NOW CARE PAIN RELIEF CENTER

Get pain relief now

Initial Visit Pain Intake Form

Date: _____

Name: _____
(First) **(Middle Initial)** **(Last)**

Address: _____

_____
(City) **(State)** **(Zip)**

Home Phone: _____

Work Phone: _____

Cell Phone:_____

How Did You Hear About Us (circle one)

Healthcare Provider TV Internet Friend/Relative Employee Other_____

Emergency Contact Name and Number

_____

Referring MD: _____

Primary Care MD_____

Other Physicians currently involved in your care: _____

Gender : M □ F □ Age: _____ **Date of Birth:** _____

Marital Status M S W D other_____

Ethnicity Not Hispanic or Latino □ Hispanic or Latino □

Race Black or African American □ White □ Asian or Pacific Islander □

American Indian or Eskimo □ Other _____

Current Medications for Pain

NAME	DOSE	FREQUENCY

My pain medications provide relief:

□ **None of the time** □ **Some of the time** □ **Most of the time** □ **All of the time**

Current Medications (OTHER THAN PAIN MEDS)

Name	Dose	Frequency

ALLERGIES: Please indicate the name of any medications to which you are allergic:

_____

What type of reactions did you have? _____

I am allergic to contrast dye used for X-rays _____ **Yes** _____ **No**

Do you take a Blood thinner ? _____**Yes** ____ **No if Yes what** _____

PAST MEDICAL HISTORY:

Have you had any of the following health problems (please check all that apply)?

□ **Hypertension**	□ **Angina or Chest pain**	□ **Seizure or Epilepsy**
□ **Heart Attack**	□ **Diabetes**	□ **Lyme's Disease**
□ **Emphysema**	□ **Kidney Disease**	□ **Hepatitis**
□ **Stroke**	□ **Bleeding Problems**	□ **Cancer – specify type** _____
□ **Depression**	□ **Anxiety**	□ **Thyroid Disease**
□ **Fibromyalgia**	□ **Arthritis**	□ **HIV/AIDS**
□ **Bipolar**	□ **Other** _____	

Past Surgical History:

Approximate Date	Type of Operation

SOCIAL HISTORY:

SLEEP: Recent change in sleep patterns: _____ Yes _____ No
Hand Dominance: Right _____ Left _____ Ambidextrous (Equal) _____

Have you ever been a smoker? □ Yes-Current □ Yes In Past □ No-Never
Alcohol: Do you drink Alcohol? □ Yes-Current □ Yes In Past □ No-Never

Employment: Your current or most recent occupation: _____

Current Employment Status: Please check one:
□ Employed Full-time □ Employed Part-time □ Not Work
If you are unemployed, is this due to your preset pain condition? □ Yes □ No
If you are currently unemployed, indicate how long you have been off work: _____

Legal Issues: Please indicate any of the following legal issues related to your pain problem:
□ Worker's Compensation □ Personal Injury/Liability □ Social Security Disability Insurance

PSYCHOLOGOCIAL TREATMENT
Have you ever had psychiatric evaluation or treatments for any problem? □ Yes □ No
For what diagnosis were you treated? _____
Please list your current or last therapist _____
Have you ever considered suicide? □ Yes □ No □ When
Have you ever attempted suicide? □ Yes □ No □ When

SUBSTANCE ABUSE

Do you have history of alcoholism? □ Yes □ No □ Current problem
Have you abused prescription pain meds? □ Yes □ No □ Current problem
Cocaine or intravenous substance abuse? □ Yes □ No □ Current problem
How many years has it been since you abused alcohol or drugs _____ years

PLEASE LIST ANY CONDITIONS THAT RUN IN YOUR FAMILY:

Relative: _____ Condition: _____

Relative: _____ Condition: _____

Relative: _____ Condition: _____

PAIN DESCRIPTION:

What is the main problem for which you are seeking treatment?

_____

How long have you had your pain problem? _____years _____ months _____ weeks

Previous Treatment Received ?

Physical Therapy Yes No If Yes Where and When _____

Injections? Yes No If Yes Where and When_____

Bracing ? Yes No If Yes what type Back Neck Knee Ankle Wrist When _____

Pain Management ? Yes No If Yes Where and When _____

ONSET: How did pain start? (check appropriate box)

□ Suddenly □ Bending □ Injured at work
□ Gradually □ Pulling □ Injured during sports
□ Lifting □ Injured in auto accident □ No apparent cause
□ Fall

SEVERITY OF PAIN: Please describe the intensity of your pain

□ Mild □ Moderate □ Moderate-Severe □ Severe

TIMING OF PAIN: How often do you have your pain?

