THE INTERVENTIONAL PAIN SPECIALISTS

New Patient Intake Form

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on this accuracy and completeness to provide you with the best possible care. Please inquire at our front desk if you have any questions on how to complete any section of this form.

Patient Information

☐ New Consult ☐ Re-consult Date:_____

Name:_____ DOB:_____ Gender:_____

Referring Physician:_____ Age:_____

Primary Care Physician: _____

Emergency Contact:_____ Phone:_____

Your Contact Info: Cell Phone:_____ Email:_____

Dominant hand? ☐ Right ☐ Left ☐ Ambidextrous

Is this pain related to: ☐ WSIB? ☐ MVA? ☐ Military Duty? if so, Date Of Onset:_____

Is the pain problem related to work? ☐ **YES** ☐ **NO** Is there a lawsuit due to this pain? ☐ **YES** ☐ **NO**

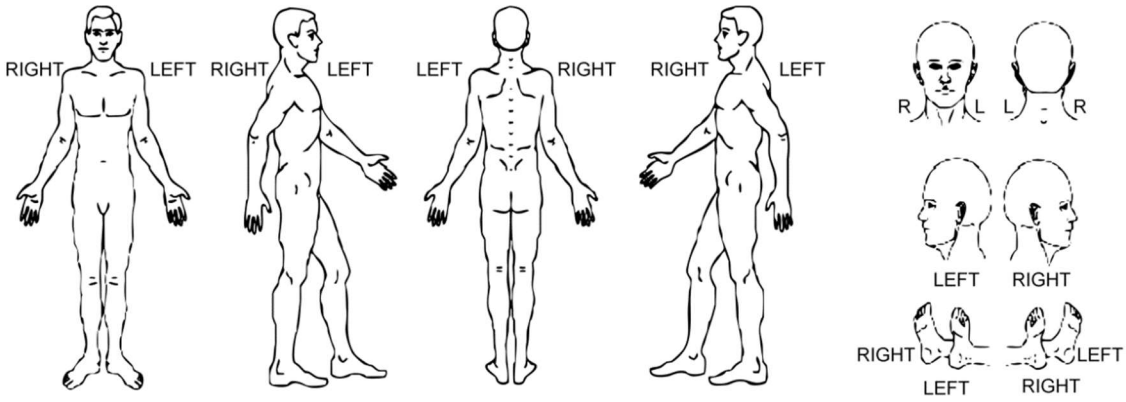
Pain History

Chief Complaint:(#1Reason for your visit today):_____

Does this pain radiate? If so, where? _____

Please list additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark/shade location of your pain with an "X".



Onset of Symptoms

☐ Sudden ☐ Slow ☐ I had something similar before

Approximately when did it begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? _____

Since your pain began, how has it changed? _____

Pain Description

Check all that apply:

☐ Dull/aching ☐ Hot/burning ☐ Shooting
☐ Throbbing ☐ Painful Cold ☐ Stabbing/sharp ☐ Numbness
☐ Squeezing ☐ Spasming ☐ Cramping ☐ Tingling/ pins and needles

Does your pain cause:
☐ Painful Skin
☐ Skin color changes
☐ Hair / Nail changes

When is your pain at its worst?

☐ Mornings ☐ Daytime ☐ Evenings
☐ Always the same ☐ After a specific activity

How often does the pain occur?

☐ Constant ☐ Changes in severity but is always present ☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right now:_____ The best it gets: _____ The worst it gets: _____

Most severe pain experience in your life (what do you compare it to?):_____

Mark the effect each on your pain level	*No change*	*Worsened pain*	*Improved pain*
Bending backward	☐	☐	☐
Bending forward	☐	☐	☐
Changes in weather	☐	☐	☐
Climbing stairs	☐	☐	☐
Coughing/sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

What affects your pain not mentioned above?

_____

Please mark all of the following treatments you have used for pain relief	*No change*	*Worsened pain*	*Improved pain*
Spine surgery	☐	☐	☐
Physiotherapy	☐	☐	☐
Chiropractic care	☐	☐	☐
Psychological therapy	☐	☐	☐
Brace support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/cold packs	☐	☐	☐
Massage therapy	☐	☐	☐
Medications	☐	☐	☐
TENS unit	☐	☐	☐
Other?			
_____	☐	☐	☐

Diagnostic Tests And Imaging

Mark all the following tests you have related to your current pain complaints

☐ MRI of the:_____ Place: Date:
☐ X-ray of the: _____ Place: Date:
☐ CT scan of the : _____ Place: Date:
☐ EMG/NCV study of the : _____ Place: Date:
☐ Other diagnostic testing: _____ Place: Date:
☐ I have NOT had any diagnostic tests for my current pain complaint.

