Northeast Pain Management Intake Survey

FIRST NAME_____ LAST NAME_____ MI _____ DATE OF BIRTH _____

MAILING ADDRESS: _____

PHONE: (H) _____ (W) _____ (C) _____

EMAIL ADDRESS: _____ PREFERRED CONTACT □ EMAIL □ HOME PHONE □ CELL PHONE

PRIMARY CARE PROVIDER: _____ PHONE: _____ FAX:_____

REFERRING PROVIDER: _____ PHONE: _____ FAX:_____

RACE:

□ WHITE (CAUCASIAN)
□ BLACK
□ AMERICAN INDIAN OR ALASKAN NATIVE
□ ASIAN
□ OTHER: _____

ETHNICITY:

□ WHITE (NOT HISPANIC OR LATINO)
□ AFRICAN AMERICAN
□ LATIN AMERICAN
□ OTHER: _____

PREFERRED LANGUANGE □ ENGLISH □ SPANISH □ OTHER _____

DO YOU HAVE MEDICAL INSURANCE COVERAGE? □ YES □ NO

IF YOU ARE COVERED UNDER WORKER'S COMPENSATION OR MOTOR VEHICLE INSURANCE, ENTER INFO BELOW:

NAME OF WORKER'S COMP OR MOTOR VEHICLE ACCIDENT INSURANCE CARRIER	CLAIM NUMBER	EMPLOYER
_____	_____	_____

CARRIER ADDRESS:_____

ADJUSTER/CASE MANAGER:_____ PHONE:_____

ADDITIONAL QUESTIONS:

IS THE PROBLEM THAT BROUGHT YOU HERE WORK-RELATED?	□ YES □ NO
IF YES, WHAT WAS THE DATE OF INJURY?	_____
HAVE YOU FILED A CLAIM WITH YOUR EMPLOYER?	□ YES □ NO
ARE YOU CURRENTLY WORKING?	□ YES □ NO
IF YOU ARE NOT WORKING, WHEN DID YOU LAST WORK?	_____
IS THE PROBLEM RELATED TO A MOTOR VEHICLE ACCIDENT?	□ YES □ NO
IF YES, WHAT WAS THE DATE OF THE ACCIDENT?	_____
IS THE PROBLEM RELATED TO ANY OTHER ACCIDENT OR INJURY?	□ YES □ NO
IF YES, WHAT WAS THE DATE OF THE ACCIDENT?	_____
IS THERE ANY LEGAL ACTION PENDING?	□ YES □ NO

ATTORNEY: _____ PHONE: _____

HEIGHT: _____ WEIGHT: _____

ALLERGIES & DRUG REACTIONS

□ PENICILLIN □ LATEX □ OTHER:_____
□ SULFA DRUGS □ BETADINE □ OTHER:_____
□ CHLORHEXIDINE □ CONTRAST DYE

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PAST MEDICAL HISTORY

CARDIOVASCULAR
- □ ABNORMAL HEART RHYTHM
- □ CORONARY ARTERY DISEASE
- □ CONGESTIVE HEART FAILURE
- □ CAROTID ARTERY DISEASE
- □ DEEP VEIN THROMBOSIS
- □ HYPERTENSION
- □ HEART ATTACK
- □ PERIPH VASCULAR DISEASE

NEUROLOGICAL
- □ ALZHEIMER'S DISEASE
- □ ADD/ADHD
- □ STROKE/CVA
- □ MIGRAINE HEADACHES
- □ MULTIPLE SCLEROSIS
- □ PARKINSON'S DISEASE
- □ SEIZURE DISORDER
- □ TIA

GASTROINTESTINAL
- □ GALL STONES
- □ CROHNS DISEASE
- □ GERD
- □ HEPATITIS
- □ PANCREATITIS
- □ PEPTIC ULCER DISEASE
- □ ULCERATIVE COLITIS

HEMATOLOGICAL
- □ IRON DEF ANEMIA
- □ BLEEDING DISORDER

ALLERGY/IMMUNE/SKIN
- □ ECZEMA
- □ PSORIASIS
- □ CHRONIC SINUSITIS
- □ IMMUNE DEFICIENCY

PULMONARY
- □ ASTHMA
- □ CHRONIC BRONCHITIS
- □ COPD
- □ PULMONARY EMBOLISM
- □ SLEEP APNEA
- □ TUBERCULOSIS

MUSCULOSKELETAL
- □ FIBROMYALGIA
- □ GOUT
- □ RHEUMATOID ARTHRITIS
- □ OSTEOARTHRITIS
- □ OSTEOPOROSIS
- □ LUPUS

ENDOCRINE
- □ ADDISON'S DISEASE
- □ CUSHING'S DISEASE
- □ DIABETES TYPE I
- □ DIABETES TYPE 2
- □ HYPOTHYROIDISM
- □ HYPERTHYROIDISM

