Today's Date:_____
Name:_____
DOB:_____
Weight:_____
Height: _____

New Patient Intake Paperwork

Onset of Symptoms

Approximately when did this pain begin? _____
What caused your current pain episode? _____
Is your pain the result of a Motor Vehicle Accident or Personal Injury *(legal term used to describe an injury sustained to you by the negligence of another)* □ Yes □ No
How did your current pain episode begin? □ Gradually □ Suddenly
Since you pain began, how has it changed? □ Decreased □ Increased □Stayed the same

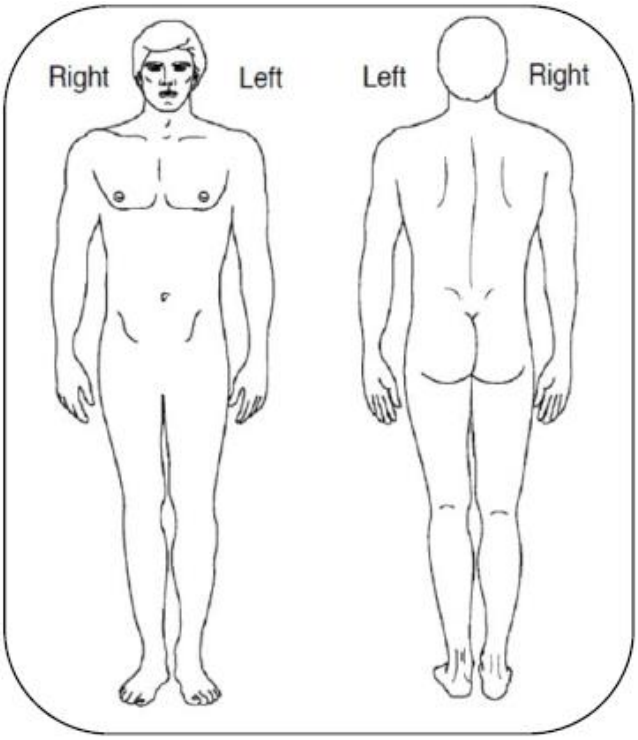
Where is your worst area of pain located? _____
Does this pain radiate? If so, where? _____
What makes the pain better? _____
What makes the pain worse? _____

MARK ALL OF THE FOLLOWING ACTIVITIES THAT ARE ADVERSELY/NEGATIVELY AFFECTED BY YOUR PAIN:

□ Enjoyment of life □ Normal Work □ General Activity □ Recreational Activities
□ Walking □ Mood □ Relationships with People □ Other:_____

_____What number on the pain scale (0-10) best describes your pain **right now?**
_____What number on the pain scale (0-10) best describes your **worst pain?**
_____What number on the pain scale (0-10) best describes your **average pain over the last month?**

Use this diagram to indicate the location of your pain



Pain Description

Check all of the following that describe your pain:
□ Dull □ Electric □ Hot/Burning □ Numbness
□ Stabbing/Sharp □ Cramping □ Throbbing □ Deep
□Shooting

What word best describes the frequency of your pain?
□ Constant □ Intermittent

When is your pain at its worst?
□ Morning □ During the day
□ Evenings □ Middle of the Night
□ Worse on Activity □ Worse at rest

In the past three months have you developed ANY NEW:

□ Bladder Incontinence (not including frequency) □ Bowel Incontinence (not including diarrhea or constipation)
□ Balance Problems □ Chills □ Difficulty Walking □ Fevers □ Nausea □ Vomiting

□ **Numbness/Tingling – Where?** _____ □ **Weakness – Where?** _____
□ I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIOINS.

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

□ MRI of the _____ Date: _____ Facility: _____
□ X-Ray of the _____Date: _____ Facility: _____
□ CT scan of the _____ Date: _____ Facility: _____
□EMG/NCV study of the _____Date: _____ Facility: _____
□ Other diagnostic testing: _____
□ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

□ Physical Therapy
□ Chiropractic
□ Spine Surgery
□ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
□ Joint Injection – Joint(s) _____
□ Medial Branch Blocks of Facet Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
□ Radiofrequency Ablation – (circle all levels that apply) Cervical/Thoracic/Lumbar
□ Spinal Column Stimulator – (circle one) Trial Only/ Permanent Implant
□ Other: _____
□ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.**

Do you take any of these Blood Thinners? (Mark all that apply)

□ Aspirin	□ Fish Oil	□ Aggrenox	□ Coumadin/Warfarin	□ Effient/Prasugrel
□ Lovenox/Enoxaparin		□ Plavix/Clopidogrel	□ Pletal/Cilostazol	□ Pradaxa/Dabigatran
□ Ticlid /Ticlopidine		□ Brilinta/Ticagrelor	□ Xarelto/Rivaroxaban	□ Eliquis/Apixaban
□ Heparin/Subcutaneous		□ Arixtra/Fondaparinux	□ Edoxaban/Savaysa	

□ Other _____

Patient Signature: _____ **Date:** _____