New Patient Intake Form

Name: _____ **Date:** _____

Referring Physician _____

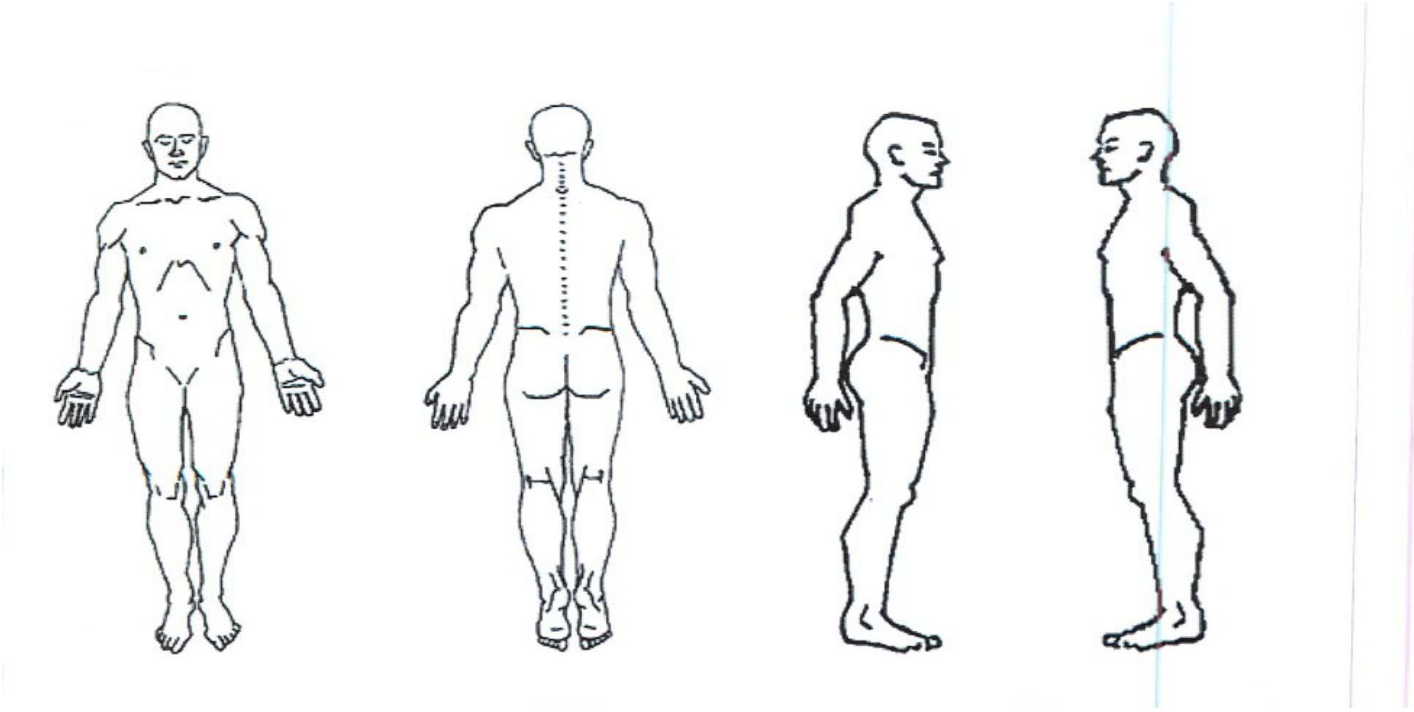
Primary Care Physician _____

Please List All Current Medications

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you take Coumadin/Warfarin/Plavix/Lovonox or Aspirin? Yes_____ No_____ Last dose?_____

Please shade in the areas where you have pain



Characteristics of your pain

Pain Intensity (0 no pain, 10 worst pain ever)
Please list number that best describes you pain

Average Pain _____
Worse Pain _____
With Activity _____

Associated Systems please circle if applies to you

I do not have any other symptoms
Fatigue
Loss of bowel/bladder control
Nausea
Numbness
Tingling, burning, or pricking feeling
Spasm
Weakness

Circle activities that make pain worse

All Activities
Bending Forward
Exertion/Exercise
Getting out of chair
Lifting
Lying Down
Moderate Physical activity
Nonspecific activity
Position Change
Reaching
Significant Physical Activity
Sitting
Standing
Turning the Head
Twisting
Walking
Other _____

Circle things activities that make pain better

None
Bending Forward
Injections
Lying down
Medications
Moving
Position Change
Physical Activity
Procedures
Rest
Sitting
Standing
Other _____

Circle the qualities of your pain

Aching
Burning
Dull
Sharp
Shooting
Stabbing
Throbbing
Pressure
Crushing
Cramping
Spasmodic
Pulling
Tender
Tight
Knife like
Hot
Sore

Circle the duration of your pain

Constant
Intermittent

If you are allergic to anything please list below:

Circle any conditions you have

Headaches
Migraines
Seasonal Allergies
Sinusitis

Angina
Arrhythmia
Coronary Artery Disease
Deep Venous Thrombosis
High Blood Pressure
High Cholesterol
Past Heart Attack
Mitral Valve Prolapse
Heart Murmur
Pacemaker
Peripheral Vascular Disease

