Northeast Pain Management Patient Intake Survey

First Name____________________Last Name____________________MI____ Date of Birth___________
Family Physician:____________________________ Phone:__________________ Fax: ______________

Describe the problem that brings you here: ____
____
How long has you had this problem? ____

List any other providers you have seen for this problem: ____
What treatments have you tried for your current problem? Please circle from the list below:

Tens Unit	Nerve Block	Physical Therapy	Surgery	OMT/Chiropractor
Massage Therapy	Injections	Medications	Psychology	

Is this related to an accident or injury at work? Yes No
If yes Date of Injury: ____
Have you filed a claim with your employer? Yes No
Are you currently receiving Worker's Compensation? Yes No
Are you currently receiving Disabilty? Yes No
Are you currently working? Yes No
If no when did you last work: ______________________________________
Is this related to a motor vehicle accident? Yes No
Date of accident____
Is this related to any other accident or injury? Yes No
If yes please explain:____
Is there any legal action pending? Yes No
Attorney _____________________________________Phone_____________________________

Do you have medical insurance coverage? Yes No If so, please list information below:

Name of Primary Insurance: ____ **Policy Number:** ___________________________________ **Group Number:** ________________

Name of Policy Holder if other than the patient ____ Policy Holder Date of Birth ________________________________

Secondary Insurance: ____________________________________ **Policy Number:** ___________________________ **Group Number:** ________________

Other Insurance ____________________________________ Policy Number: ___________________________ Group Number: ________________

If Work Related: Name of Insurance Carrier: ____
Address: ____
Claim Number:______________________________________ Employer:______________________________

Name of Adjuster/Case Manager_____________________________Phone:_________________________

Patient Intake Page 2

Name:____Date of Birth__________________

Describe your pain: (example: sharp, shooting, burning, tingling, ache etc.)

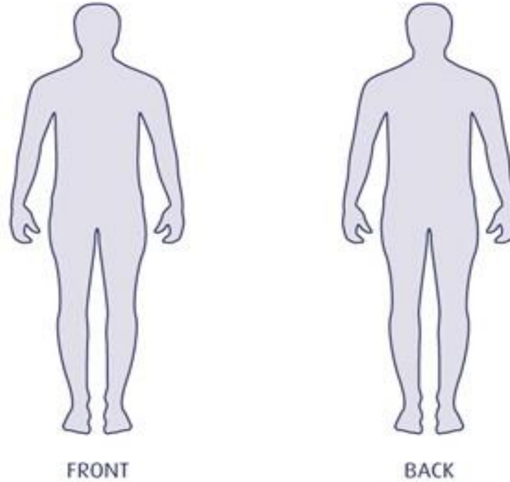
____

Pain Intensity Scale: Circle the number below that best describes your pain score

0 = no pain at all 10= the worst imaginable pain

0	1	2	3	4	5	6	7	8	9	10

On the diagram please shade in the area(s) where you have pain:



Height: ____________________

Weight: ___________________

Please list all medication **Allergies:** ____

____

____

Are you allergic to Iodine ? Yes No Contrast Dye? Yes No

Are you allergice to Shellfish? Yes No

Please list all current **MEDICATIONS**, including dose and frequency:

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

Please list all **Surgeries** you have had with dates: _______________________________________

____

____

Do you have a **Family History** of :

Cancer	Yes	No
Heart Disease	Yes	No
Diabetes	Yes	No

Marital Status: Married/ Divorced/ Single

Current Occupation____

Education: High School/ GED/ College/ Masters/Doctorate

Do you currently or have you ever smoked? _______if yes, how much: ___________Quit Date________

Do you drink Alcohol? _____if yes, how often Socially/ Regulary/ History of Alcoholism

Have you ever had problems with substance abuse? _______________if so when__________________

Which substance? _____________________________

Exercise regimen if any: _________________________________Days per week:_________________

Your Medical History

First Name________________________**Last Name**___________________**MI**____ **Date of Birth**_____________

Please check any of the items below that pertain to you.

Cardiovascular

_____ Abnormal Heart Rhythm
_____ Arterial Clot
_____ Coronary Artery Disease
_____ Congestive Heart Failure
_____ Carotid Artery Disease
_____ Deep Vein Thrombosis
_____ High Cholesterol
_____ Hypertension
_____ Heart Attack
_____ Peripheral Vascular Disease
_____ Phlebitis
_____ Heart Valve Disease
_____ Bleeding Disorder

Pulmonary

_____ Asthma
_____ Bronchiectasis
_____ Chronic Bronchitis
_____ COPD
_____ Cystic Fibrosis
_____ Pneumonia
_____ Pulmonary Embolism
_____ Pulmonary Hypertension
_____ Sarcoditis
_____ Sleep Apnea
_____ TB

Gastrointestinal

_____ Gall Stones
_____ Cirrhosis
_____ Colon Polyps
_____ Chron's Disease
_____ Incontinence
_____ GERD
_____ Hepatitis A, B, C
_____ Irritable Bowel Syndrome
_____ Pancreatitis
_____ Peptic Ulcer Disease
_____ Rotavirus
_____ Ulcerative Colitis

Renal

_____ Acute Renal Failure
_____ Benign Prostate Hypertrophy
_____ Chronic Renal Failure
_____ Bed Wetting
_____ Erectile Dysfunction
_____ Glomerulonephritis
_____ Infertility
_____ Polycystic Kidney Disease
_____ Kidney Stones
_____ Urinary Incontinence
_____ Frequent Bladder Infections

Musculoskeletal

_____ Chondromalacia Patella
_____ Chronic Pain
_____ Fibromyalgia
_____ Fractures
_____ Gout
_____ Rheumatoid Arthritis
_____ Osteoarthritis
_____ Osteoporosis
_____ Paget's Disease
_____ Polymyalgia Rheumatica
_____ Systemic Lupus Erythematosus

Endocrine

_____ Addison's Disease
_____ Cushing's Disease
_____ Diabetes Type I Type ll
_____ Hyperthyroidism
_____ Hypothyroidism

Neurological

_____ Alzheimer's Disease
_____ ADD/ ADHD
_____ Cerebral Palsy
_____ Stroke
_____ Tension Headache
_____ Migraine Headache
_____ Huntington's Disease
_____ Meningitis
_____ Multiple Sclerosis
_____ Muscular Dystrophy
_____ Parkinson's Disease
_____ Siezures
_____ TIA's
_____ Dementia

Hematologic

_____ Hemolytic Anemia
_____ Iron Deficiency Anemia
_____ Pernicious Anemia
_____ Sickle Cell Anemia
_____ Thallasemia
_____ Allergy/Immune/Skin
_____ Allergies, Seasonal
_____ Allergies, Other
_____ Chicken Pox
_____ Exzema
_____ Psoriasis
_____ Immune Deficiency
_____ Sinusitis (frequent)

Cancers

_____ Bone
_____ Brain
_____ Breast
_____ Colon
_____ Hepatic/Liver
_____ Leukemia
_____ Lung
_____ Lymphoma
_____ Melanoma
_____ Pancreatic
_____ Prostate
_____ Renal/Kidney
_____ Skin
_____ Testicular
_____ Thyroid
_____ Other

Psychiatric

_____ Anxiety
_____ Anorexia Nervosa
_____ Bipolar Disorder
_____ Bulimia
_____ Depression
_____ Obsessive Compulsive
_____ Schizophrenia

Other

_____ Cataract
_____ Glaucoma
_____ Over Weight
_____ Trouble Sleeping