RESTORATIVE PAIN CARE

NEW PATIENT INTAKE FORM

Today's Date: _____

Patient's Name
Last: _____ First: _____ **DOB:** _____

Referring Physician: _____ **Primary Care Physician:** _____

How did you hear about us? (Check One) ____ Family ____ Friend ____ Internet ____ Other

Current Employment Status: (Please Check One)

____ Full Time ____ Part Time ____ Unemployed ____ Retired ____ Disability

Occupation: _____ **Name of Employer:** _____

Employer Address: _____

Employer Phone Number: _____

What is the main problem for which you are seeking treatment?

How long have you had your current problem? _____ Years _____ Months _____ Weeks

How did your current pain problem start? _____

Is your pain due to: (Check one) ____ Work Injury ____ Non-work Injury ____ Motor vehicle accident ____ Illness, non-injury.

ACCIDENT INFORMATION-COMPLETE ONLY IF VISIT DUE TO AN ACCIDENT
(Please give your insurance card to the receptionist)

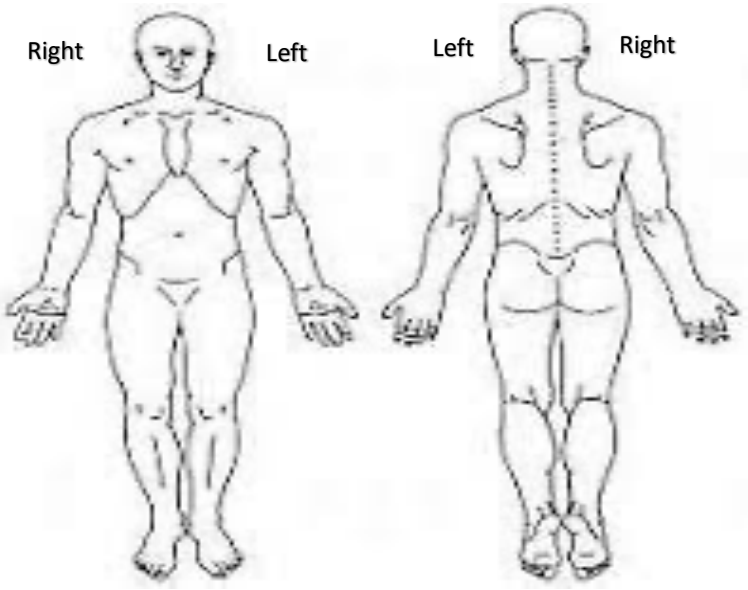
Workers Comp: _____
Auto Insurance: _____
Policy # _____ **Claim #** _____

Date of Injury: _____ **State the accident/injury occurred in:** _____

Adjuster Name: _____ Phone: _____ Fax: _____

Attorney Name: _____ Phone: _____ Fax: _____

Pain Location: Please mark the location(s) of your pain on the diagram below with an "x". If whole areas are painful, please shade in these areas.



How severe is your pain? In general, the intensity of my pain has been **(Check One)**
____ Mild ____ Moderate ____ Moderate-Severe ____ Severe

How often do you have your pain? (Check One)

____ Constantly (100% of the time) ____ Near Constantly (60% to 95% of the time)

____ Intermittently (30% to 60% of the time) ____ Occasionally (less than 30% of the time)

How would you describe your pain? (Check all that apply)

____ Dull ____ Sharp ____ Aching ____ Burning ____ Cramping ____ Throbbing ____ Stabbing

____ Shooting ____ Electric/Shock-like

I feel the following associated with my pain: ____ Numbness ____ Pins/Needles ____ N/A

Do you have any weakness? ____ Yes **(Check below)** ____ No

Where is your weakness located?
____ Upper extremities
____ Lower extremities
____ Dropping objects
____ Falling
____ Loss of bladder or bowel control, if so please explain_____
____ Other:_____

How do the following affect your pain level? (Please Check one for each item)

	Decrease	No Change	Increase
Lying Down			
Standing			
Sitting			
Walking			
Exercise			
Relaxation			
Bowel Movement			
Coughing/Sneezing			

