Interventional Pain Wellness Center

New Patient Intake Form

Name: _____Cell Number_____Email Address_____

Primary Care Physician (PCP) Name: _____ Contact information: _____
Referring Physician Name: _____ Contact information: _____
Preferred Pharmacy: _____
What is your primary Insurance? _____ **Secondary Insurance**: _____
Does your visit involve workman's compensation? YES NO
Does your visit involve Auto Insurance? YES NO
If involved in either a workman's compensation or Auto Insurance please put your adjusters information below: _____

Have you ever seen a pain physician? If so: Who? When? Where? Why? _____

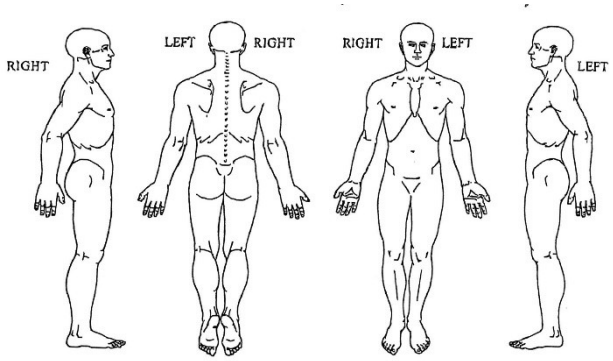
Reason for today's visit _____

Onset: When did your pain Start? (Days, weeks, months, years) _____

Pain is related to? Accident Fall Sports Injury Surgery Unknown

Have you had any loss of bowel or bladder control? YES NO

Where is your Pain (Circle on chart)? _____



Describe your Pain (circle one)
Aching Cramping Dull Sore Stiffness Swelling Tender Throbbing
Burning Numbness Pins/Needles Sharp Shooting Stabbing Weakness

Rate your pain (0 is no pain, 10 is worst):
WORST: 0 1 2 3 4 5 6 7 8 9 10
LEAST: 0 1 2 3 4 5 6 7 8 9 10
AVERAGE: 0 1 2 3 4 5 6 7 8 9 10

What makes the pain worse?
Sitting Standing Leaning backward Laying down Walking Exercise Lifting Weather Other _____

What makes the pain better?
Heat Ice Massage Brace Medication

Does your pain affect your Daily Activities? YES NO
Does your pain affect your sleep? YES NO
Does your pain affect your mood or anxiety? YES NO

What medications have you tried in the past?
Topical: Bengay Diclofenac/Voltaren Gel Flector Patch Lidocaine ointment/Gel/patch

Over the Counter: Tylenol Ibuprofen/Motrin Celecoxib/Celebrex Diclofenac Naproxen/Aleve Meloxicam/Mobic

Muscle relaxants: Baclofen Carisoprodol/Soma Cyclobenzaprine/Flexeril Diazepam/Valium Methocarbamol/Robaxin Tizanidine/Zanaflex

Neuropathic agents: Amitriptyline/Elavil Desipramine/Norpramin Duloxetine/Cymbalta cGabapentin/Neurontin Gabapentin Extended Release/ Gralise Lamotrigine/Lamictal Levitiracetam/Keppra Nortriptyline/Pamelor Paroxetine/Paxil Phenytoin/Dilantin Pregabalin/Lyrica Sertraline/Zoloft Topiramate/Topamax Trazodone/Desyrel Valproic acid/Depakote Venlafaxine/Effexor

Sleep Aids: Trazadone/Desyrel Zolpidem/Ambien

Benzodiazapines: Clonazepam/Klonopin Diazepam/Valium Lorazepam/Ativan Temazepam/Restoril

Opiates: Fentanyl spray/patches Hydromorphone/Dilaudid Hydromorphone Extended Release/Exalgo Hydrocodone/Norco Morphine Sulfate Morphine Extended Release/MS Contin Oxycodone/Percocet Oxycodone Extended Release/Oxycontin Oxymorphone/Opana Tapentadol/Nucynta Tramadol/Ultram

Have you had any Tests?

Test	Yes/No	Date	Results
X-ray			
CT scan			
MRI			
Nerve Conduction Study			
Other			

Have you tried anything for the Pain?

Therapy	Tried	Helpful	Date of last treatment
Physical Therapy			
Water/Aqua Therapy			
Acupuncture/Yoga			
Chiropractic/Massage			
TENS unit			
Brace			
Injection (Epidural)			
Surgery			
Psychological Counseling			
Other			

Past Medical History: (circle all that apply)
General: Weight loss, Weight gain, Fever, Chills, Cancer, HIV/AIDS
Neurologic: Stroke, Seizure/Epilepsy, Bleeds, Headache, Migraines, Fainting
Psychiatric: Anxiety, Bipolar, Depression, Opiate use, Schizophrenia, , Substance use
Cardiovascular: Hypertension/Blood pressure, Cholesterol, Heart attack/failure, Abnormal rhythm, Blood clots
Respiratory: Asthma, COPD, Emphysema
Renal: Kidney disease, Dialysis use
Endocrine: Diabetes, Insulin use, Thyroid disease, Steroid use
Gastrointestinal: Acid Reflex, GERD, Gastritis, Bloody stools, Liver disease, Hepatitis
Musculoskeletal: Arthritis, Scoliosis, Back pain, Neck pain, Joint pain, Cramps, Spasms
Other: _____

Past Surgical History: (Please list all surgeries) _____
Neck or low back surgery?_____
Joint surgery? _____

Family Medical History:
Mother- _____
Father- _____

Social History:
What is your level of education? High School Bachelor Masters/Graduate Other _____
Are you currently working? YES NO Occupation? _____
What is your marital status? Single Married Divorced/Separated Other_____
What are your living arrangements? Living alone With partner With children Other_____
Do you drink alcohol? YES NO If yes, how many drinks per day and for how long? _____
How much do you smoke? Number of cigarettes per day? _____
Have you ever used any tobacco products? When was last use? _____
Do you use any illicit substances? Such as cocaine, Marijuana, LSD, Heroin, etc. YES NO

Allergies: (Please list all and the type of reaction)

_____

Pain Medications: Please list drug name, dosage and frequency (I.e. Tylenol 500mg, 3 times per day)

_____

Medications: Please list all medications you take (with drug dosage and frequency)
_____
_____

Do you take any blood thinners? (Such as Aspirin, Clopidogrel/Plavix, Warfarin/Coumadin)
YES _____ NO

Review of System (ROS):

General	Weight changes	Fever/Chills	Sweating	Other-
Neurologic	Headaches	Dizziness	Numbness	Other-
Psychiatric	Memory problems	Depressed Mood	Suicidal thoughts	Anxiety
	Stress	Delayed thinking	Fogginess	Other-
Cardiovascular	Chest pain	Irregular heart beat	Leg swelling	Other-
Respiratory	Shortness of breath	Breathing difficulty	Cough	Other-
Gastrointestinal	Nausea/Vomiting	Diarrhea	Constipation	Other-
Urinary/Sexual	Urinary retention	Loss of libido	Loss of orgasm	Other-
Musculoskeletal	Weakness	Back pain	Joint pain	Other-
Hematology	Bleeding	Bruising	Cancer	Other-
Dermatology	Skin Rash	Color Changes	Swelling	Other-