Asthma
COPD
Obstructive Sleep Apnea

Gallstones
GERD
GI Bleed
Hiatal Hernia
Irritable Bowel Syndrome
Pancreatitis
Ulcers

Enlarged Prostate
Frequent Bladder Infections
Kidney Stones
Renal Failure
Renal Insufficiency

Diabetes
Obesity
Thyroid Disease

Anemia
Bleeding Disorder
Transfusions

Hepatitis
HIV
Shingles

Stroke
Parkinson's Disease
Seizure Disorder
TIA

ADD
Anxiety
Bi-polar Disorder
Dementia
Depression
Schizophrenia

Bladder Cancer
Breast Cancer
Colon Cancer
Lung Cancer
Melanoma
Prostate Cancer

Back Pain
Connective Tissue Disorder
Fibromyalgia
Kyphoscoliosis
Osteoarthritis
Osteoporosis
Rheumatoid arthritis
Scoliosis

List all past surgeries followed by approximate dates

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____
8. _____ _____
9. _____ _____
10. _____ _____

Circle Prior Treatments

	X if it was helpful	Details
Acupuncture	_____	_____
Biofeedback Relaxation Therapy	_____	_____
Botox Injections	_____	_____
Chiropractic	_____	_____
Heat	_____	_____
Home Exercise	_____	_____
Ice	_____	_____
Massage	_____	_____
Minimally Invasive Procedures	_____	_____
Occupational Therapy	_____	_____
Physical Therapy	_____	_____
Surgery	_____	_____
TENS	_____	_____

Circle all medications taken for your pain in the past

	X if it helped	Details
NSAIDS	_____	_____
Celebrex	_____	_____
Diclofenac	_____	_____
Flector Patch	_____	_____
Ibuprofen	_____	_____
Mobic	_____	_____
Nabumetone	_____	_____
Naproxen	_____	_____
Voltaren gel	_____	_____
Flexeril	_____	_____
Skelaxin	_____	_____
Soma	_____	_____
Zanaflex	_____	_____
Actiq	_____	_____
Hydrocodone	_____	_____
Hydromorphine	_____	_____
Percocet	_____	_____
Duragesic	_____	_____
Methadone	_____	_____
Morphine	_____	_____
Oxycontin	_____	_____
Oxymorphine	_____	_____
Cymbalta	_____	_____
Lyrica	_____	_____
Neurontin	_____	_____
Savellla	_____	_____
Topamax	_____	_____
Trileptal	_____	_____
Lidoderm Patch	_____	_____
Tramadol	_____	_____
Tylenol	_____	_____
Blood thinners	_____	_____
Other Medications	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle what applies

Single
Married
Domestic Partner
Widowed
Separated
Divorced

Number of Children _____
Ages of Children _____

Retired
Disabled
Unemployed
Self-employed
Employed Part Time
Employed Full Time
Current Occupation _____
Previous Occupation _____

Circle Highest Level of Education
Elementary Education
Some High School
High School Diploma
GED
Some College
College Degree
Master's Degree
Doctorate Degree

Currently smoke every day
Currently smoke some days
Former Smoker
Never Smoker
Cigarettes Packs per day _____
Cigars per day _____
Pipe times per day _____
Chew cans per day _____
Total years _____

No Alcohol Use
Rarely Use Alcohol
Socially Use Alcohol
Daily Use Alcohol
Details _____

I do not use recreational drugs
I use Marijuana
I use Cocaine
I use Heroin
I use Morphine
I use Methamphetamines
I use LSD
I use Mushrooms
I use Ecstasy
I use _____

I never exercise
I exercise 1-2 times per week
I exercise 3-5 times per week
I exercise 6-7 times per week
Type of Exercise I do:
Aerobics
Biking
Running
Hiking
Swimming
Climbing
Treadmill/Elliptical
Walking
Weight Lifting
Other _____

Family History place an X if this relative has the following:

	Father	Mother	Sister	Brother	Other
Arthritis	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____	_____
Coronary Artery Disease	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Congestive Heart Failure	_____	_____	_____	_____	_____
COPD	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Irritable Bowel Syndrome	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Heart Attack	_____	_____	_____	_____	_____
Peripheral Artery Disease	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____
Other					
_____	_____	_____	_____	_____	_____

Circle if you have the following

Depression Describe:_____
Anxiety Describe:_____
Psychosis Describe:_____

Circle what applies

I am currently not in treatment
I am currently seeing a psychiatrist
I am currently seeing a psychologist

I have had thoughts of suicide
I have not had thoughts of suicide

I am coping well with my chronic pain
I am frustrated with my chronic pain

Circle all that apply to you:

Fever
Chills
Fatigue
Poor Appetite
Weight Gain
Weight Loss

Hearing Loss
Sore Throat
Blurred Vision
Decreased Vision

Shortness of Breath
Wheezing
Cough

Chest Pain
Irregular Heart Beats
Swelling in Leg

Rash
Itching
Lesions
Bruise Easily

Joint Pain
Joint Swelling
Stiffness
Weakness

Abdominal Pain
Nausea
Vomiting
Diarrhea
Heartburn
Constipation

Sexual Problems
Problems Urinating

Headache
Dizziness
Loss of Consciousness
Weakness
Numbness
Tingling

Depression
Anxiety