

New Patient Intake Form

Welcome to Northwest Pain Care. We look forward to serving you.

Please complete this form for the **one pain location** for which you have been referred.

For example, **Back/leg or Neck/arm, not both.** Please do **not** complete form for multiple pain areas.

****We will be unable to see you unless this form is completely filled out. We value your thoroughness.****

Today's Date _____

Name _____ M F Date of Birth _____ Age _____

E-mail Address (For Patient Portal) _____

Do you have Advance Directives or a Living Will? Yes No

Referring doctor: _____ Primary doctor: _____

Pharmacy: _____

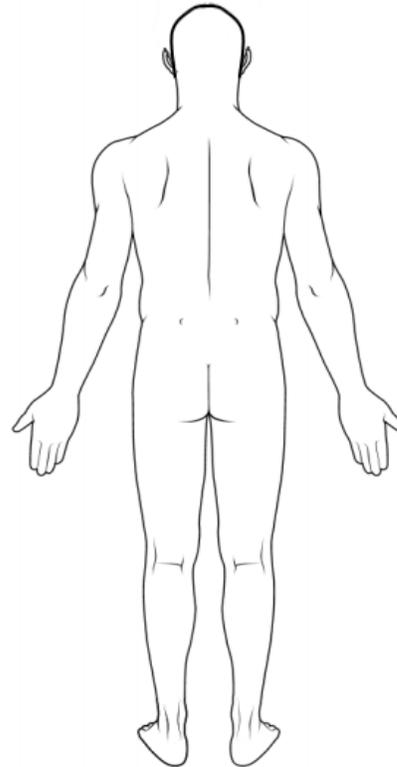
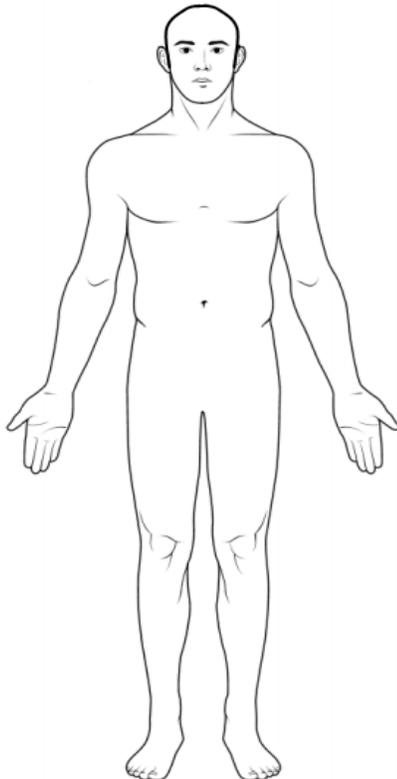
General Information

Where is your pain located? (Describe)

Where is the pain located? (Mark on diagram below)

FRONT

BACK



How would you describe the onset of your pain? Sudden Gradual

What does it feel like? Is it continuous or intermittent (comes and goes)? **Please check all that apply.**

- | | | | | | |
|--|-------------------------------------|---------------------------------------|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aching: | <input type="checkbox"/> Continuous | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Dull: | <input type="checkbox"/> Continuous | <input type="checkbox"/> Intermittent |
| <input type="checkbox"/> Sharp: | <input type="checkbox"/> Continuous | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Shooting: | <input type="checkbox"/> Continuous | <input type="checkbox"/> Intermittent |
| <input type="checkbox"/> Burning: | <input type="checkbox"/> Continuous | <input type="checkbox"/> Intermittent | | | |

When did your pain start? About _____ days ago weeks ago months ago years ago

Is your pain the result of an injury? Yes No

If yes, please describe the injury. _____

Is your pain related to a work injury? Yes No

If yes, please explain the injury.

Is your pain related to a motor vehicle accident? Yes No

If yes, please explain the injury.

Does the pain radiate? Yes No

If yes, to where? _____

Rate your pain on a scale of 0 to 10; 0 is no pain and 10 is the worst pain imaginable.

