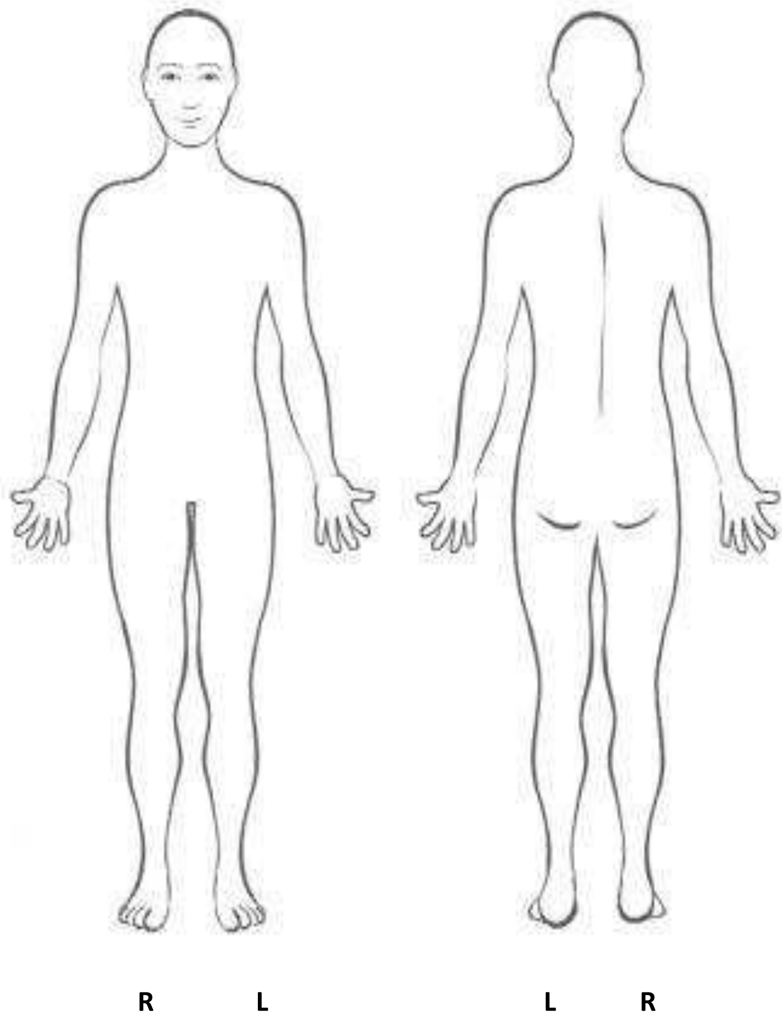
PAIN INFORMATION SHEET

PLEASE MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE SENSATIONS DESCRIBED BELOW.
PLEASE USE THE APPROPRIATE SYMBOL & INCLUDE ALL AREAS.

****	====	OOOO	XXXX	////
ACHE ****	NUMBNESS ====	PINS & NEEDLES OOOO	BURNING XXXX	STABBING ////
****	====	OOOO	XXXX	////



WHEN DID THE PAIN START? ____

NAME ____

DATE ____

NEW PATIENT INTAKE FORM

Today's Date: ________________________

Name: ______________________________ □ Male □ Female Date of Birth: _____________ Age: _____

What is the **primary** reason for today's visit?

____

How long have you had this problem?

____

How did this problem occur? □ Suddenly □ Gradually
□ Motor Vehicle Accident (date): _________________________________
□ Work related injury (date and claim number): ______________________

Please rate your pain by **circling** the one number that best describes your **AVERAGE** pain in the last 7 days.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst imaginable pain

Please **circle** all the words that describe to your pain:

Throbbing Shooting Sharp Electric/Burning Numbness Tingling

Does the pain travel or radiate? □ Yes □ No
If so, where to? ____

Which activity or position *aggravates* your pain?
□ Sitting □ Standing □ Walking □ Other (please describe): _______________________________

Which activity or position *relieves* your pain?
□ Sitting □ Standing □ Walking □ Other (please describe): _______________________________

Are there any **new** changes in your bowel or bladder function related to this condition? □ Yes □ No
If so, please describe: ____

Describe your sleep pattern? □ Normal □ Difficulty falling asleep □ Difficulty staying asleep

FUNCTIONAL HISTORY:

Please describe activities you CANNOT perform due to your pain:

____
____
____

PREVIOUS WORK-UP/ TREATMENT:

Have you seen other physicians/surgeons for this condition? ☐ Yes ☐ No If yes, indicate who below:

___

___

Please list your most recent diagnostic tests: ☐ I did NOT have any prior tests or imaging

