New Patient Intake – Pain Management

Patient's Name: ____ **DOB:** ________________________

Chief Complaint (Reason for Visit): ____

Where is the exact location of your pain today? ____

When did the pain first begin? ____

Is the pain constant? ☐ Yes | ☐ No How long does it last? ____

Have you been treated by a previous Pain Specialist? ☐ Yes | ☐ No

If Yes, When? _________________________ By who? _________________________

Who is your Primary Care Provider? ____

What previous treatments have you tried for this pain?____

Have you tired physical therapy? ☐ Yes | ☐ No If Yes, When? _________________________________

Rate your pain:

Pain Scale: (0 = No pain and 10 = Unbearable pain)

Rate your pain, as you feel right now: 0☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7☐ 8 ☐ 9 ☐ 10 ☐

☐ I am currently not taking any pain medications

With medication: 0☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7☐ 8 ☐ 9 ☐ 10 ☐

Without medication: 0☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7☐ 8 ☐ 9 ☐ 10 ☐

Pain Quality:

Improved comfort with pain medications? ☐ Yes | ☐ No Improved function with pain medications? ☐ Yes | ☐ No

Taking your medications as directed? ☐ Yes | ☐ No If no, please explain:_______________________________________

Able to care for yourself? ☐ Yes | ☐ No Able to care for your family? ☐ Yes | ☐ No Able to work? ☐ Yes | ☐ No

Pain Description:

Describe your pain (Check all that apply):

☐Sharp ☐Burning ☐Throbbing ☐Shooting ☐Aching ☐Cramping ☐Crushing ☐Electric ☐Other: _____________

What makes you pain worse (Check all that apply):

☐Medications ☐Sitting ☐Standing ☐Ice/Heat ☐Walking ☐Twisting ☐Bending ☐Lying Down ☐Exercise ☐Rest

What makes you pain better (Check all that apply):

☐Medications ☐Sitting ☐Standing ☐Ice / Heat ☐Walking ☐Twisting ☐Bending ☐Lying Down ☐Exercise ☐Rest

Allergies (Please list all medication/drug allergies with the reaction):

Name of Medication:	Reaction:

Current Medication (Please list all the medications you are currently taking):

Name of Medication	Dose	Directions	What is it for?	Who prescribes it?

Are you taking anything for anxiety or depression from another physician? Example: Valium or Xanax? ☐Yes | ☐No
If yes, please provide physician name and medication: ____

What medications have you tried in the past for your pain?

____

Preferred Pharmacy: ☐Advanced Rx ☐Other: ____

***Advanced Rx pick up or mail next day available (Shipping and Handling included). ***

Have you had any imaging? (Please list dates, type of imaging, body part and facility)

Date	Type of Imaging	Body Part	Imaging Facility

Family Medical History:

Has your mother ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other____________________

Has your father ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____________________

Have any of your siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____________________

Have any of your children ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____________________

Has your mother's parents ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____________________

Has your mother's siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____________________

Has your father's parents ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____________________

Has your father's siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____________________

Any other family history and relation to you:____

Please Provider Your Past Medical Conditions/Diagnosis

Condition/Diagnosis	Details	Treating Physician

Any additional details:

____

____

Please Provider Your Past Surgical History

Date of Surgery	Type of Surgery	Hospital	Performed By

Hospitalization other than surgery (include dates):____

____

Social History

Any tobacco use? ☐ Yes | ☐ No | ☐ Prior Use

If yes, packs per day __________ for _____________ years. If prior user, year quit? ___________________

Any alcohol use? ☐ Yes | ☐ No

If yes, drinks per day __________ for _____________ years.

Any recreational drug use? ☐ Yes | ☐ No Drugs Used____

Review of Systems:

Constitutional	Y	N
Fever		
Chills		
Night Sweats		
Weight Loss		
Weight Gain		
Change in Appetite		
Fatigue		
Somnolence		

Respiratory	Y	N
Cough		
Wheezing		
Snoring		
Shortness of Breath		

Genitourinary	Y	N
Pelvic Pain		
Burning w/ Urination		
Frequent Urination		
Urgent Urination		
Blood in Urine		
Incomplete Bladder Empting		
Urine Incontinence		

Neurologic	Y	N
Headache		
Muscle Weakness		
Numbness		
Coldness		
Crawling or Prickling Sensation		
Memory Loss		
Seizure		
Dizziness		

HEENT	Y	N
Vision Loss		
Blurred Vision		
Double Vision		
Eye Pain		
Ear Pain		
Hearing Loss		
Ear Ringing		
Nasal Bleeding		
Nasal Discharge		
Neck Pain		

Musculoskeletal	Y	N
Bone Pain		
Joint Pain		
Joint Swelling		
Muscle Pain		

Psychiatric	Y	N
Anxiety		
Sadness		
Irritability		
Insomnia		
Suicidal Thoughts		

Hematologic or Lymphatic	Y	N
Lymph Node Enlarged		
Easy Bleeding		
Easy Bruising		

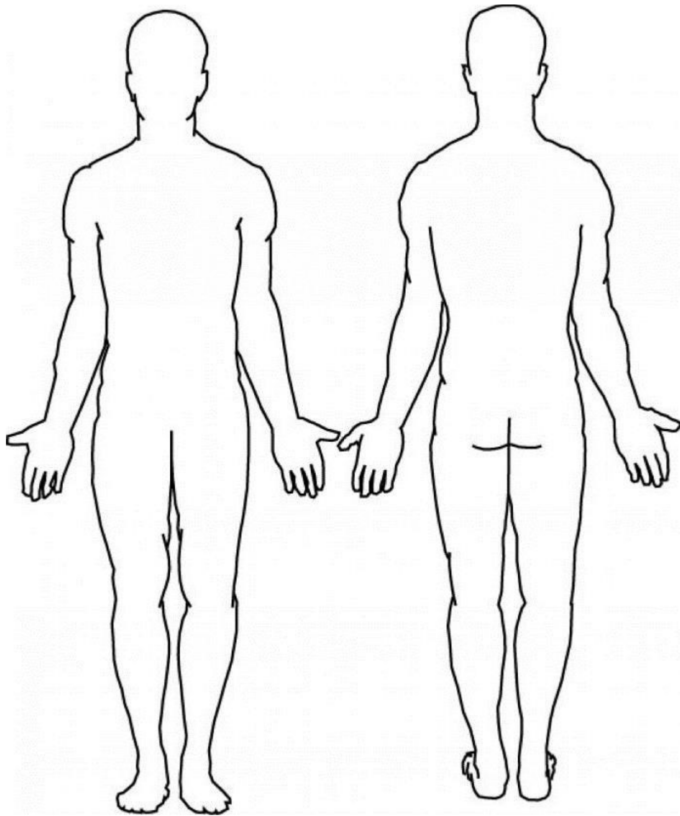
Cardiovascular	Y	N
Chest Pain		
Palpitations		
Leg Swelling		
Leg Pain		

Gastrointestinal	Y	N
Nausea		
Vomiting		
Diarrhea		
Constipation		
Stool Incontinence		
Abdominal Pain		

Skin	Y	N
New Rashes or Moles		
Non-healing Scores		
Hives		
Skin Itchy		
Hair Loss		

Endocrine	Y	N
Heat or Cold Intolerance		
Excessive Thirst		
Excessive Hunger		

Please shade your area(s) of pain



Patient Signature: ____ **Employee's Initials**: ______**Provider's Initials**:______