Mark the following physicians or specialists you have consulted for your current pain problem

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/psychologist ☐ None
☐ Chiropractor ☐ Orthopedic surgeon ☐ Rheumatologist ☐ Neurologist
☐ Physical therapist ☐ Internist
☐ ***Other pain physicians?:***

_____

Review of Systems

*Mark symptoms you <u>had in the last 2 weeks</u> **NOT** <u>related to your principal pain</u> problem:*

Constitutional:

☐ Chills	☐ Difficulty sleeping	☐ Easy bruising
☐ Night sweats	☐ Fatigue	☐ Fevers
☐ Insomnia	☐ Low sex drive	☐ Tremors
☐ Unexplained weight gain	☐ Unexplained weight loss	☐ Weakness

Eyes:

☐ Recent visual changes

Ears/Nose/Throat/Neck:

☐ Dental problems	☐ Earaches	☐ Hearing problems
☐ Nose bleeds	☐ Sinus problems	

Cardiovascular:

☐ Chest pain	☐ Bleeding disorder	☐ Blood clots
☐ Fainting	☐ Palpitations	☐ Swelling in the feet
☐ Shortness of breath during sleep		

Respiratory:

☐ Cough	☐ Wheezing

Gastrointestinal

☐ Constipation	☐ Acid reflux	☐ Abdominal cramps
☐ Diarrhea	☐ Nausea/Vomiting	☐ Hernia

Musculoskeletal:

☐ Back pain	☐ Joint pains	☐ Joint stiffness
☐ Joint swelling	☐ Muscle spasms	☐ Neck pain

Genitourinary/Nephrology:

☐ Flank pain	☐ Blood in urine	☐ Painful urination
☐ Decreased urinary flow/frequency/volume		

Neurological:

☐ Dizziness	☐ Headaches	☐ Tremors
☐ Numbness/tingling	☐ Seizures	

Psychiatric:

☐ Depressed mood	☐ Feeling anxious	☐ Stress problems
☐ Suicidal thoughts	☐ Suicidal planning	☐ Thoughts of harming others

☐ **All other review of systems negative**

Past Medical History

General medical history
- ☐ Cancer – type: _____
- ☐ Diabetes – type _____

Cardiovascular/hematologic
- ☐ Anemia
- ☐ Heart attack
- ☐ Coronary artery disease
- ☐ High blood pressure
- ☐ Peripheral vascular disease
- ☐ Heart valve disorders

Gastrointestinal
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ Constipation

Urological
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis

Neurological
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Stroke/TIA

Other:
- _____
- _____

Head/Ears/Eyes/Nose/Throat
- ☐ Severe Head injury
- ☐ Migraines
- ☐ Hearing Impaired / Deafness
- ☐ Hypothyroidism
- ☐ Glaucoma

Respiratory
- ☐ Asthma
- ☐ Bronchitis/pneumonia
- ☐ Emphysema/COPD
- ☐ Sleep Apnea

Musculoskeletal/Rheumatologic
- ☐ Carpal Tunnel Syndrome
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis (Brittle bones)
- ☐ Rheumatoid Arthritis
- ☐ Lyme Disease

Infectious
- ☐ HIV
- ☐ HEPATITIS A / B / C
- ☐ M.R.S.A. (Antibiotic-resistant Infection)
- ☐ C.DIFF
- ☐ Meningitis (Brain Infection)
- ☐ Osteomyelitis (Bone Infection)

Psychological
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Depression

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

☐ I have NEVER had any surgical procedures performed.

Interventional Pain Treatment History

☐ Epidural steroid injection Where/when? _____
☐ Nerve blocks – area/nerve(s)
☐ Medial branch blocks/facet injections
☐ Radiofrequency nerve ablation
☐ Vertebroplasty/kyphoplasty
☐ Trigger point injection
☐ Joint injection
☐ Other: _____

Which procedures from above helped your pain? _____

Current Medications

Are you taking any blood thinners or anti-coagulants? ☐ **YES** ☐ NO
If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Others:
Are you able to stop blood thinners for procedures (do you have a written note from your doctor?)
☐ **YES** ☐ **NO** ☐ **I don't know!**

*Please list **all medications** you are currently taking including vitamins. Attach additional sheet if required.*

	Medication Name	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			

Please list medications that you have been on at any point for your current pain.

	Medication Name	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			

Allergies

Do you have any drug/medication allergies? ☐ **YES** ☐ **NO**

If so, please list all medications allergic to:

	Medication Name	Allergic Reaction
1.		
2.		
3.		
4.		

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Family History

Mark all appropriate diagnoses as they pertain to your five degree relatives:

☐ Arthritis ☐ Cancer ☐ Diabetes
☐ Headaches/Migraines ☐ High Blood Pressure ☐ Kidney Problems
☐ Liver Problems ☐ Osteoporosis ☐ Rheumatoid arthritis
☐ Seizures ☐ Stroke ☐ Other Medical Problems:
☐ I have NO significant family medical history

Social History

Occupation: _____ When was the last time you worked? _____
What is your status?
☐ *Temporary Disability* ☐ *Permanent Disability* ☐ *Retired* ☐ *Unemployed*
Who lives in your current household? _____
Are there any stairs? _____

Alcohol Use:
☐ Social use ☐ History of Alcoholism ☐ Current Alcoholism ☐ Daily use of alcohol ☐ Never

Tobacco Use:
☐ Current user ☐ Former user ☐ Never used
☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit date: _____

Illegal Drug Use:
☐ Denies any illegal drug use ☐ Currently uses illegal drugs ☐ Formerly used illegal drugs(not current)
Have you ever abused narcotics or prescription medications? ☐ **YES** ☐ **NO**