ADVANCED PAIN CARE

Pain Management New Patient Intake

Patient Name: ___________________________ **DOB:** ______________________

Reason for Visit: ____

Location of Pain: ____

Date of Onset: ____

Check all that apply

Quality: aching burning gnawing stabbing throbbing sharp dull

superficial deep occasional frequent constant worsening

improving no change Other: ________________________

____

Pain Severity: Current pain level _____ / 10 Pain level with medication ______ /10

Pain level without medication _____ / 10

____

Context/Inciting Incident: fall or accident injury MVA Other: __________________

____

Alleviating factors: sitting standing lying down position change heat ice rest

elevation exercise stretching physical therapy chiropractic care medication

brace Other: _______________________

____

Aggravating factors: sitting standing lying down walking lifting carrying

twisting pushing/pulling gripping grasping squeezing throwing

weightbearing exercise cold weather damp weather Other: _______________________

____

Previous Pain Management Procedures/ Injections? Yes No

If yes, please list (with dates): ____

____

Were they helpful? Yes No If no, why? ____

Previous Physical Therapy: None If yes, Date/ Facility/ Body part: ____

Was Physical Therapy helpful? Yes No

Are you working? No Regular duty Modified duty

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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 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

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Please Provider Your Past Medical Conditions/Diagnosis

Condition/Diagnosis	Details	Treating Physician

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____

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:____

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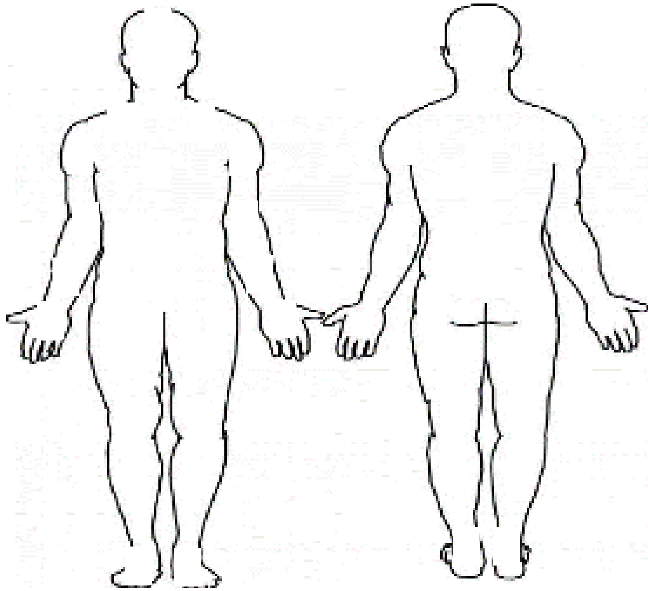
Please check your area(s) of pain.



Patient Signature:________________________________**Employee's Initials**: _________ **Provider's Initials**:_________