PAIN CLINIC – PATIENT INTAKE FORM

Name ____ Date of Birth ____/____/____ **Room #** _____

Address ____ Sex ___________ Age ____

____ Primary Care Physician __________________

Home Phone (________) _________-__________________ Referring Physician ______________________

Cell Phone (________) _________-__________________

CHIEF COMPLAINT:

Describe in your own words why you came to the Pain Clinic today: ________________________________

____

What are you expecting from your visit to the Pain Clinic today? __________________________________

____

HISTORY OF PRESENT ILLNESS:

When did you first notice your pain/problem? ____

What do you think caused your pain/problem? ____

____

Where is your pain? (Please draw on figure on page 5) ______

Is your pain worse on one side than the other, if so, which side? __________________________________

Describe your pain (for example, dull, sharp, burning, achy, etc.) _________________________________

____

Does your pain migrate or radiate to other parts of your body, if so, where? ___________________________

____

Please use the following scale to rate your pain below: **0-10**

0 meaning no pain and **10** meaning the worst pain you've ever had or can imagine.

My pain at BEST is ____. My pain NOW is ____. My pain at its WORST is ____.

List the things that make your pain better ____

____

List the things that make your pain worse ____

____

How is your sleeping? _________________________________

Have there been any changes in your mood? (for example, irritable, sad, not eating, etc.)

If so, please explain ____

____

What have other physicians told you is causing your pain? _______________________________________

____

____

____

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Has your physician prescribed or have you tried any of the following forms of treatments for pain relief? If so, please note the date(s) you tried or began treatment, the effectiveness (for example, good, bad, very, etc.) and the percentage of pain relief, if any.

	DATE(S)	EFFECTIVENESS	% PAIN DECREASED
Restricting Activity			0% - 100% - _______%
Medication(s)			0% - 100% - _______%
Ice / Heat			0% - 100% - _______%
Physical/Occupational Therapy			0% - 100% - _______%
Tens Unit			0% - 100% - _______%
Chiropractic			0% - 100% - _______%
Biofeedback / Counseling			0% - 100% - _______%
Nerve Blocks / Injections			0% - 100% - _______%
Surgery			0% - 100% - _______%

Is this pain the result of a work related accident? ______________________________

If yes, is legal action or an insurance settlement pending? ______________________________

If yes, describe the current status of such action ______________________________

If no, do you plan to pursue legal action or insurance settlement in the future? ______________________________

Have you had any of the following pain related evaluations and if so please give the date(s) and the facility in which you had the evaluations.

	DATE(S)	FACILITY
X-rays		
Cat Scans		
MRI		
Myelogram		
Bone Scan		
Nerve and Muscle Tests (EMGs)		

Previous Medical History:

Have you ever been diagnosed with any of the following medical conditions, and if so, when?

	Date Diagnosed		Date Diagnosed
Asthma / COPD		High BP	
Heart Disease		Ulcers / GERD	
Kidney Problems		Hepatitis	
Bleeding Tendencies		Cancer	
Diabetes		Other	

Previous Surgical History:

Please list any surgeries that you've had, and the dates of those surgeries below:

Surgery	Date of Surgery

Height ____________________ Weight ______________________

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Drug Allergies	**Reaction**

Medications	**Dose**

Please circle if you are currently taking any of the following prescribed medications and write next to it the date you last took it.

