



# THE PAIN INSTITUTE

## PATIENT INTAKE FORM

DATE \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_

SECONDARY NOTIFICATION:  
NAME AND RELATIONSHIP: \_\_\_\_\_ PHONE NO (\_\_\_\_) \_\_\_\_\_

## SOCIAL HISTORY

MARITAL STATUS:  MARRIED  SINGLE  WIDOWED  DIVORCED

DO YOU SMOKE?  YES  NO HOW MUCH? \_\_\_\_\_

DO YOU DRINK ALCOHOLIC BEVERAGES:  YES  NO HOW MUCH? \_\_\_\_\_

HAVE YOU EVER RECEIVED TREATMENT FOR ANY TYPE OF ADDICTION?  YES  NO

IF YES, DESCRIBE: \_\_\_\_\_

ARE YOU PREGNANT OR PLAN TO BECOME PREGNANT?  YES  NO

WHAT TYPE OF EXERCISES/HOBBIES DO YOU LIKE? \_\_\_\_\_

DOES YOUR PAIN INTERFERE WITH YOUR EXERCISES/HOBBIES?  YES  NO

IF YES, HOW? \_\_\_\_\_

NAME OF EMPLOYER: \_\_\_\_\_

OCCUPATION: WHAT WORK DO YOU DO? WHAT DOES YOUR WORK INVOLVE? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOW MANY HOURS DO YOU WORK PER WEEK? \_\_\_\_\_

HOW MUCH WORK, IF ANY, HAVE YOU MISSED IN THE PAST MONTH DUE TO PAIN? \_\_\_\_\_

## PAIN HISTORY

DESCRIBE IN YOUR OWN WORDS WHAT YOUR PAIN IS LIKE (WHERE IT IS, HOW IT FEELS, IS IT CONSTANT, DOES IT COME AND GO, ETC.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOW LONG HAVE YOU HAD THIS PROBLEM? \_\_\_\_\_

\_\_\_\_\_

WHAT IS THE CAUSE OF PAIN? \_\_\_\_\_

\_\_\_\_\_

## PREVIOUS TREATMENT FOR PAIN

PLEASE CHECK ONE	HELPFUL				
	YES	NO	YES	NO	
NERVE BLOCKS/PAIN MGMT					NAME OF PHYSICIAN: DATE:
SURGERY					NAME OF SURGEON:
TENS UNIT					COMMENTS:
OCCUPATIONAL/PHYSICAL THERAPY					NAME OF THERAPIST:
BIOFEEDBACK					NAME OF THERAPIST:
HYPNOSIS					NAME OF THERAPIST:
COUNSELING					NAME OF THERAPIST:
CHIROPRACTOR					NAME OF CHIROPRACTOR:

WHICH OF THE FOLLOWING TESTS HAVE YOU HAD TO EVALUATE YOUR PAIN PROBLEM WITHIN THE PAST 6 MONTHS TO A YEAR? PLEASE LIST THE APPROXIMATE DATE OF TEST, THE NAME OF THE FACILITY WHERE THE TEST WAS PERFORMED, THE NAME OF THE ORDERING PHYSICIAN AND THE RESULTS, IF KNOWN.

TEST	DATE	FACILITY	PHYSICIAN	RESULTS
X-RAY				<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
CT SCAN				<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
MRI				<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
LABORATORY				<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
EMG				<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
MYELOGRAM				<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
RECTAL/HEMOCCULT				<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
BONE SCAN				<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL

## MEDICAL HISTORY

WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD OR PRESENTLY HAVE AND NOTE WHEN THIS WAS DIAGNOSED.

CONDITION	DATE DIAGNOSED	CONDITION	DATE DIAGNOSED
<input type="checkbox"/> DIABETES		<input type="checkbox"/> EMPHYSEMA	
<input type="checkbox"/> ASTHMA		<input type="checkbox"/> ALLERGIES	
<input type="checkbox"/> CANCER		<input type="checkbox"/> ULCER	
<input type="checkbox"/> ARTHRITIS		<input type="checkbox"/> KIDNEY PROBLEMS	
<input type="checkbox"/> HIGH BLOOD PRESSURE		<input type="checkbox"/> BLEEDING DISORDER	
<input type="checkbox"/> HEART PROBLEMS		<input type="checkbox"/> SEIZURE DISORDER	
<input type="checkbox"/> PSYCHOLOGICAL DISORDERS		<input type="checkbox"/> ANXIETY DISORDER	
<input type="checkbox"/> OTHER:		<input type="checkbox"/> OTHER:	

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICAL HISTORY**

LIST ANY SURGERIES YOU HAVE HAD:

TYPE OF SURGERY

DATE:


ARE YOU ALLERGIC TO ANY MEDICATIONS? IF YES, WHICH ONES? \_\_\_\_\_

ARE YOU ALLERGIC TO LATEX PRODUCTS?     YES     NO

ARE YOU TAKING ANY BLOOD THINNING MEDICATION?     YES     NO

IF SO, PLEASE LIST \_\_\_\_\_

CURRENT MEDICATIONS: WHAT MEDICATIONS, IF ANY, ARE YOU TAKING NOW.  
PLEASE LIST ALL MEDICATIONS BOTH PRESCRIPTION AND OVER THE COUNTER.

