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 _____

IF YOU'RE COVERED UNDER WORKER'S COMPENSATION OR MOTOR VEHICLE INSURANCE, ENTER INFO BELOW, IF NOT SKIP TO HEIGHT & WEIGHT

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

ADJUSTER/CASE MANAGER:_____ **PHONE:** _____ **FAX:** _____

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: _____**Feet** _____**Inches** **WEIGHT:** _____**Lbs**

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

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

PSYCHIATRIC
- ☐ ANXIETY
- ☐ BIPOLAR DISORDER
- ☐ DEPRESSION

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

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

PSYCHIATRIC
- ☐ OCD
- ☐ SCHIZOPHRENIA

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

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

EYES
- ☐ CATARACTS
- ☐ GLAUCOMA

HEMATOLOGICAL
- ☐ IRON DEF ANEMIA
- ☐ BLEEDING DISORDER

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

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

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 _____

FAMILY HISTORY

PLEASE LIST ANY MAJOR HEALTH PROBLEMS AMONG YOUR FIRST DEGREE RELATIVES. BE SPECIFIC.

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

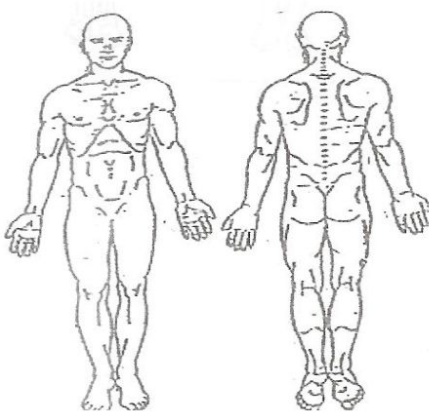
DO YOU HAVE A HISTORY OF ALCOHOLISM ☐ NO ☐ YES

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

WHAT SUBSTANCE(S) DID YOU ABUSE? _____

Name: _____ DOB:_____

HISTORY OF CURRENT PAIN PROBLEM – PLEASE COMPLETE ALL SECTIONS



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 WEEKS ☐PAST 1-3 YEARS
☐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 DESCRIBE YOUR PAIN

☐SHARP ☐DULL ☐BURNING ☐TINGLING

PAIN WORSE WITH

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

PAIN BETTER WITH

☐STOPPING ACTIVITY ☐CHANGING POSITION ☐REST ☐ICE/HEAT

FUNCTIONAL IMPACT – PAIN INTERFERES WITH THE FOLLOWING ACTIVITIES:

☐EATING ☐BATHING ☐USING TOILET ☐DRESSING ☐RISING FROM A BED OR CHAIR

PAIN SCALE **0 = NO PAIN** **10 = "SUFFICIENT TO PASS OUT"**

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

RED FLAG QUESTIONS

☐CURRENT INFECTION ☐POSSIBLY PREGNANT ☐CURRENT BLOOD THINNER USE

CONSERVATIVE CARE YOU HAVE TRIED

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

Name: _____ DOB:_____

FAILURE OF CONSERVATIVE CARE (CONTINUED)

INSURANCE COMPANIES HAVE INFLEXIBLE REQUIREMENTS TO APPROVE TREATMENT. PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE: DOCUMENTING PHYSICAL THERAPY/MEDICATIONS IS VERY IMPORTANT.

	START DATE	END DATE	# OF SESSIONS
PHYSICAL THERAPY			
CHIROPRACTIC			
MEDICALLY SUPERVISED EXERCISE PROGRAM			

MEDICATION CLASSES TRIED

☐NSAIDS ☐STEROIDS ☐ANTI-CONVULSANTS (gabapentin, Lyrica)
☐TYLENOL ☐OPIOIDS ☐MUSCLE RELAXANTS (baclofen, Flexeril, Robaxin, Skelaxin, Zanaflex)

REVIEW OF SYSTEMS – CHECK IF YOU HAVE ANY OF THESE SYMPTOMS

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
☐SHORT OF BREATH

GASTROINTESTINAL
☐CONSTIPATION
☐DIARRHEA
☐NAUSEA
☐VOMITING

GENITOURINARY
☐BLOOD IN URINE
☐URINE INCONTINENCE

MUSCULOSKELETAL
☐JOINT PAIN
☐MUSCLE PAIN

INTEGUMENTARY
☐RASH
☐HAIR/NAL CHANGE
☐SKIN CHANGE

NEUROLOGICAL
☐DIZZINESS
☐NUMBNESS
☐WEAKNESS
☐SEIZURES

HEMATOLOGIC/LYMPH
☐EASY BRUISING
☐TEENDER YMPH NODES

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

ALLERGIC/IMMUNE
☐SEASONAL ALLEGIES
☐LATEX ALLERGY

PSYCHIATRIC
☐ANXIETY
☐DEPRESSION
☐INSOMNIA
☐MANIC EPISODES

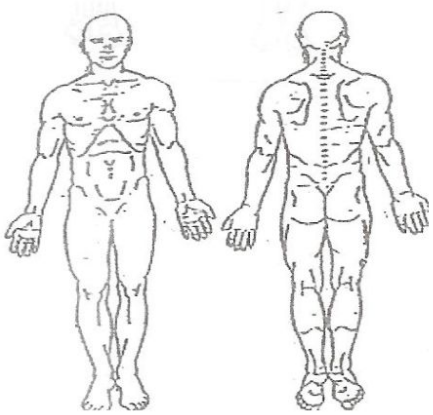
MEDICARE REQUIRES THAT WE ASK <u>ALL PATIENTS</u> THE FOLLOWING QUESTIONS. WE ARE PENALIZED IF THIS SECTION IS INCOMPLETE. PLEASE RESPOND TO ALL ITEMS, EVEN IF THE QUESTIONS ARE DUPLICATED ELSEWHERE.

WHAT IS YOUR CURRENT NUMERICAL (0-10) PAIN SCORE: 0 1 2 3 4 5 6 7 8 9 10
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 activities of daily living?	☐YES ☐NO
Are you A FEMALE BETWEEN 65 AND 85 YEARS OLD AND HAD A DEXA SCAN?	☐YES ☐NO
If you are 65 OR OLDER did you receive the PNEUMOCOCCAL VACCINE?	☐YES ☐NO
Do you currently use ANY TOBACCO PRODUCTS?	☐YES ☐NO
Do you have a diagnosis of HIGH BLOOD PRESSURE?	☐YES ☐NO
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 impair your balance?	☐YES ☐NO
Does your home have FALL HAZZARDS?	☐YES ☐NO
Do MEDICATIONS impair your balance?	☐YES ☐NO
Did you receive the INFLUENZA VACCINE THIS SEASON (OCT 1 – MAR 31)?	☐YES ☐NO

Name: _____ DOB:_____

HISTORY OF CURRENT PAIN PROBLEM – PLEASE COMPLETE ALL SECTIONS



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