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**:_____

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

**Reason for today's visit:** _____

**Does your visit involve an accident? Work related Injury? Workman's Compensation?** YES ☐ NO ☐

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**When did your pain start?** (Days, weeks, months,years) _____

**How long have you had pain?** _____

**Is the 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?** _____

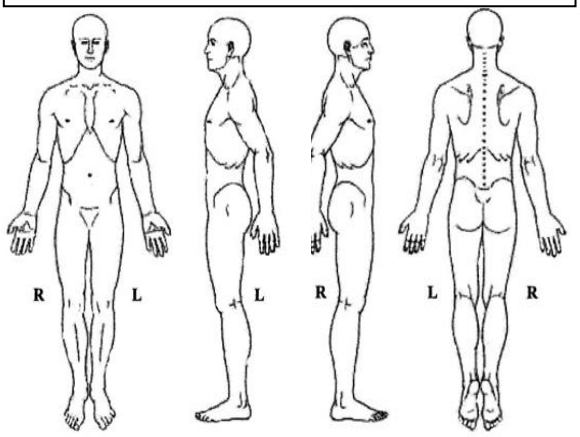
**Describe your Pain ?** _____
(Circle One)

Aching Cramping Dull Sore Stiffness Swelling Tender

Throbbing Burning Numbness Pins/Needles

Sharp Shooting Stabbing Weakness

Circle Location of Pain




**Rate your pain (0 is no pain, 10 is worst):**

LEAST: 0 1 2 3 4 5 6 7 8 9 10

WORST: 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? (Circle ALL that have been tried)

**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 Gabapentin/Neurontin Gabapentin Extended Release/ Gralise Nortriptyline/Pamelor Paroxetine/Paxil Pregabalin/Lyrica Sertraline/Zoloft Topiramate/Topamax Trazodone/Desyrel Venlafaxine/Effexor*
**Sleep Aids:** *Trazadone/Desyrel Zolpidem/Ambien*
**Benzodiazapines:** *Clonazepam/Klonopin Diazepam/Valium Lorazepam/Ativan Temazepam/Restoril*
**Opiates:** Buprenorphine/Suboxone *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 Methadone*

Have you had any Tests?

| Test | Yes or 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 | | | |

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**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:** _____

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

**Family History:**
Mother- _____ _____ Siblings-_____
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_____
Have you used any tobacco containing products? YES/NO
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: (IV contrast?)** _____ _____ _____
(Please list all and 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):** (Circle any that apply)

| | | | | |
|---|---|---|---|---|
| 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- |