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New Patient Intake Form

Name:_____ **Email:** _____ DOB:_____ Today's Date:_____

Referring Physician:_____ Primary Care Physician:_____

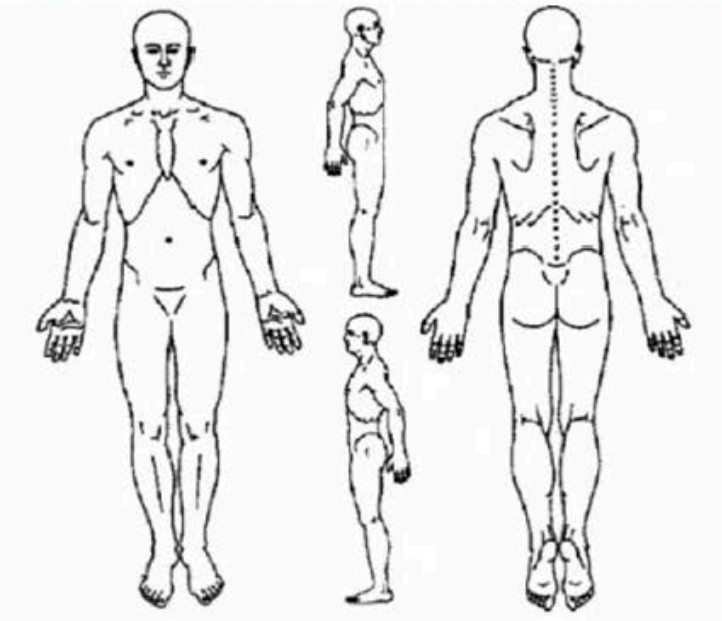
Preferred Pharmacy/Phone Number:_____ **Patient's Address:** _____

Did the pain start: ☐ Immediately ☐ Gradually How bad is the pain on a 0-10 scale (*10 being the worst pain*)?: _____

Did the pain start after a specific event? ☐ Yes ☐ No If yes, what specific event?_____

Does the pain radiate to the arms or legs? ☐ Yes ☐ No How long have you had this pain: _____Months _____ Years

Please shade areas where you are having pain.



Describe the pain (*check all that apply*) :

☐ Sharp ☐ Burning ☐ Shooting
☐ Stabbing ☐ Dull ☐ Aching
☐ Throbbing ☐ Other:_____

Any additional symptoms (*check all that apply*)?:

☐ Numbness ☐ Difficulty walking
☐ Muscle weakness ☐ Sexual dysfunction
☐ Other:_____

What makes the pain worse (*check all that apply*)?:

☐ Coughing/Sneezing ☐ Stress ☐ Sitting
☐ Bending/Twisting ☐ Heat ☐ Standing
☐ Weather changes ☐ Cold ☐ Lying

What makes the pain better (*check all that apply*)?:

☐ Nothing ☐ Medications ☐ Heat
☐ Rest ☐ Exercise/activity ☐ Cold
☐ Other:_____

Treatment History

Have you had any prior treatment for this pain? ☐ Yes ☐ No

Please select the previous treatments you have had for your current pain symptoms:

☐ Physical Therapy ☐ Work Hardening ☐ TENS Unit ☐ Injections ☐ Psychological support
☐ Chiropractic care ☐ Acupuncture ☐ Trigger Point ☐ Surgery ☐ Psychological
☐ Pain clinics If yes, where and when?:_____

Treatment History (cont.)

Please check all diagnostic tests that have been performed and indicate when/where they were performed.

TEST PERFORMED	DATE	LOCATION OF TEST
Plain x-ray		
CT scan		
MRI scan		
EMG/Nerve Conduction Study		
Myelogram		
Discogram		

Please list all other physicians who have treated you and describe what they have recommended.

PHYSICIAN NAME	DESCRIPTION

Please CHECK any of the following that you are CURRENTLY experiencing related to your pain complaint:

Constitutional: ☐ trouble sleeping ☐ weight loss ☐ weight gain ☐ poor appetite

Ear/Nose/Throat: ☐ snoring ☐ hearing loss ☐ dizziness ☐ ringing in the ears

Cardiovascular: ☐ swelling in feet/legs ☐ leg pain/poor circulation ☐ chest pain

Respiratory: ☐ chronic cough ☐ wheezing ☐ shortness of breath ☐ Home oxygen

Gastrointestinal: ☐ constipation ☐ diarrhea ☐ nausea/vomiting ☐ abdominal pain

Genitourinary: ☐ incontinence of urine ☐ kidney stones

Skin: ☐ rashes ☐ infections

Neurologic: ☐ headache ☐ difficulty walking ☐ recent falls ☐ poor memory ☐ progressive weakness ☐ progressive sensation loss

Musculoskeletal: ☐ joint pain ☐ joint stiffness ☐ muscle cramps/spasms ☐ muscle loss

Psychiatric: ☐ frequent sadness ☐ excessive worry ☐ anxiety

PAST MEDICAL /FAMILY/SOCIAL HISTORY

Do you take prescription blood thinners? ☐ Yes ☐ No

Are you or could you be pregnant? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Have you ever had mental health treatment? ☐ Yes ☐ No

Have you ever been treated for cancer? ☐ Yes ☐ No If yes, what type:_____

Are you currently being treated for an infection? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following *(check all that apply)*

☐ Asthma	☐ Fibromyalgia	☐ Hypertension	☐ Peripheral Neuropathy	☐ Stroke
☐ Bleeding disorder	☐ Glaucoma	☐ Kidney disease	☐ Rheumatoid Arthritis	☐ Urinary incontinence
☐ Bowel incontinence	☐ Headache	☐ Liver disease (hepatitis)	☐ Seizure	☐ Other:_____
☐ Diabetes	☐ Heart disease	☐ Osteoarthritis	☐ Stomach ulcer or GI bleed	

PAST MEDICAL /FAMILY/SOCIAL HISTORY (cont.)

Please list all current medications (including over-the-counter medications). Please attach additional sheets if necessary.

MEDICATION	INDICATION	DOSE	PRESCRIBING PHYSICIAN

Please list any drug allergies below:

Drug Allergy	Reaction	Date of Onset (if known)

Please check if you have allergies to any of the following:

- ☐ No known drug alleriges
- ☐ Contrast Dye (IVP) allergy
- ☐ Latex allergy
- ☐ Iodine allergy

Have you had any severe allergic reactions (anaphylaxis) to anything? ☐ Yes ☐ No If yes, to what

Family history of medical problems?:_____

Occupation:_____ ☐ Full time ☐ Part Time ☐ Retired ☐ Disabled

Do you have physical work restrictions? ☐ Yes ☐ No

If unemployed, what was your last job and how long have you been out of work?_____

Marital Status:_____ Number of children?:_____ Ages:_____ Highest level of education?_____

Do you use tobacco? ☐ Yes ☐ No If yes, how much?_____ Do you use alcohol? ☐ Yes ☐ No If yes, how much?_____

Used recreational (street) drugs in the past five years? ☐ Yes ☐ No Do you have a history of prescription drug abuse? ☐ Yes ☐ No

Is there litigation pending about your pain complaint? ☐ Yes ☐ No

Please list any other previous injuries (including fractures, head injuries, car accidents, falls, etc.).

Insurance	Company	Policy # and / or Claim #
Medication and health insurance		
Accident insurance (if claim is still open)		
Agents name:	**Phone:**	Fax:
Lawyers name:	**Phone:**	Fax:

Please complete this intake form and return by fax, email , or drop off as soon as possible in order to have your consultation in a timely manner

By signing below, I hereby certify that the above information is true and correct to the best of my knowledge.

Patient Signature Date

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