□ Constantly □ Nearly constantly □ Intermittently

How do the following affect your pain (please check one for each item)

	DECREASE	NO CHANGE	INCREASE
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
RELAXATION			
COUGHING/SNEEZING			
PUSH/PULL			
BEND			

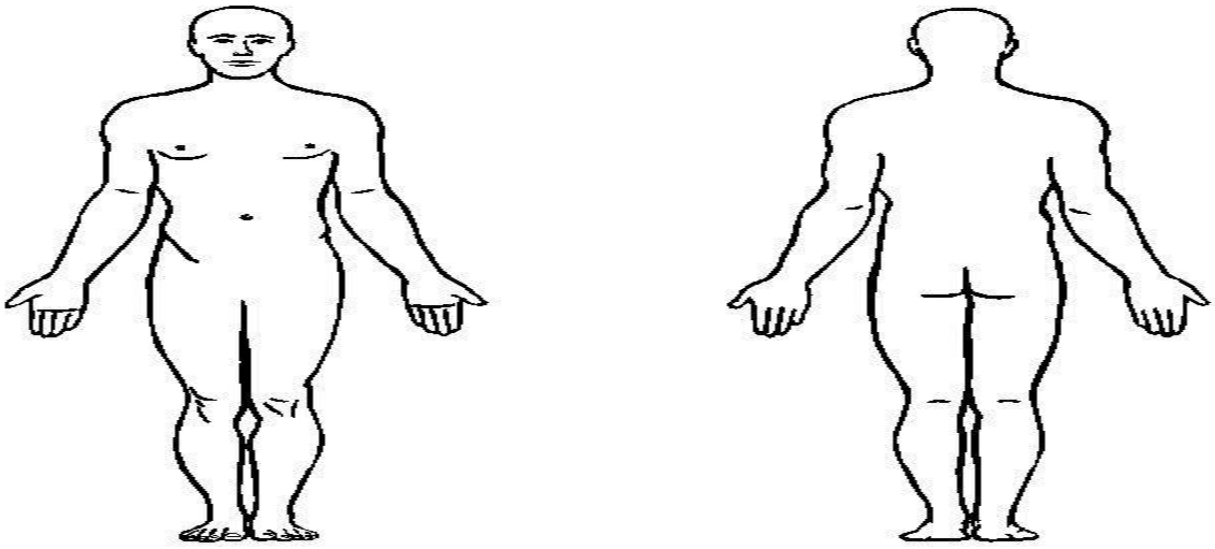
IS YOUR SLEEP DISTURED DUE TO YOUR PAIN □ Yes □ No

PAIN TREATMENTS: Please check your response to the treatments you have tried.

TREATMENT	NEVER TRIED	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
SURGERY				
TRACTION				
INJECTION				
PHYSICAL THERAPY				
ACUPUNCTURE				
CHIROPRACIC				

PAIN LOCATION: Please mark the location(s) of our pain on the diagram

Right **Left** **Left** **Right**



FRONT **BACK**

I have weakness in my: Upper extremities □ Dropping objects? □ Yes
Lower extremities □ Falling? □ Yes

ACTIVITIES AND YOUR PAIN

How many blocks can you walk? □ Less than a block _____Blocks (how many?)

Is sitting tolerance limited? _____ No _____Yes Is standing tolerance limited? _____ No _____Yes

To assist walking, I use a: □ Cane □ Walker □ Wheelchair □ No assistance device

Have you had a recent change in bowel or bladder habits? _____No _____Yes

Are your activities of daily living limited due t pain? _____ No _____ Yes

Have you seen a pain doctor(s) prior? If so, please name the doctor(s):_____

Have you had testing of your nerves (EMG/NCS)? _____No _____Yes _____Not Sure

DIAGNOSTIC STUDIES: Have you had any of these diagnostic studies for **this** pain problem?

X-rays	Yes _____	No _____
CT (computed tomography) scan	Yes _____	No _____
Electromyogram (EMG)	Yes _____	No _____
Discogram	Yes _____	No _____
MRI (magnetic resonance imaging)	Yes _____	No _____
DEXA (bone density testing)	Yes _____	No _____

PHYSICAL EXAMINATION

How much do you weigh? _____ pounds How tall are you? _____feet _____ inches

PLEASE LIST ANY PRIOR (NOT CURRENT) OPIOID PAIN MEDICATIONS and RESPONSE

Medication	Have you taken prior?	If yes, did it help pain?	Were there side effects?
Hydrocodone (Vicodin)	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Fentora	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Dilaudid	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Magnacet	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Oxycodone (Percocet)	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Darvocet	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Codeine	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Methadone	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Fentanyl (Duragesic)	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Morphine/MSContin	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Opana/Oopana ER	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Oxycontin	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Cymbalta	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Lyrica	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Soma	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Skelaxin	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Amtrix	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____
Flexeril	Yes_____ No _____	Yes___ No ____ Not Sure ___	Yes_____ No _____

REVIEW OF SYSTEMS: Please check all items you feel are applicable to you:

General/Constitutional Symptoms:

- □ Recent significant gain of weight
- □ Recent significant loss of weight
- □ Fever
- □ Fatigue

Head/Ears/Eyes/Nose/Throat:

- □ Difficulty swallowing (Dysphagia)
- □ Facial pain
- □ Decreased hearing
- □ Vertigo

Respiratory:

- □ Shortness of breath (Dyspnea)
- □ Wheezing

Cardiovascular:

- □ Edema (Swelling of feet)
- □ Irregular heartbeat

Gastrointestinal:

- □ Nausea
- □ Diarrhea
- □ Vomiting
- □ Constipation

Genitourinary:

- □ Difficulty initiating urine stream
- □ Incontinence

Metabolic/Endocrine:

- □ Jaundice
- □ Insulin reactions

Neuro/Psychiatric:

- □ Memory loss
- □ Seizures
- □ Anxiety
- □ Dizziness
- □ Incoordination
- □ Depression

Dermatologic:

- □ Pruritus
- □ Rash

Musculoskeletal:

- □ Back Pain
- □ Muscle (Myalgias)

Hematologic:

- □ Easy or excessive bleeding