PAIN MANAGEMENT INSTITUTE

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NEW PATIENT INTAKE INFORMATION

Patient Name: _____ Date of Birth: _____

Date of Birth: _____ Age: _____ Sex: ☐Male ☐Female

Pain Complaint: _____

Approximately when did this pain begin? _____

Is your pain the result of a ☐ Work Comp Injury ☐ Auto Injury ☐ Personal Injury

Are you involved in litigation regarding this pain? ☐ Yes ☐No Have you ever been on disability ☐ Yes ☐No

Are you working now? ☐ Yes ☐No Last date of work? _____What kind of work do you do?_____

Check all of the following that best describes your pain:

☐ Aching	☐ Hot/Burning	☐ Shooting	☐ Stabbing/Sharp
☐ Cramping	☐ Numbness	☐ Spasming	☐ Throbbing
☐ Dull	☐ Shock-like	☐ Squeezing	☐ Tiring/Exhausting
☐ Tingling/Pins and Needles		☐ Other: _____	

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain at its worst? ☐ Mornings ☐ During the day ☐Evenings ☐Middle of the night

Other: _____

How many minutes can you walk until you must stop due to pain? _____

What Specific activities is the pain preventing you from doing? _____

_____

My Pain is improved by ☐ Sitting ☐ Standing ☐ Laying down ☐Flexion (bending forward) ☐ Extension (bending back)

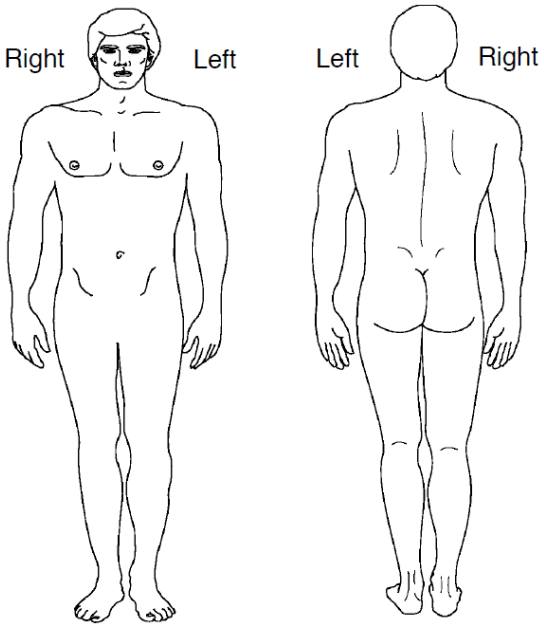
List Doctors you have seen & City:

_____

_____

_____

Use this diagram to indicate areas where you have your pain.



Pain Intensity:
Please use the pain scale described below to rate your pain for the questions below:

No pain ⟵ 0 — 5 — 10 ⟶ Worst pain possible

_____ What number on the pain scale (0-10) best describes your pain right now?

_____ What number on the pain scale (0-10) best describes your pain most of the time?

_____ What number on the pain scale (0-10) best describes your worst pain?

_____ What number on the pain scale (0-10) best describes your least pain?

Mark all of the following diagnostic tests you have had that are related to your current pain complaints.

☐ MRI of the _____ Date: _____ Facility: _____

☐ X-ray of the _____ Date: _____ Facility: _____

☐ CT scan of the _____ Date: _____ Facility: _____

☐ EMG/NCV study of the _____ Date: _____ Facility: _____

☐ Other diagnostic testing _____

Mark all of the following pain treatments you have undergone prior to today's visit:

☐ Chiropractic ☐ Physical Therapy ☐ Massage ☐ Acupuncture ☐ Spine Surgery ☐Psychological Therapy

☐ Discogram – (Circle all levels that apply) Cervical / Thoracic / Lumbar

☐ Epidural Steriod Injection - (Circle all levels that apply) Cervical / Thoracic / Lumbar

☐ Joint Injections – Joint(s) _____

☐ Medical Branch Blocks or Facet Injections – (Circle all levels that apply) Cervical / Thoracic / Lumbar

☐ Nerve Blocks – Area/Nerve(s) _____

☐ Radiofrequency Ablation - (Circle all levels that apply) Cervical / Thoracic / Lumbar

☐ Spinal Stimulator - (Circle one) Trial Only / Permanent Implant

☐ Trigger Point Injection – Where? _____

☐ Vertebroplasty / Kyphoplasty – Level(s)? _____

☐ Other: _____

PAST MEDICAL HISTORY

Do you currently or have you ever had any of the following?

	YES	NO		YES	NO			
Heart Murmur	☐	☐	Shortness of breath	☐	☐	Gastritis or ulcers	☐	☐
Palpitations	☐	☐	Bronchitis	☐	☐	Hital Hernia	☐	☐
Heart Attack	☐	☐	TB	☐	☐	Thyroid Disease	☐	☐
Stroke	☐	☐	Asthma	☐	☐	Diabetes	☐	☐
Irregular Heart Beat	☐	☐	Emphysema	☐	☐	Kidney Problems	☐	☐
High Blood Pressure	☐	☐	Sleep Disturbance	☐	☐	Liver Disease	☐	☐
Angina (Chest Pain)	☐	☐	Sleep Apnea	☐	☐	Difficulty Urinating	☐	☐
Seizures	☐	☐	Migraine Headaches	☐	☐	Hepatitis	☐	☐
Arthritis	☐	☐	Weight Change	☐	☐	HIV or exposure	☐	☐
Cancer (if yes, please explain)	☐	☐				(Others that are not listed, please explain)		

_____

_____

_____

_____

PAST SURGICAL HISTORY

Please list any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

ALLERGIES:

Do you have any known drug allergies? ☐Yes ☐ No

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

Medication Name	Allergic Reaction Type

Are you allergic to ☐ Iodine ☐ Latex ☐ Tape ☐Shellfish ☐Eggs ☐ Sulfa

CURRENT MEDICATIONS:
Please list ALL medications you are currently taking, include dosage and the name of doctor prescribing.

Medication Name	Dose/Strength	Frequency Taken	Ordering Physician

PSYCHIATRIC HISTORY:
Are you currently seeing a psychiatrist or psychologist? ☐ Yes ☐No

If yes, whom? _____

Have you had any recent thoughts or ideations of suicide or harming others? ☐ Yes ☐No

SOCIAL HISTORY:
What is your occupation _____

What is your current work status _____

Do you smoke? ☐ Yes ☐No If yes, what and how much? _____

Do you drink alcohol? ☐ Yes ☐No If yes, what and how much? _____

Do you take Street drugs? ☐ Yes ☐No If yes, what and how much? _____

Have you ever abused narcotic or prescription medications? ☐ Yes ☐No If yes, what? _____

I certify that the above information is accurate, complete and true.

_____ _____
Patient's Signature Date