RENAL
- □ CHRONIC RENAL FAILURE
- □ PROSTATE ENLARGEMENT
- □ GLOMERULONEPHRITIS
- □ POLYCYSTIC KIDNEYS
- □ KIDNEY STONES
- □ BLADDER INCONTINENCE

PSYCHIATRIC
- □ ANXIETY
- □ BIPOLAR DISORDER
- □ DEPRESSION

PSYCHIATRIC
- □ OCD
- □ SCHIZOPHRENIA

EYES
- □ CATARACTS
- □ GLAUCOMA

CANCERS
- □ TYPE _____

REMISSION? □ YES □ NO

OTHER: _____

PAST SURGICAL HISTORY

COMMON (GENERAL)
- □ CATARACT
- □ TONSILLECTOMY
- □ PACEMAKER/AICD
- □ CORONARY ARTERY BYPASS
- □ CORONARY STENT
- □ HEART VALVE REPLACEMENT
- □ APPENDECTOMY
- □ GALL BLADDER
- □ GASTRIC BANDING/BYPASS

COMMON SPINE
- □ CERVICAL FUSION
- □ LUMBAR FUSION
- □ LUMBAR LAMINECTOMY
- □ SPINALCORD STIMULATOR
- □ SPINAL DRUG PUMP
- □ LUMBAR DISCECTOMY
- □ VERTEBROPLASTY
- □ KYPHOPLASTY

COMMON ORTHOPEDIC
- □ CARPAL TUNNEL
- □ SHOULDER SCOPE
- □ ROTATOR CUFF REPAIR
- □ KNEE SCOPE
- □ HIP REPLACEMENT
- □ KNEE REPLACEMENT
- □ ORIF (SURGERY TO FIX BROKEN BONE)

WHAT BONE? _____

COMMON MALE/FEMALE
- □ TURP (PROSTATE)
- □ OPEN PROSTATECTOMY
- □ BLADDER SLING
- □ CESARIAN SECTION
- □ HYSTERECTOMY
- □ TUBAL LIGATION
- □ BREAST LUMPECTOMY
- □ MASTECTOMY

OTHER/ENTER DETAILS HERE: _____

_____

_____

FAMILY HISTORY

PLEASE LIST ANY MAJOR HEALTH PROBLEMS AMONG YOUR FIRST DEGREE RELATIVES.
BE SPECIFIC. FOR EXAMPLE, IF YOU LIST CANCER, WHAT TYPE WAS IT?

FATHER _____ □ NONE □ UNKNOWN
MOTHER _____ □ NONE □ UNKNOWN
BROTHERS _____ □ NONE □ UNKNOWN
SISTERS _____ □ NONE □ UNKNOWN

SOCIAL HISTORY

MARITAL STATUS: □ MARRIED □ DIVORCED □ SINGLE □ WIDOWED □ SIGNIFICANT OTHER

CURRENT OCCUPATION: _____ WORKING NOW? □ YES □ NO

EDUCATION: □ HIGH SCHOOL □ GED □ COLLEGE □ MASTERS □ DOCTORATE

TOBACCO USE STATUS:

CURRENT SMOKER □ EVERY DAY □ SOME DAYS | □ FORMER SMOKER – QUIT DATE _____ | □ NEVER SMOKED

TOBACCO PRODUCTS CURRENTLY USED: □ CIGARETTES/CIGARS □ SMOKELESS TOBACCO

DO YOU DRINK ALCOHOL? □ NO □ YES | IF YES, HOW OFTEN? □ DAILY □ WEEKLY □ RARELY

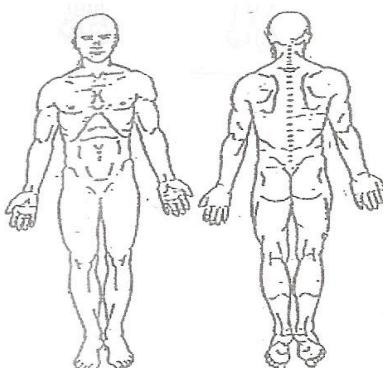
DO YOU HAVE A HISTORY OF ALCOHOLISM □ NO □ YES

HAVE YOU EVER HAD A SUBSTANCE ABUSE PROBLEM? □ NO □ YES

WHAT SUBSTANCE(S) DID YOU ABUSE? _____

NAME:_____ **DOB:** _____ **(PLEASE ENTER)**

HISTORY OF CURRENT PAIN PROBLEM - PLEASE COMPLETE EACH SECTION



WHERE IS YOUR PAIN?

