**PAIN RELIEF ASSOCIATES NEW PATIENT INTAKE**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_**

**Best Phone Number to Reach You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status: M S D W Children (names and ages): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

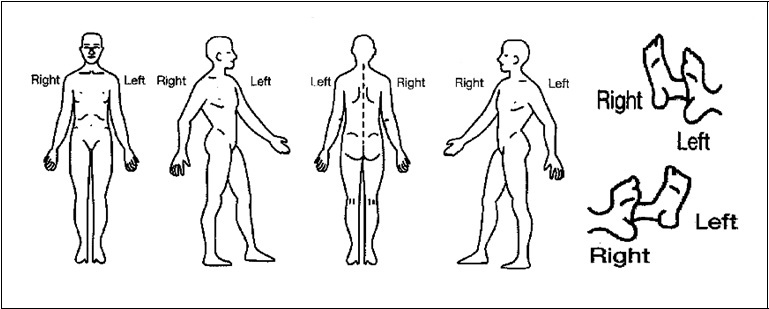
**Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Chief Complaint (Why are you seeing the doctor today?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle the area(s) of the body where you are experiencing symptoms and mark the circled area(s) with:**

“**BP**” for burning pain, “**SHP**” for sharp pain, “**STP**” for stabbing pain, “**DP**” for dull pain, “**AP**” for achy pain, “**N**” for numbness, and “**T**” for tingling

****

**Timing of Pain/ Alleviating and Aggravating Factors:**

**What makes your pain feel better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What makes your pain feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Duration of Pain:**

**How long have you had the pain you are currently experiencing (Or, date of the injury)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What caused your current pain to start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often do you have your pain?**

**\_\_\_\_\_\_\_\_\_\_ a. Constantly (80-100% of the time) \_\_\_\_\_\_ c. Intermittently (25-50% of the time)**

**\_\_\_\_\_\_\_\_\_\_ b. Nearly Constant (50-80% of the time) \_\_\_\_\_\_\_d. Occasionally (less than 25% of the time)**

**Past Treatment:**

|  |  |  |
| --- | --- | --- |
| **Treatment** | **Did it give you relief? For how long?** | **When and why did you discontinue?** |
|  |  |  |
|  |  |  |
|  |  |  |

**Do you have any known (drug) allergies? (Explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

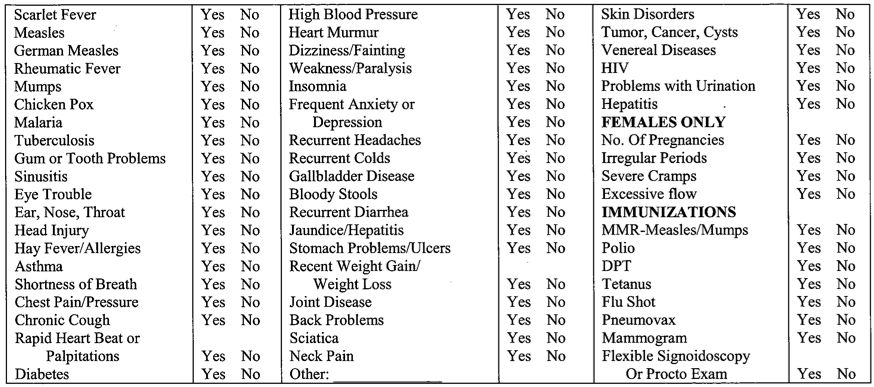
**Education: K-8 \_\_\_ High School \_\_\_ 2 Year College \_\_\_ College Graduate \_\_\_ Post Graduate \_\_\_**

**Do you or have you ever smoked cigarettes, cigars or pipes? Yes / No If Yes, How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many packs per day? \_\_\_\_\_\_ Age you started: \_\_\_\_ Have you quit? Yes / No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you consume alcohol? Yes / No Number of drinks per day, week, or month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever undergone treatment for drug or alcohol addiction? Yes / No**

**Have you had any of the following conditions?**

**Please List any Hospitalization or Surgery Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY MEDICAL HISTORY:**

**Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alive? \_\_\_\_\_\_\_ State of Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Deceased? \_\_\_\_\_\_\_ Age at Death: \_\_\_\_\_\_\_ Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alive? \_\_\_\_\_\_\_\_ State of Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Deceased? \_\_\_\_\_\_\_ Age at Death: \_\_\_\_\_\_\_ Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Grandparent** | **Age** | **Sex** | **Illness, Congenital Abnormalities or Cause of Death** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Medications: Please list any medications, dosage, how many times per day and for how long:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **How Often?** | **When Did You Start?** | **Comments** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Please circle YES or NO to the following question.**

1. **Do you have weakness in your legs, feet, arms, or hands? Yes No Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Do you have numbness in your legs, feet, arms, or hands? Yes No Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Do you suffer from burning in your legs or feet? Yes No Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **Do your legs or feet ever fall asleep? Yes No Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **Do you have back pain? Yes No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
6. **Do you ever have headaches? Yes No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
7. **Do you often trip or catch your toe while walking? Yes No Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
8. **Have you ever been diagnosed with arthritis? Yes No Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
9. **Do you ever suffer from dizziness? Yes No Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
10. **Do you have difficulty maintaining your balance? Yes No Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
11. **Do your knees crack, pop, or give you pain? Yes No Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Activity:**

**Circle the number that best describes how your pain has interfered with your:**

**Does Not Interfere Completely Interferes**

* **Bending: 1 2 3 4 5 6 7 8 9 10**
* **Changing Position (Sit-Stand) 1 2 3 4 5 6 7 8 9 10**
* **Sitting: 1 2 3 4 5 6 7 8 9 10**
* **Standing: 1 2 3 4 5 6 7 8 9 10**
* **Lifting: 1 2 3 4 5 6 7 8 9 10**
* **Walking: 1 2 3 4 5 6 7 8 9 10**
* **Kneeling: 1 2 3 4 5 6 7 8 9 10**
* **Climbing Stairs: 1 2 3 4 5 6 7 8 9 10**
* **Sleeping: 1 2 3 4 5 6 7 8 9 10**
* **Driving: 1 2 3 4 5 6 7 8 9 10**
* **Taking Care of Children: 1 2 3 4 5 6 7 8 9 10**
* **Household Chores: 1 2 3 4 5 6 7 8 9 10**
* **Yard Work 1 2 3 4 5 6 7 8 9 10**
* **Extended Computer Use: 1 2 3 4 5 6 7 8 9 10**
* **Bathing: 1 2 3 4 5 6 7 8 9 10**
* **Getting Dressed: 1 2 3 4 5 6 7 8 9 10**
* **Self-Care: 1 2 3 4 5 6 7 8 9 10**
* **Sexual Activities: 1 2 3 4 5 6 7 8 9 10**
* **Pet Care: 1 2 3 4 5 6 7 8 9 10**
* **Reading: 1 2 3 4 5 6 7 8 9 10**
* **Family Relationships: 1 2 3 4 5 6 7 8 9 10**
* **Relationship with Spouse/Partner: 1 2 3 4 5 6 7 8 9 10**
* **Social Activities with Others: 1 2 3 4 5 6 7 8 9 10**
* **Work/Job Duties: 1 2 3 4 5 6 7 8 9 10**
* **Concentration: 1 2 3 4 5 6 7 8 9 10**
* **Mood: 1 2 3 4 5 6 7 8 9 10**
* **Enjoyment of Life: 1 2 3 4 5 6 7 8 9 10**

**TREATMENT GOALS - Please list the specific goals you would like to achieve through treatment (i.e., *golf, sleep, work, etc*):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your single most important reason for wanting to reduce or eliminate your pain?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**