MEDICATION	WHY PRESCRIBED	DOSAGE	EFFECTIVENESS

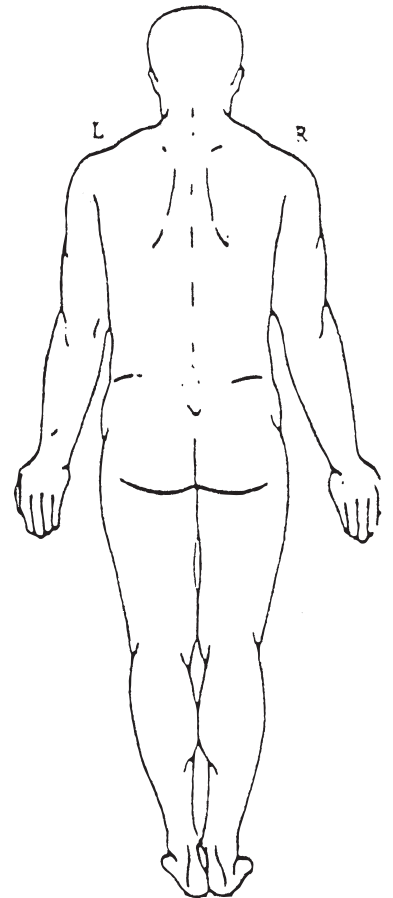
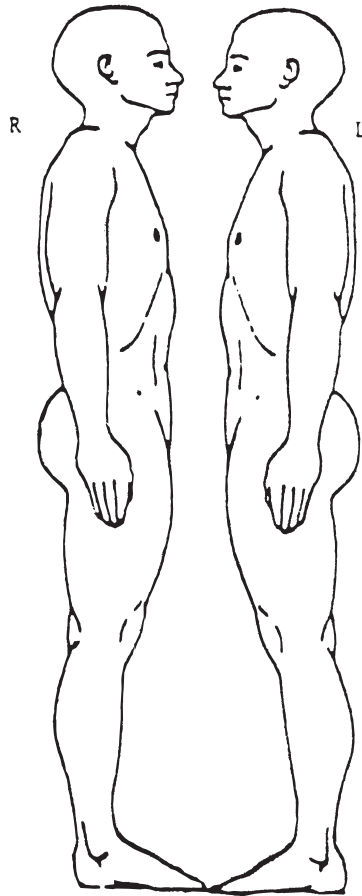
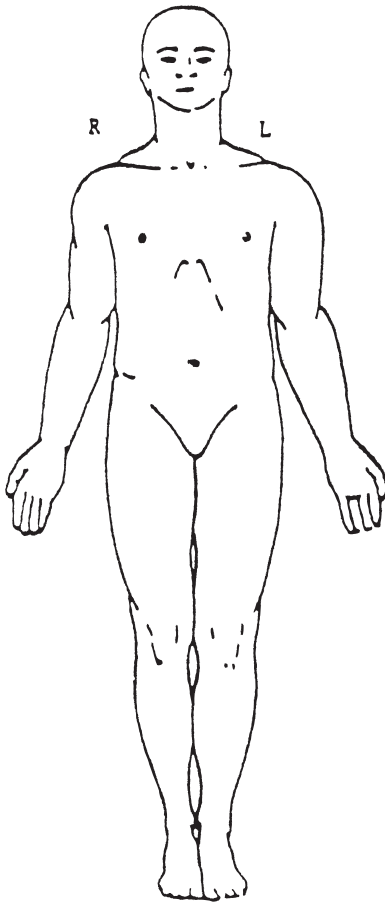
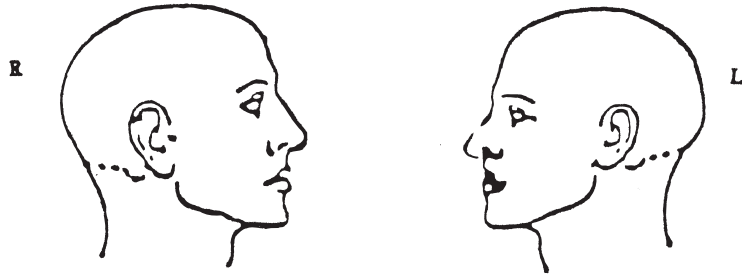
LITIGATION: IF YOUR PAIN IS DUE TO AN ACCIDENT, IS LITIGATION (LEGAL SUIT) OR AN INSURANCE SETTLEMENT PENDING? DO YOU HAVE PLANS TO PURSUE A LEGAL OR INSURANCE SETTLEMENT IN THE FUTURE? IF YES TO EITHER QUESTION, PLEASE DESCRIBE: \_\_\_\_\_

**RELEASE OF RECORDS**

I GIVE PERMISSION TO THE PAIN INSTITUTE, INC., TO OBTAIN COPIES OF RECORDS, DIAGNOSTIC PROCEDURES, ETC., FROM PREVIOUS TREATING PHYSICIANS AND FACILITIES THAT MAY BENEFIT IN THE UNDERSTANDING AND TREATMENT OF MY CURRENT PAIN CONDITION.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE SHADE IN, ON THE DRAWINGS BELOW, THE AREA WHERE YOU FEEL PAIN.



CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN:



INTAKE FORM COMPLETED PER PATIENT RESPONSES

DATE: \_\_\_\_\_ RN/MEDICAL ASSISTANT: \_\_\_\_\_