COLOR IN YOUR USUAL PAIN AREAS

CIRCLE YOUR WORST SPOT

Many patients have more than one pain problem. Pick the ONE PROBLEM for which you were referred to describe in detail below.

ONSET

WHEN DID YOU FIRST HAVE THIS PAIN?

☐ PAST 7 DAYS ☐ PAST 8 WKS ☐ PAST 1-3 YRS
☐ PAST 14 DAYS ☐ PAST YEAR ☐ > 3 YRS AGO

WAS THERE A SPECIFIC DATE?

☐ NO ☐ YES _____

RELATED EVENT

☐ NONE ☐ VEHICLE ACCIDENT ☐ FALL ☐ LIFTING INJURY ☐ SURGERY
☐ OTHER _____ **WORK-RELATED? ☐ YES ☐ NO**

WORDS THAT MOST CLOSELY DESCRIBE YOUR PAIN

☐ SHARP ☐ DULL ☐ TINGLING ☐ BURNING

PAIN WORSE WITH

☐ WALKING	☐ BENDING FORWARD	☐ LIFTING	☐ PRESSING ON AREA	☐ OTHER _____
☐ STANDING	☐ BENDING BACKWARD	☐ COUGHING	☐ PHYSICAL EXERTION	_____
☐ SITTING	☐ LAYING FLAT	☐ RIDING IN CAR	☐ NONE- PAIN IS SPONTANEOUS	_____

PAIN BETTER WITH

☐ STOPPING ACTIVITY ☐ CHANGING POSITION ☐ REST ☐ ICE/HEAT ☐ PASSAGE OF TIME

FUNCTIONAL IMPACT

DOES PAIN INTERFERE WITH ANY OF THE FOLLOWING ACTIVITIES? (CHECK THOSE THAT APPLY)
☐ EATING ☐ BATHING ☐ USING TOILET ☐ DRESSING ☐ GETTING UP FROM BED OR CHAIR

PAIN SCALE

0 = NO PAIN 10 = PAIN 'SUFFICIENT TO PASS OUT'

CURRENT	0	1	2	3	4	5	6	7	8	9	10
WORST IN 24 HRS	0	1	2	3	4	5	6	7	8	9	10

RED FLAG QUESTIONS

Do you currently have an INFECTION anywhere (urinary, sinus, chest, skin, etc)? ☐ YES ☐ NO
Is there any chance you might be PREGNANT now? ☐ YES ☐ NO
Are you currently taking a BLOOD THINNER (Coumadin, Plavix, or others)? ☐ YES ☐ NO

FAILURE OF CONSERVATIVE CARE

WHAT CONSERVATIVE CARE OPTIONS HAVE YOU TRIED THAT FAILED TO IMPROVE YOUR PAIN PROBLEM?
PLEASE BE THOROUGH

☐ REST
☐ ICE
☐ HEAT
☐ ACTIVITY MODIFICATION
☐ MEDICAL ASSISTIVE DEVICES
☐ MEDICATIONS
☐ CHIROPRACTIC
☐ PHYSICAL THERAPY
☐ PHYSICIAN SUPERVISED HOME EXERCISE PROGRAM

(OVER)

NAME:_____ DOB: _____ (PLEASE ENTER)

HISTORY OF CURRENT PAIN PROBLEM (CON'T)

FAILURE OF CONSERVATIVE CARE (CON'T)

MANY INSURANCE COMPANIES NOW HAVE MORE RIGOROUS REQUIREMENTS PRIOR TO APPROVING TREATMENTS AND ADVANCED IMAGING (CT/MRI). PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE:

