Apex Pain Specialists - New Patient Medical History Intake Form

Name_____ Age ____ Today's Date: _____/_____/_____

Date of Birth: _____/_____/_____ Referred By:_____

Where is your pain?

When did it start?

Was there a cause?

Please make a mark on the line below to indicate the level of discomfort you have today

No Pain _____ Worst Pain Ever

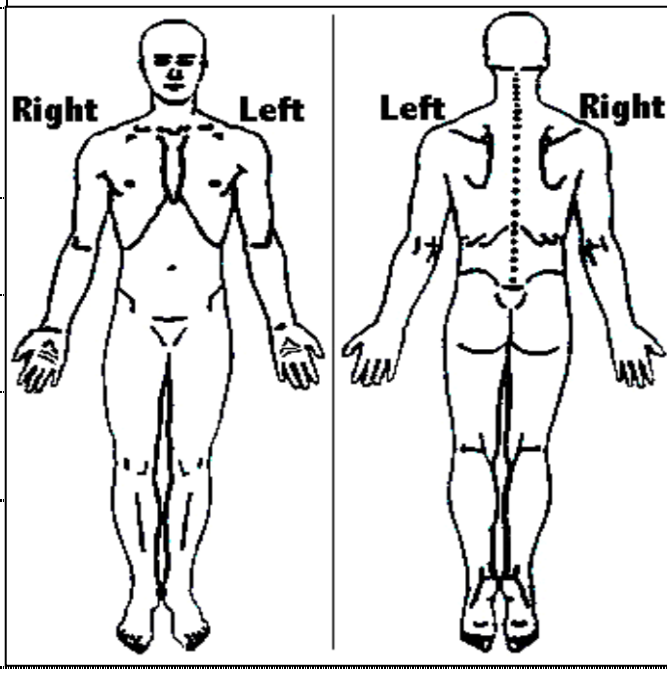
0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like:

Dull Sharp Achy Burning Cold Crampy Numbness

Shooting Stabbing Throbbing Tingling Tight

Please draw where you have pain or discomfort



Please describe the time course of your pain:

Constant Intermittent Worsening Improving Unchanging

What makes it better?

What makes it worse?

Do you have any associated symptoms?

None Tingling Numbness Arm/Leg Weakness Incontinence

What do you do for exercise?

Do you use a cane or walker?

List activities you are now unable to perform because of pain. Is your sleep affected by the pain?

What diagnostic tests have you had for this problem?

X-ray MRI CT scan EMG Bone Scan

What treatments have you had for this problem?

Acupuncture Behavioral Therapy Chiropractic Physical Therapy Injections: Surgery:

Is this a Worker's Compensation Claim or is there litigation pending? Yes No

Current Medications: (include previously trialed pain medications)

Allergies: *Reaction?*

Medical History:

Surgical History:

Family History: *Please circle all that apply*

Bipolar disorder	Heart disease	Cancer	Depression
Diabetes	High blood pressure	Substance abuse	Arthritis

Social History: **Marital Status:** Married Single Divorced Widowed

	Current	Quit (When)	Never
Tobacco use (cigarette, cigar, pipe, chew):			
Illicit drug use (cocaine, marijuana, heroin, ecstasy, PCP):			
Opioid use (hydro/oxycodone, morphine, oxycontin, fentanyl):			
History of substance abuse/addiction?			
Number of alcoholic beverages per week?			

Occupation:

Employment Status:	Full-time	Part-time	Light Duty	Off Duty due to injury	Full-time Parent

Review of Symptoms: Please indicate by circling if you are experiencing any of the following symptoms

Fatigue	Fever	Loss of appetite	Unintentional weight loss		
Change in vision	Loss of vision	Double vision	Difficulty swallowing		
Chest pain	Irregular heartbeat	Leg swelling	Cold extremities		
Shortness of breath	Wheezing	Cough			
Nausea	Vomiting	Black/bloody stools	Loss of control of stools	Constipation	Heartburn
Loss of control of urine	Urinary frequency	Difficulty urinating	Pain/burning on urination		
Possibly pregnant	Painful intercourse				
Easy bleeding	Easy bruising	Taking blood thinners	Enlarged lymph nodes		
New rash	Dry/sensitive skin				
Arm/leg weakness	Numbness	Tingling	Dizziness	Loss of balance	Headache	Seizures
Back/neck pain	Joint pain	Joint swelling	Muscle cramps/pain		
Anxiety	Serious depression	Sleep disturbance	Suicidal thoughts		