Dr Shoham New Patient Intake Paperwork

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible.

NAME: _____ DOB_____ TODAY'S DATE_____

Weight:_____ Height: _____

Pain Description

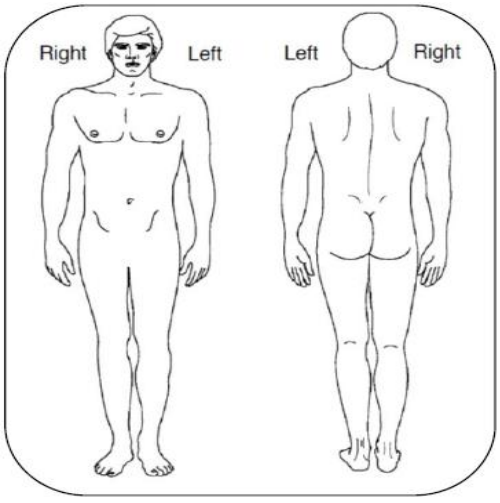
Please use the pain scale described below to rate your pain for the questions below:

0- Pain Free
1- Very minor annoyance, occasional minor twinges
2- Minor annoyance, occasional strong twinges
3- Annoying enough to be distracting
4- Can be ignored if you are really involved in your work/task, but still distracting
5- Cannot be ignored for more than 30 minutes
6- Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7- Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8- Physical activity is severely limited/ you can read and talk with effort. Nausea and dizziness caused by pain.
9- Unable to speak, crying out or moaning uncontrollably, near delirium
10- Unconscious. Pain makes you pass out

_____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 **least 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 and type of you pain. Mark the drawing with the following letters that best describe your symptoms:

"B" = burning
"D" = deep
"DU" = dull
"E" = electric
"N" = numbness
"SP" = sharp
"SH" = shooting
"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching
"T" = "Throbbing"



Where is your worst area of pain located? _____
Does this pain radiate? If so, where? :_____
Please list any additional areas of pain: _____
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: _____

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

Pain Description

Check all of the following that describe your pain:
□ Aching □ Hot/Burning □ Stabbing/Sharp □ Cramping
□ Shock-like □ Tingling/ Pins and Needles

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

In the past three months have you developed ANY NEW:

□ Balance Problems □ Bladder Incontinence □ Bowel Incontinence □ 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 you 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:
□ Chiropractic □ Physical Therapy □ 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
□ Vertebroplasty/ Kyphoplasty – Level(s) _____
□ Other: _____
□ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.

Current Medications

Please indicate which (if any) of the following blood-thinners you are taking:
□ Aggrenox □ Coumadin/Warfarin □ Effient □ Lovenox □ Plavix □ Pletal □ Pradaxa
□ Prasugrel □ Ticlid □ Other _____
Please list ***all*** medications you are currently taking.

Medication Name	**Dose**	**Frequency**	