PHYSICAL THERAPY START DATE: _____ END DATE: _____ NUMBER OF SESSIONS: _____
CHIROPRACTIC START DATE: _____ END DATE: _____ NUMBER OF SESSIONS: _____
MEDICALLY SUPERVISED EXERCISE PROGRAM: START DATE: _____ END DATE: _____
MEDICATION CLASSES TRIED: ☐ NSAIDS (ibuprofen, naproxen, etc) ☐ Tylenol ☐ Steroids ☐ Opioids (hydrocodone, etc)
☐ Anti-convulsants (gabapentin, Lyrica, etc) ☐ Muscle relaxants (baclofen, Flexeril, Soma, Robaxin, Skelaxin, Zanaflex, Valium)
☐ Anti-depressants (Amitryptiline, Nortriptyline, Cymbalta, Effexor, etc)

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THESE SYMPTOMS NOW OR IN THE RECENT PAST?

GENERAL
☐ FEVER
☐ SEVERE SHAKING CHILLS

EYES
☐ BLURRED VISION
☐ SENSITIVITY TO LIGHT

EARS/NOSE/THROAT
☐ NOSE BLEEDS
☐ BLEEDING GUMS

CARDIOVASCULAR
☐ CHEST PAIN
☐ PALPITATIONS
☐ SWELLING IN ANKLES

PULMONARY
☐ COUGH
☐ SHORTNESS OF BREATH

GASTROINTESTINAL
☐ CONSTIPATION
☐ DIARRHEA
☐ NAUSEA
☐ VOMITING

GENITOURINARY
☐ BLOOD IN URINE
☐ URINARY INCONTINENCE

MUSCULOSKELETAL
☐ JOINT PAIN
☐ MUSCLE PAIN

INTEGUMENTARY
☐ RASH
☐ HAIR OR NAIL GROWTH CHANGE
☐ SKIN COLOR OR TEXTURE CHANGE

NEUROLOGICAL
☐ DIZZINESS
☐ NUMBNESS
☐ WEAKNESS
☐ SEIZURES

HEMATOLOGIC/LYMPH
☐ EASY BRUISING
☐ SWOLLEN OR TENDER LYMPH NODES

ENDOCRINE
☐ HEAT INTOLERANCE
☐ COLD INTOLERANCE
☐ MEASURED BLOOD SUGARS >200

ALLERGIC/IMMUNE
☐ SEASONAL ALLERGIES
☐ LATEX ALLERGY

PSYCHIATRIC
☐ ANXIETY
☐ DEPRESSION
☐ SLEEP DISTURBANCE
☐ MANIC EPISODES

ALL NEW PATIENTS PLEASE COMPLETE

MEDICARE REQUIRES THAT WE ASK THESE QUESTIONS. WE ARE PENALIZED IF THIS SECTION IS INCOMPLETE. PLEASE RESPOND TO ALL ITEMS, EVEN IF THE QUESTIONS ARE DUPLICATED ELSEWHERE.

WHAT IS YOUR CURRENT NUMERICAL (0-10) PAIN SCORE? _____
WHAT IS YOUR CURRENT HEIGHT? _____ AND WEIGHT? _____

Do you have a diagnosis of ARTHRITIS in any body region? ☐ YES ☐ NO
If you HAVE ARTHRITIS, does it interfere with your activities of daily living? ☐ YES ☐ NO
Are you A FEMALE BETWEEN 65 AND 85 YEARS OLD? ☐ YES ☐ NO
If you are A FEMALE BETWEEN 65 AND 85 YEARS OLD, have you had a DEXA SCAN for OSTEOPOROSIS? ☐ YES ☐ NO
Do you currently use ANY TOBACCO PRODUCTS? ☐ YES ☐ NO
Do you have a diagnosis of HIGH BLOOD PRESSURE? ☐ YES ☐ NO
Did you receive the INFLUENZA VACCINE this season? ☐ YES ☐ NO

FALL SCREEN (AGE >= 65)
Are you able to WALK? ☐ YES ☐ NO
In the past YEAR have you FALLEN more than two times? ☐ YES ☐ NO
In the past YEAR have you FALLEN ONCE, and INJURED YOURSELF? ☐ YES ☐ NO
Do you have problems with your BALANCE? ☐ YES ☐ NO
Do you get DIZZY WHEN YOU STAND UP? ☐ YES ☐ NO
Does POOR VISION seem to impair your BALANCE? ☐ YES ☐ NO
Does your home have FALL HAZARDS? ☐ YES ☐ NO
Do your MEDICATIONS seem to impair your BALANCE? ☐ YES ☐ NO
..... ☐ YES ☐ NO