Current pain: ___/10 Average pain: ___/10 Least pain: ___/10 Worst pain: ___/10

What time of day is your pain the worst?

- | | | | | | |
|--|--|--|------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Night | <input type="checkbox"/> Early Morning | <input type="checkbox"/> Late Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening | <input type="checkbox"/> Bed time |
| <input type="checkbox"/> Pain is always the same | | <input type="checkbox"/> Pain varies, no particular time | | | |

What positions or activities make your pain better?

- | | | | | |
|---------------------------------------|---|---|----------------------------------|--|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Laying |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Working | <input type="checkbox"/> Twisting | <input type="checkbox"/> Stairs | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Pain Meds | <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Coughing | <input type="checkbox"/> Ice | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Looking Up | <input type="checkbox"/> Looking Down | | <input type="checkbox"/> Riding in a car |
| <input type="checkbox"/> Turning Head | <input type="checkbox"/> Bending Back | <input type="checkbox"/> Bending Forward | | <input type="checkbox"/> Bending Neck |
| <input type="checkbox"/> Back | <input type="checkbox"/> Bending Neck Forward | <input type="checkbox"/> Straining for a Bowel Movement | | |

If yes, when did it start?

Have you had any recent numbness (complete loss of sensation)? Yes No

If yes, where?

Have you had any tingling (feeling your limbs going to sleep)? Yes No

If yes, where?

Have you had any weakness? Yes No

If yes, where?

Emotional Effects of Pain

Please check all of the following that are significantly affected by your pain.

- General activity Mood Walking Normal work routine
 Social activity Sleep Enjoyment of life

Do you feel that your pain symptoms are effecting you emotionally? Yes No

If yes, how have your pain symptoms made you feel? (Check all that apply)

- Angry Anxious Concerned Confused Desperate Exasperated
 Fatigued Fearful Frustrated Insecure Irritable Preoccupied
 Stressed Trapped Unhappy Worried

Activity

Rate your current activity level on a scale of 0 to 10; 0 is no activity and 10 is full activity.

Average activity: ___/10 Least activity: ___/10 Most activity: ___/10

How far can you walk without stopping (in city blocks)?

- < 1/2 block 1 block 1-3 blocks 3-5 blocks 5-10 blocks >10 blocks

How long can you stand without moving?

- < 1 minute 1-3 mins 3-5 mins 5-10 mins 10-15 mins > 15 mins

Do you bend over and hold on to a cart while shopping? Yes No

How many hours do you spend sleeping per day? _____ hours.

How many hours do you spend sitting per day? _____ hours.

How many hours do you spend lying down per day? _____ hours.

How many hours do you spend walking per day? _____ hours.

How many hours do you spend working per day? _____ hours.

How many hours do you spend exercising? _____ hours.

How many days per week do you exercise? _____ days.

Treatment

Have you tried any over the counter medications to treat your pain? Yes No
If yes, what is the name of the medication? _____

Are you currently taking any prescription medication to treat your pain? Yes No
If yes, what is the name of the medication? _____

Have you recently seen/been referred to another healthcare provider for your pain? Yes No
If yes, what is the specialty of the healthcare professional? _____