Does your pain limit your ability to walk? ____Yes ____No
How long can you sit? ____ 0-15 min. ____16-30 min. ____31-45 min. ____>= 1 Hr.
How long can you stand? ____ 0-15 min. ____16-30 min. ____31-45 min. ____>= 1 Hr.
To assist with walking, I use a: ____Cane ____Walker ____Wheelchair ____No assistance

Which of the following daily activities are you **NOT able** to perform? **(Check all that apply)**

____Going to work ____Performing household chores ____Doing yard work ____Shopping

____Socializing with friends ____Recreational activities

Previous Pain Treatment: (Please check all that apply)

____Surgery ____Nerve block/injection ____Epidural steroid injection
____Exercise ____TENS ____Heat treatment ____Ice treatment ____Physical Therapy
____Psychotherapy ____Biotherapy
____Chiropractic manipulation ____Brace/Traction

Medications: Please list ALL current prescription medications:

Medication Name	Dose	Frequency

If medication list doesn't fit in this table, please list the others on the back of this sheet.

Pharmacy Name, Location, and Phone Number:

_____

Medication Allergies: Please indicate the names of any medication to which you are allergic: _____

What type of reaction did you have?

_____

Are you allergic to contrast dye used for X-ray? ____Yes ____No

Prior Medications: (Please Check all that apply)

Opioids	**Anti-Depressants**	**Muscle Relaxants**
Hydrocodone (Norco)	Prozac	Soma
Oxycodone (Percocet)	Zoloft	Skelaxin
Oxycontin/Xtampza	Effexor	Flexeril (Cyclobenzaprine)
Morphine/Morphine ER	Pristiq	Zanaflex (Tizanidine)
Dilaudid/Exalgo	Wellbutrin	Robaxin
Fentanyl	Paxil	
Methadone		
Tramadol		
Nucynta		

All other medications: (Please Check al that apply)

NSAIDS/Tylenol	**Anti-Anxiety**	**Nerve Pain**
Tylenol	Clonazepam/Klonopin	Gabapentin/Neurontin
Aspirin	Alprazolam/Xanax	Pregabalin/Lyrica
Ibuprofen/Motrin	Diazepam/Valium	Amitriptyline
Naproxen/Aleve	Lorazepam/Ativan	Cymbalta
Indocin		Topiramate/Topamax
Celebrex		Oxcarbazepine/Trileptal
Toradol		Carbamazepine/Tegretol
Meloxicam/Mobic		

Diclofenac		

Past Medical History: Check all that apply

____Hypertension ____Coronary artery disease ____Angina/Chest Pain ____Heart Attack

____Diabetes ____Asthma/Wheezing ____Emphysema/COPD ____Kidney disease

____Liver disease ____Stroke ____Seizure/Epilpesy ____Bleeding disorder

____Depression ____Anxiety ____Thyroid disease ____HIV ____Hepatitis C

____Arthritis - specify location: _____

____Cancer – specify location: _____

____Other: specify: _____

Past Surgical History: Please list the approximate date and surgery:

_____
_____
_____

Family History: Please specify any medical or psychiatric conditions common in your family who suffers with these ailments:

_____
_____
_____

Social History:

Have you ever been a smoker? ____Yes ____No If Yes, how many cigarettes/day? How many years did you smoke? Tobacco use? (Circle one) Light / Moderate / Heavy
Do you drink alcohol? ____Yes ____No If yes, how many drinks/week? Do you have a history of alcoholism? ____Yes ____No ____Current problem
Have you ever abused prescription drugs? ____Yes ____No ____Current problem
Any history of Cocaine or IV substance abuse? ____Yes ____No ____Current problem

Psychological Treatment:

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem, including pain?

____Yes, treated for? _____ ____No

Have you ever considered/planned/attempted suicide? ____Yes ____No

If so, when? _____

Sleep Disturbances:

Do you have difficulty sleeping? ____Yes ____No

Do you snore? ____Yes ____No

Are you tired upon awakening? ____Yes ____No

Review of Systems: Please check all items you feel are applicable to you:

___Fever ____Chills ____Recent infections

____Easy/excessive bruising ___Easy/excessive bleeding

____Urinary/bladder incontinence ____Bowel incontinence ____Nausea ____Vomiting

____Constipation ____Diarrhea ____Weight loss ____Night sweats

____Rashes ____Muscle weakness ____Joint stiffness ____Swelling