	Date Last Took		Date Last Took
Coumadin (also called warfarin)	________	**Elmiron**	________
Aspirin	________	**Diclofenac**	________
Plavix (also called clopidogrel)	________	**Ketorolac**	________
Pletal (also called cilostazol)	________	**Lodine (also called etodalac)**	________
Pradaxa (also called dabigatran)	________	**Indomethacin**	________
Xarelto (also called rivaroxaban)	________	**Mobic (also called meloxicam)**	________
Eliquis (also called apixaban)	________	**Nabumetone**	________
Persantine (also called dipyridamole)	________	**Oxaprozin**	________
Aggranox	________	**Feldene (also called piroxicam)**	________
Arixtra (also called fondaparinux)	________	**Reopro (also called abciximab)**	________
Effient (also called prasugrel)	________	**Integrilin (also called eptifibatide)**	________
Brilinta (also called ticagrelor)	________	**Aggrastat (also called tirofiban)**	________

Aspirin (also called bayer or excederin) ______________
Ibuprofen (also called advil or motrin) ______________
Aleve (also called naproxen) ______________

Are you or do you believe you are taking any medications not listed that may thin your blood? Yes / No; if so please list ______________________________________

Do you take any antidepressants? Yes / No; if so please list______________________________

Do you take any herbal supplements? Yes ? No; if so please list ___________________________

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Social History:

I work at ____.

I am retired from __________________________________.

I have missed work in the last month _______________ (Y / N)

If yes, how many days? ___________________________

Tobacco use Y / N ____ ppd ______ # of years ______ Quit? ____________ (Date)

Alcohol use Y / N ____ amount/day ___________ History of abuse? _______ (Y / N)

Illicit Drug use Y / N ____ History of use Y / N ____

I am: Single, Married, Divorced, Widowed? ____________________

I am: Pregnant, or Planning to become Pregnant ________ (Y / N / NA) Last menstrual period ___________

Does anyone live with you? _______ If so, who? ___________________________

Education Background: (circle all that applies)

GED High School College Technical School Other _______________

Family History: Do any of your immediate family members have a history of a major disease? (For example: heart disease, lung disease, bone disease) if so, please list here:

Mother ____

Father ____

Sister ____

Brother ____

Review of Systems:

Do you have any of the following symptoms? Please list all symptoms that apply.

CONSTITUNTIONAL

Fever/chills/sweats/weight change ____

EYES, EARS, NOSE

Headaches/eye, ear or nose problems ____

CARDIOVASCULAR

Chest pains/murmur/fluttering in chest ____

RESPIRATORY

Short of breath/productive cough ____

GASTROINTESTIONAL

Diarrhea/constipation/incontinence ____

NEUROLOGIC

Weakness/loss of balance/falls ____

SKIN

Skin rash/hives/ulcers ____

PSYCHIATRIC

Depression/anxiety ____

ENDOCRINE

Diabetes/thyroid ____

HEMATOLOGIC

Bleeding problems/anemia/swollen nodes ____

ALLERGY/IMMUNOLOGIC

Seasonal allergies/asthma/hay fever ____

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LATEX ALLERGY

Have you ever been tested for a Latex Allergy? (Y / N) ____________
If so, what were the results? (Negative / Positive) ________________
Do you have eczema or problems with rashes? (Y / N) ____________
Do you have swelling, itching, hives, or other symptoms after contact with:

- Balloons (Y / N) __________________________
- Dental Examination or Procedure (Y/ N) ______
- Vaginal or Rectal Exam (Y / N) _____________
- Using a Diaphragm or Condom (Y / N) _______
- Wearing Rubber Gloves (Y / N) _____________

Have you experienced an unexplained anaphylactic episode? (For example: rapid heart, swelling of your throat and respiratory distress all at the same time) (Y / N) _________
If yes, which one? ____

FOOD ALLERGY

Are you allergic to any of the following? If so, indicate which ones and the reaction.
Bananas / Avocados ____
Kiwi Fruit / Chestnuts ____

Nursing If patient answers yes to BOTH a **LATEX ALLERGY** and **ANY** of the above questions were answered yes, NOTE **LATEX ALLERGY** on the front of the chart.

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Please SHADE in, on the drawings below, the areas where you feel pain.

Intake form completed per patient responses.

Date ___________________ RN Signature ____

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DIAGNOSIS: ____

____

____

____

PLAN:____

____

____

____

______________________	____________
PHYSICIAN SIGNATURE	**DATE**

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