Mini – Stroke (TIA)

- Kidney (Renal) Problems: _____

- Liver Problems: _____

  ( ) Cirrhosis ( ) Hepatitis _____

  If Hepatitis C, have you received treatment? _____

Do you have or have you ever had any of the following:

- Gastrointestinal Disorders: _____
- Cancer: _____
- Other: _____

Is your Mother still living? Yes or No; Age _____

Is your Father still living? Yes or No; Age _____

Please list medical history for the following:

Mother _____

Father _____

What medications, strength, & doses do you take? (Prescribed & over-the-counter)

_____

_____

_____

_____

_____

_____

_____

_____

List All Surgeries:

_____

_____

_____

_____

Do you experience any of the following?

( ) Shortness of Breath (with or without activity)	( ) Cough	( ) Chest Pain
( ) Shortness of breath when lying down	( ) Abdominal Pain	( ) Nausea and/or Vomiting
( ) Rectal Bleeding	( ) Paralysis	( ) Muscle Weakness
( ) Fainting	( ) Numbness/Tingling	( ) Painful urination
( ) Frequent urination	( ) Urinary Hesitancy	( ) Sexual Dysfunction
( ) Sleep Apnea	( ) Snoring	( ) Other _____

Do you have any physical limitations? _____

Do you have any language barriers? _____

Have you had any recent unexplained weight loss? Yes or No

WOMEN: Are you pregnant? Yes or No Date of last period? _____

Social History:

Alcohol Use: Yes or No How much? _____

Tobacco Use/Cigarettes/Chew/Pipe: Yes or No How much? _____

Do you use a vapor pen/electronic cigarette? Yes or No With Nicotine: Yes or No

Present or past (circle one) history of substance abuse? Yes or No

If yes, what drug(s) _____

Do you live in an abusive environment Yes or No (for any signs of abuse, we are required to notify social services)

Occupation: _____

Time at Present Job: _____

Last time at Work: _____

Are you on disability? Yes or No

Current weight _____ Height _____