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):** _____

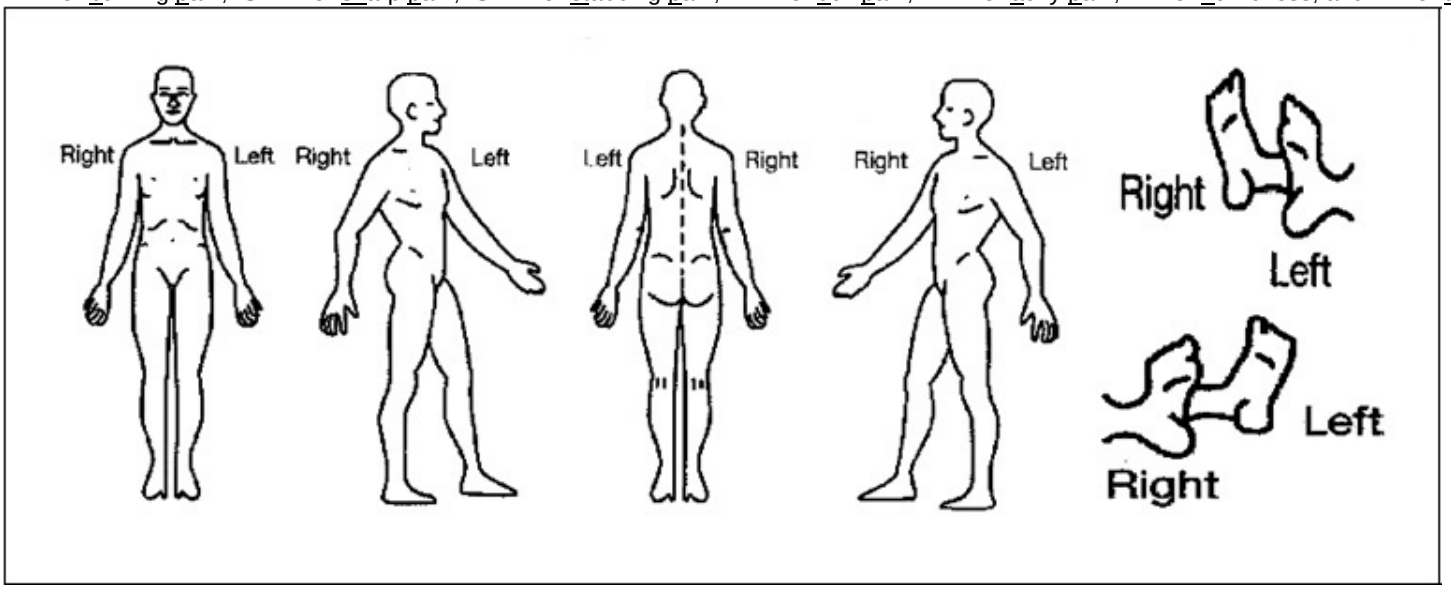
Spouse Name: _____ **Spouse Employer:** _____

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?

Scarlet Fever	Yes	No	High Blood Pressure	Yes	No	Skin Disorders	Yes	No
Measles	Yes	No	Heart Murmur	Yes	No	Tumor, Cancer, Cysts	Yes	No
German Measles	Yes	No	Dizziness/Fainting	Yes	No	Venereal Diseases	Yes	No
Rheumatic Fever	Yes	No	Weakness/Paralysis	Yes	No	HIV	Yes	No
Mumps	Yes	No	Insomnia	Yes	No	Problems with Urination	Yes	No
Chicken Pox	Yes	No	Frequent Anxiety or	Yes	No	Hepatitis	Yes	No
Malaria	Yes	No	Depression	Yes	No	**FEMALES ONLY**		
Tuberculosis	Yes	No	Recurrent Headaches	Yes	No	No. Of Pregnancies	Yes	No
Gum or Tooth Problems	Yes	No	Recurrent Colds	Yes	No	Irregular Periods	Yes	No
Sinusitis	Yes	No	Gallbladder Disease	Yes	No	Severe Cramps	Yes	No
Eye Trouble	Yes	No	Bloody Stools	Yes	No	Excessive flow	Yes	No
Ear, Nose, Throat	Yes	No	Recurrent Diarrhea	Yes	No	**IMMUNIZATIONS**		
Head Injury	Yes	No	Jaundice/Hepatitis	Yes	No	MMR-Measles/Mumps	Yes	No
Hay Fever/Allergies	Yes	No	Stomach Problems/Ulcers	Yes	No	Polio	Yes	No
Asthma	Yes	No	Recent Weight Gain/			DPT	Yes	No
Shortness of Breath	Yes	No	Weight Loss	Yes	No	Tetanus	Yes	No
Chest Pain/Pressure	Yes	No	Joint Disease	Yes	No	Flu Shot	Yes	No
Chronic Cough	Yes	No	Back Problems	Yes	No	Pneumovax	Yes	No
Rapid Heart Beat or			Sciatica	Yes	No	Mammogram	Yes	No
Palpitations	Yes	No	Neck Pain	Yes	No	Flexible Signoidoscopy		
Diabetes	Yes	No	Other: _____			Or Procto Exam	Yes	No

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?

_____