	X-ray	CT scan	MRI	EMG	Bone Scan	Other
Body Part						
Date						
Location						

Have you had any of the following treatments? ☐ Yes ☐ No

Treatment	Describe (# treatments, location, etc.)	Effective?
☐ Physical Therapy	__ less than 6 weeks __ more than 6 weeks	☐ Yes ☐ No
☐ Massage		☐ Yes ☐ No
☐ Chiropractic care		☐ Yes ☐ No
☐ Acupuncture		☐ Yes ☐ No
☐ Injections		☐ Yes ☐ No
☐ Surgery		☐ Yes ☐ No

MEDICAL AND SURGICAL HISTORY:

High blood pressure (HTN) ☐ Yes ☐ No
Diabetes (T2DM) ☐ Yes ☐ No
Atrial Fibrillation (AFIB) ☐ Yes ☐ No
Acid Reflux (GERD) ☐ Yes ☐ No
Irregular heartbeat ☐ Yes ☐ No
Seizure disorder ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Fibromyalgia ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Bipolar disorder ☐ Yes ☐ No
Coronary artery disease (CAD) ☐ Yes ☐ No
Bleeding disorder ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Substance abuse (specify below) ☐ Yes ☐ No
Cancer (specify below) ☐ Yes ☐ No

Others (please list)

___

___

Have you had any prior surgeries? ☐ Yes ☐ No If yes, please indicate below:

Surgery and Date

___

___

___

___

FAMILY HISTORY:
Please list any major illnesses in your family, including cancer, stroke, diabetes, chronic pain, and others.

____
____

SOCIAL HISTORY:
Do you smoke? ☐ Yes ☐ No If yes, how much/often? ________________________
Do you drink? ☐ Yes ☐ No If yes, how often? ________________________
Use illicit drugs? ☐ Yes ☐ No If yes, please list: ________________________

Do you work? ☐ Yes ☐ No If yes, what is your occupation? ________________________
Are you on disability? ☐ Yes ☐ No

Do you have an attorney (or lawyer) and any litigation pending? ☐ Yes ☐ No
If yes, please list attorney name and law firm: ________________________

ALLERGIES:
☐ No allergies ☐ Latex ☐ Contrast dye ☐ Iodine ☐ Shellfish ☐ Steroids
Please list any other allergies:

____
____

MEDICATIONS:
Do you take any blood thinners? ☐ Yes ☐ No
If yes, please list blood thinner: ________________________

Please list any medications you are **CURRENTLY** taking for **YOUR PAIN CONDITION:**

Medication Name	Dose/Frequency	Currently Using?	Effective for Pain?	Prescribed by whom
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	

Please mark if you have used any of the following medications **IN THE PAST:**

Over-the Counters	**Nerve Pain**	**Opioids/Narcotics**		**Muscle Relaxers**
☐Tylenol	☐Gabapentin	☐Hydrocodone	☐Tramadol	☐Flexeril
☐Ibuprofen	☐Lyrica	☐Oxycodone	☐Fentanyl	☐Tizanidine
☐Naproxen	☐Topamax	☐Oxycontin	☐Dilaudid	☐Baclofen
☐Diclofenac	☐Cymbalta	☐Percocet	☐Morphine	☐Methocarbamol

Please list all medications currently using for **OTHER MEDICAL CONDITIONS:**

________________________ ________________________
________________________ ________________________
________________________ ________________________

REVIEW OF SYSTEMS: If you currently have a *problem* in any of these areas, please circle below:

☐ Check box if none below apply to you

General
- Fevers
- Chills
- Weight loss

ENT
- Hearing loss
- Sore throat
- Difficulty Swallowing

Cardiovascular
- Chest pain
- Irregular heartbeat
- Blood clot

Respiratory
- Cough
- Shortness of Breath
- Wheezing

Gastrointestinal
- Heartburn
- Nausea
- Vomiting
- Constipation
- Diarrhea

Urinary
- Kidney stones
- Difficult urinating
- Urinary incontinence

Neurological
- Sensation loss
- Fainting
- Seizures
- Headache
- Coordination loss

Skin
- Easy bruising
- Bleeding disorder
- Rash

Endocrine
- Heat/Cold Intolerance
- Excessive thirst
- Change in sexual desire

Psychiatry
- Depression
- Anxiety
- Panic attacks
- Suicidal ideations

ADDITIONAL INFORMATION:

How did you learn about EMA Puget Sound? (Please check all that apply)

☐ Physician ☐ Physical Therapist ☐ Case Manager ☐ Other (please specify):
☐ Chiropractor ☐ Family Member/Friend ☐ Attorney

Who is your primary care physician? ____

Who referred you for this evaluation?

Name: ____

Specialty: ____

Email Address (For Patient Portal access): ____

Preferred Pharmacy and City: ____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM