Expert Pain Physicians
Pain & Spine Wellness Center

Intake Form

PATIENT INFORMATION

Name: ______________________

Address: ______________________

____

Email: ______________________

Home Phone: ______________________

Cell Phone: ______________________

Date of Birth: ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced

Sex: ☐ Female ☐ Male

LANGUAGE: ______________________

ETHNICITY: ______________________

REFERRING PHYSICIAN

Name: ______________________

Specialty: ______________________

City, State: ______________________

PRIMARY CARE PHYSICIAN

Name: ______________________

City, State: ______________________

EMERGENCY CONTACT

☐ I authorize this person may be contacted if I cannot be reached

Name: ______________________

Phone Number: ______________________

Relationship: ______________________

PHARMACY (please provide only one pharmacy)

Name: ______________________

City: ______________________

Address: ______________________

Phone Number: ______________________

GUARANTOR

☐ Same as patient

Name: ______________________

Address: ______________________

Date of Birth: ______________________

Phone Number: ______________________

PATIENT EMPLOYMENT

Employer Name: ______________________

Address: ______________________

____

Work Phone Number: ______________________

If your present symptoms/conditions are related to a work or auto injury, please fill out the section below that applies to you:

WORKERS COMPENSATION

Claim #: ______________________

Injury Date: ______________________

Employer Name: ______________________

Insurance Company: ______________________

Phone Number: ______________________

Case Manager Name: ______________________

Phone Number: ______________________

Attorney's Name: ______________________

Phone Number: ______________________

AUTO INSURANCE:

Claim #: ______________________

Accident Date: ______________________

Insurance Company: ______________________

Phone Number: ______________________

Attorney's Name (if applicable): ______________________

____

Phone Number: ______________________

Adjuster Name (if known): ______________________

____

Adjuster Phone Number: ______________________
(if known)

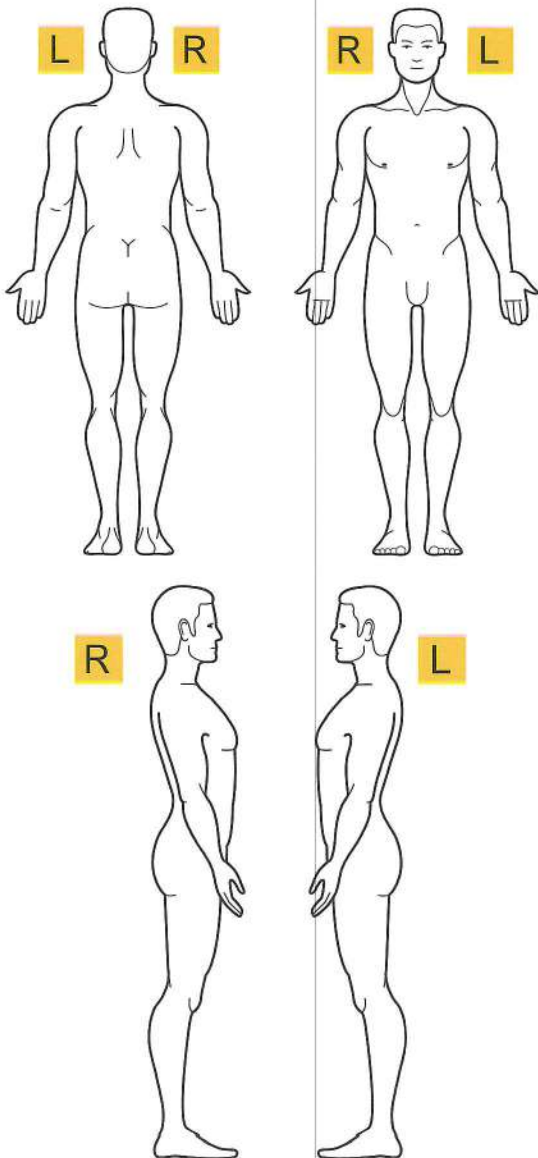
Expert Pain Physicians
Pain & Spine Wellness Center

Patient Information

Name:_______________ **DOB/Age:**__________ **Appointment Date:**_______________

Health Condition

Please shade the areas where you are having pain on this diagram



1) Where is your most severe pain located (Chief complaint)?

____

2) When did your pain begin?_______________

3) What was the injury or cause of pain (if known)?

____

4) Does your pain travel (radiate) anywhere?

- Yes
- No

• If yes, where?