What is the name of the provider? _____

When did you see the provider? _____

Have you had any of the following injections or treatments for your pain? (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Interlaminar Epidural Steroid injection | <input type="checkbox"/> Transforaminal Epidural Steroid Injection |
| <input type="checkbox"/> Caudal Epidural Steroid injection | <input type="checkbox"/> Facet Joint Injection |
| <input type="checkbox"/> Sacroiliac Joint Injection | <input type="checkbox"/> Spinal Cord Stimulation Trial |
| <input type="checkbox"/> Spinal Pump Trial | <input type="checkbox"/> Trigger Point Injection |
| <input type="checkbox"/> Botox injection for chronic migraine | <input type="checkbox"/> Kyphoplasty |
| <input type="checkbox"/> Vertebroplasty | <input type="checkbox"/> Ilioinguinal Nerve block |
| <input type="checkbox"/> Genitofemoral Nerve Block | <input type="checkbox"/> Celiac Plexus Block |
| <input type="checkbox"/> Hypogastric Plexus Block | <input type="checkbox"/> Lumbar Sympathetic Block |
| <input type="checkbox"/> Stellate Ganglion Block | <input type="checkbox"/> Cervical Radiofrequency Ablation |
| <input type="checkbox"/> Lumbar Radiofrequency Ablation | <input type="checkbox"/> Thoracic Radiofrequency Ablation |
| <input type="checkbox"/> Medial Branch Nerve Blocks | <input type="checkbox"/> Greater Occipital Nerve Block |
| <input type="checkbox"/> Greater Trochanter Injection | <input type="checkbox"/> Hip Injection |
| <input type="checkbox"/> Piriformis injection | <input type="checkbox"/> None |

Have you tried any of the following forms of adjuvant therapies?

- | | | | |
|---------------------------------------|------------|------------------------------|-----------------------------|
| <input type="checkbox"/> Hypnosis: | Effective? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Biofeedback: | Effective? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> TENS units: | Effective? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- | | | | |
|--|------------|------------------------------|-----------------------------|
| <input type="checkbox"/> Acupuncture: | Effective? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Chiropractics: | Effective? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Cognitive Behavioral Therapy: | Effective? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Massage therapy: | Effective? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you had physical therapy in the last year for your pain? Yes No
 If yes, where did you do physical therapy? _____

How many total physical therapy visits did you have? _____

Was the physical therapy helpful? Yes No

If yes, how effective? Mildly Moderately Very

Imaging: (Lumbosacral = lower back; thoracic = mid back; cervical = neck)

Have you had any recent imaging of the lumbosacral spine?

- | | | | | |
|--------------|------------------------------|-----------------------------|-------------|--------------|
| MRI | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |
| X-Ray | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |
| Bone Scan | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |
| CT Myelogram | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |
| CT Scan | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |

Have you had any recent imaging of the thoracic spine?

- | | | | | |
|--------------|------------------------------|-----------------------------|-------------|--------------|
| MRI | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |
| X-Ray | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |
| Bone Scan | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |
| CT Myelogram | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |
| CT Scan | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |

Have you had any recent imaging of the cervical spine?

- | | | | | |
|-------|------------------------------|-----------------------------|-------------|--------------|
| MRI | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |
| X-Ray | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ | Where? _____ |

Bone Scan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____	Where? _____
CT Myelogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____	Where? _____
CT Scan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____	Where? _____
Have you had any other recent imaging?				
MRI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____	Where? _____
X-Ray	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____	Where? _____
Bone Scan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____	Where? _____
CT Myelogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____	Where? _____
CT Scan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____	Where? _____

Have you had an **EMG & Nerve Conduction Study?** Yes No

If yes, when? Month _____ Year _____ **Where?** _____

Have you recently had a **PET scan?** Yes No

If yes, when? Month _____ Year _____ **Where?** _____

Have you recently had a **Bone Density Scan?** Yes No

If yes, when? Month _____ Year _____ **Where?** _____

Have you recently had other imaging of any kind? Yes No

If yes, what kind?

When? Month _____ Year _____ **Where?** _____

Substance Use

Do you currently smoke/chew tobacco? Yes No

Cigarettes Cigars Pipe Chewing tobacco Dipping tobacco

Every day Most days Some days

When did you start smoking? Month _____ Year _____

Have you ever smoked? Yes No

Cigarettes Cigars Pipe Chewing tobacco Dipping tobacco

Once A few times Many times

Are you a former smoker? Yes No
 Cigarettes Cigars Pipe Chewing tobacco Dipping tobacco
When did you quit smoking? Month _____ Year _____

How much do/did you smoke? _____ Packs per Day Month

Do you drink alcohol? Yes No
 Beer Wine Hard liquor
How often? Every day Most days Some days