____

5) Is your pain: ***(Check one)***

- Always present
- Comes and goes

6) What is the intensity of your pain on a scale of 1-10 (0=no pain, 10=worse pain ever)

At best:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
On average:	0	1	2	3	4	5	6	7	8	9	10

7) Check any of the following that describe the quality of your pain:

- Dull
- Burning
- Aching
- Sharp
- Shooting
- Pinpoint

8) Check any treatments you have tried in the past to treat your pain:

- Physical Therapy
- Massage
- TENs
- Chiropractor
- Ice/Heat
- Other

Health Condition

9. Is your pain associated with any of the following?

- Weakness ☐ Yes ☐ No
- Numbness/Tingling ☐ Yes ☐ No
- Bladder or Bowel control problems ☐ Yes ☐ No

10) Check which factors make your pain better:

☐ Sitting
☐ Standing
☐ Walking
☐ Bending forward
☐ Leaning Back
☐ Lying down

11) Check which factors make your pain worse:

☐ Sitting
☐ Standing
☐ Walking
☐ Bending forward
☐ Lying down
☐ Driving
☐ Coughing/Sneezing
☐ Leaning Back

12) List other Doctors who have treated you for this:

____

____

____

13) List any tests that have been performed (i.e. MRI, CAT scan, Myelogram, EMG, etc.) and list the year and facility where the test was done:

____

____

____

____

____

14) Have you previously had any injections/ epidurals for your pain? If yes, when and where?

____

____

____

____

15) Have you been treated by other specialists/clinics in the past? if yes, when and where?

____

____

____

____

16) List all medications you have tried in the past that did not relieve your pain or caused bad side effects. Please list what side effect occured next to the medication.

____

____

____

____

17) Please answer the following questions if your problem is the result of an injury:

Mark only one:

☐ I never had back/neck problems before this injury.

☐ I had back/neck problems before and this injury made the problem worse

Mark all that apply:

☐ This injury occurred at work.

☐ This injury did not occur at work.

☐ I have filed a claim through worker's compensation.

☐ I have pursued or will pursue legal action as a result of this injury.

Current Medications

List all of your medications and dosages

Medication and Dosage

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________

Are you taking any blood thinner? ☐ Yes ☐ No

If yes, check one: ☐ Plavix (Clopidogrel) ☐ Aspirin ☐ Warfarin (Coumadin) ☐ Heparin (Lovenox) ☐ Aggrenox (Pletal) ☐ Eliquis ☐ Arixtra (Fondaparinux) ☐ Others ________

Past Medications

Do you have any of the followng conditions?

Condition	Yes	No
High Blood pressure (Hypertension)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart Disease (Coronary Artery Disease)	☐ Yes	☐ No
Lung Disease (Ashtma/COPD)	☐ Yes	☐ No
Kidney Disease (Chronic Kidney Disease)	☐ Yes	☐ No
High Cholesterol (Hyperlipidemia)	☐ Yes	☐ No
Stomach Ulcers (GERD, Peptic Ulcer Disease)	☐ Yes	☐ No
Stroke (TIA/Cereberal Vascular Accident)	☐ Yes	☐ No
Contagious Disease (HIV/Hepatitis B or C)	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Hyperthyroidism	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No
Suppressed Immunity	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Seizure Disorder	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No
Bleeding problems	☐ Yes	☐ No
Allergies	☐ Yes	☐ No

☐ Other ____

____

____

Please List all Drug Allergies and Reactions

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

Previous Surgeries/Dates

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Family History (Blood Relatives)

☐ Chronic Pain ☐ Medication Misuse ☐ Cancer ☐ Other: ____________________

Social History

Do you Smoke? ☐ Yes ☐ No If yes how many? __________ How many packs per day? ______

Do you drink alcohol? ☐ Yes ☐ No If yes how often? ____________________

Do you have any history of alcohol or drug addiction? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No If yes what types: ____________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widowed

Occupation: ______________ ☐ Full time / Part Time ☐ Disabled ☐ Retired

Are you currently pregnant or trying to get pregnant? ☐ Yes ☐ No

Review of System

In the past few months have you experienced any of the following symptoms or complaints?

1. Chills ☐ Yes ☐ No
2. Fevers ☐ Yes ☐ No
3. Sudden weight gain/loss ☐ Yes ☐ No
4. Hearing problems ☐ Yes ☐ No
5. Persistent cough/Shortness of breath ☐ Yes ☐ No
6. Chest pain ☐ Yes ☐ No
7. Heart Palpitations ☐ Yes ☐ No
8. Diarrhea ☐ Yes ☐ No
9. Constipation ☐ Yes ☐ No
10. Acid Reflux (heart burn) ☐ Yes ☐ No
11. Nausea/Vomiting ☐ Yes ☐ No
12. Easy bruising ☐ Yes ☐ No
13. Joint pain ☐ Yes ☐ No
14. Swollen joints ☐ Yes ☐ No
15. Weakness ☐ Yes ☐ No
16. Numbness ☐ Yes ☐ No
17. Depression ☐ Yes ☐ No
18. Sleep loss ☐ Yes ☐ No

Vitals

Height: __________ **Weight:** __________ **Pain Index Score** 0 1 2 3 4 5 6 7 8 9 10