When did you start drinking? Month _____ Year _____

Have you ever consumed alcohol? Yes No
 Beer Wine Hard liquor

How often? Once A few times Many times

How much do you drink? _____ (Bottles Cans Glasses) per (Day Month)

Have you ever felt you should cut down on your drinking? Yes No

Have people criticized your drinking in the past? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink early in the morning to calm yourself or to get rid of a hangover?
 Yes No

How many cups of coffee do you consume per day? _____

How many cups of tea do you consume per day? _____

How many caffeinated, carbonated drinks/sodas do you consume per day? _____

How many energy drinks do you consume per day? _____

How many ounces of chocolate do you consume per day? (1.5 ounces = 1 bar of chocolate) _____

Do you take caffeine tablets (ex. No-Doz, Vivarin)? Yes No

If so, how often? _____

Do you currently use recreational drugs? (please list) Yes No

Have you ever used recreational drugs in the past? (please list) Yes No

Do you currently smoke marijuana? Yes No

Have you ever smoked marijuana? Yes No

Employment History

Are you employed? Yes No

What is your occupation? _____

How long have you been working at this line of work? _____

If unemployed, how long have you been unemployed? _____

Family

Marital status: Single Married Separated Divorced Widow(er)

Do you have a history of sexual abuse? Yes No

Do you have a history of physical abuse? Yes No

Family Medical History: Please list all known medical problems for family members, ages, whether they are living or deceased, and age at death.

Mother: Is your mother living? Yes No

If no, how old was she at her death? _____

Medical Problems: _____

Father: Is your father living? Yes No

If no, how old was he at his death? _____

Medical Problems: _____

Grandmother: Is your grandmother living? Yes No

If no, how old was she at her death? _____

Medical Problems: _____

Grandfather: Is your grandfather living? Yes No

If no, how old was he at his death? _____

Medical Problems: _____

Sister(s): _____

Brother(s): _____

Son(s): _____

Daughter(s): _____

Medical History

Please list all past medical problems:

None

Please list all past surgeries with date, location, and surgeon's name:

None

Please list all hospitalizations:

None

Do you have any medication allergies? (Please list)

Yes

No

Are you allergic to contrast dye?

Yes

No

Medication: Please list all current medications including blood thinners.

None

Medication	Dosage	Frequency

Please list all past pain medications.

None

Medication	Dosage (If known)	Frequency (If known)

Review of Systems: Please check all that currently apply to you.

Constitutional:

- Chills Fatigue Recent Fever Generalized Weakness
 Recent Weight Gain Recent Weight Loss

Eyes:

- Blurry vision Cataracts Eye discharge Double vision
 Excessive tearing Eye pain Eyeglass use Glaucoma
 Eye infections Pain w/ light Recent eye injury Eye redness
 Vision loss

ENT (nose):

- Nasal discharge Frequent colds Hay fever Nasal obstruction
 Recent nose bleeds Chronic sinusitis

ENT (mouth):

- Recent gum bleeding Change in dentition Recent hoarseness Dentures

ENT (ears):

- Ear discharge Dizziness Hearing aid use Ear infections
 Ear pain Ringing in the ears Hearing loss

ENT (throat/neck):

- Frequent sore throats Neck tenderness Enlarged tonsils Neck mass

Respiratory:

- Asthma Recent cough Recent wheezing Bronchitis
 Coughing up blood Pleurisy (Pain with Breathing) Shortness of Breath
 Sputum production History of TB Recent pneumonia Recent night sweats
 Recent chest wall pain

Cardiovascular:

- Recent chest pain Congestive heart failure Palpitations Varicose veins
 Cool extremities Discolored extremities Heart murmur High blood pressure
 History of heart attack Leg pain while walking History of rheumatic fever
 Shortness of breath with exertion Leg swelling Leg ulcers
 Mitral valve prolapse Unable to breathe while flat Difficulty breathing

Gastrointestinal:

- Recent abdominal pain Recent constipation Recent Diarrhea Recent heartburn
 Jaundice Liver disease Rectal bleeding Black, tarry stools
 Recent change in stool color Decreased appetite Excessive Thirst Gallbladder disease
 Hemorrhoids Recent nausea Recent vomiting Difficulty swallowing
 Bloody stools Hepatitis C Hepatitis B Hepatitis A
 Vomiting up blood Increased appetite

Musculoskeletal:

- Arthritis Joint pain Gout Back problems Joint stiffness
 Muscle cramps Muscle stiffness Muscle weakness Neck problems

Mid-back problems

Psychiatric:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Recent anxiety | <input type="checkbox"/> Recent depression | <input type="checkbox"/> Recent behavioral change | <input type="checkbox"/> Recent disorientation |
| <input type="checkbox"/> Disturbing thoughts | <input type="checkbox"/> Excessive stress | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Mood changes | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Bipolar disease |
| <input type="checkbox"/> Paranoia | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Personality disorder | <input type="checkbox"/> Previous psychiatric care |
| <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Inability to sleep | <input type="checkbox"/> Obsessive/Compulsive | <input type="checkbox"/> Nervousness |

Skin:

- | | | | | |
|--|----------------------------------|--|--|--|
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Itching | <input type="checkbox"/> Dryness | <input type="checkbox"/> Easy Bruisability | <input type="checkbox"/> Hair texture change |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Lumps | <input type="checkbox"/> Increased mole size | <input type="checkbox"/> Nail changes | <input type="checkbox"/> Recent rashes |
| <input type="checkbox"/> Skin color change | | <input type="checkbox"/> New skin moles | | |

Neurological:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Burning sensation | <input type="checkbox"/> Dizziness | <input type="checkbox"/> History of head injury | <input type="checkbox"/> Recent headaches |
| <input type="checkbox"/> Recent memory loss | <input type="checkbox"/> Recent numbness | <input type="checkbox"/> History of paralysis | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Recent tingling | <input type="checkbox"/> Recent tremors | <input type="checkbox"/> Unsteady gait | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Discoordination | <input type="checkbox"/> Recent passing out | <input type="checkbox"/> Speech difficulty | |

Endocrine:

- | | | | |
|---|--|--|----------------------------------|
| <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Intolerance to cold | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Intolerance to heat | <input type="checkbox"/> Increased thirst | |
| <input type="checkbox"/> Recent sweats | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Excessive urination | |

Hematological/Lymph:

- | | | | |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Radiation exposure |
| <input type="checkbox"/> Transfusion reaction | <input type="checkbox"/> Tender lymph nodes | | <input type="checkbox"/> Swollen lymph nodes |
| <input type="checkbox"/> Current Blood thinner use | <input type="checkbox"/> History of blood transfusions | | <input type="checkbox"/> Easy bruising |

Allergy/Immunologic:

- | | | | |
|--|---|--------------------------------------|--|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Itchy nose | <input type="checkbox"/> Recurrent infections |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Food allergies | <input type="checkbox"/> Insect allergies | <input type="checkbox"/> Dye allergy | <input type="checkbox"/> Pollen/Seasonal allergy |
| <input type="checkbox"/> Environmental allergy | | | |

Urinary:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Difficulty starting stream | <input type="checkbox"/> Recent flank pain | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Urine odor | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Sexual difficulty | <input type="checkbox"/> Frequent UTI's | <input type="checkbox"/> Urinary burning | <input type="checkbox"/> Unusual urine color |
| <input type="checkbox"/> Elevated creatinine | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Painful menstrual cycle | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Urinary retention |
| <input type="checkbox"/> Kidney transplant | <input type="checkbox"/> Awakening to urinate | <input type="checkbox"/> Nighttime Urination | <input type="checkbox"/> Urgent Urination |

Please be sure that you have completely filled out this form. We look forward to seeing you at your appointment.

A link to Northwest Pain Care's Privacy Protection Policies is located on our website, at www.northwestpaincare.com.