BEACHES LASER SPINE & PAIN

NEW PATIENT INTAKE ASSESSMENT

Pt Name: _____
Pt Address: _____
Pt Phone Number: _____
Pt E-mail: _____

PCP Name: _____
PCP Address/ Phone:_____

History of Present illness:
Please briefly describe why you are seeing pain management today?
_____
_____
_____
_____

What caused your pain?
_____
_____
_____

How long have you had pain?
_____

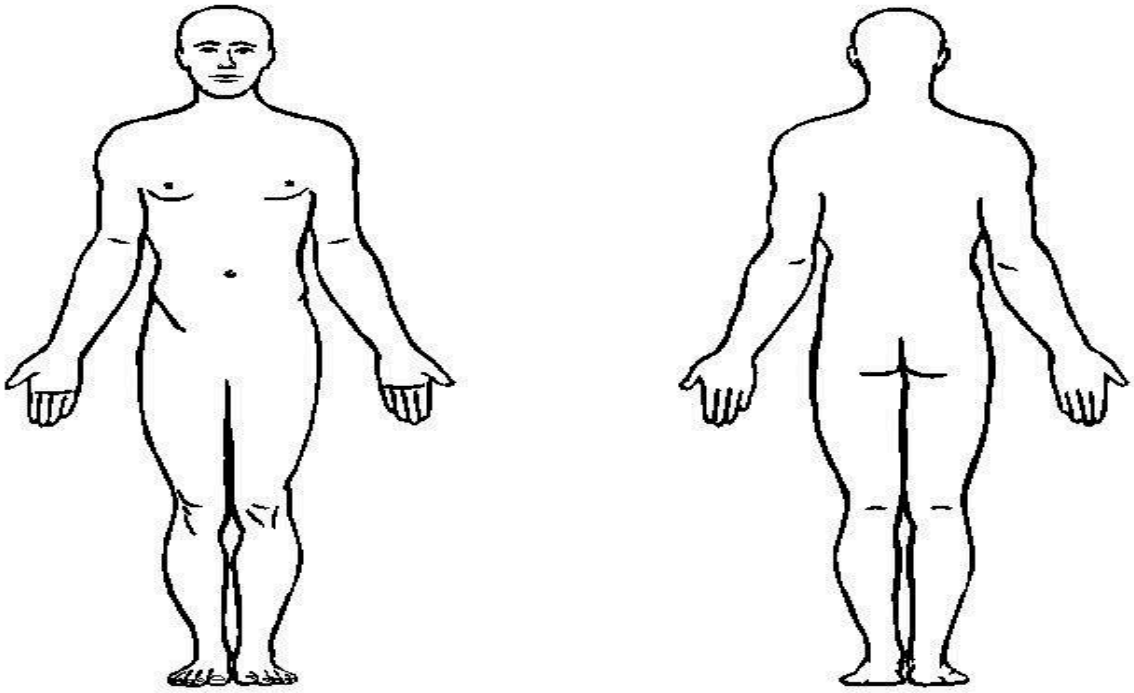
Please describe the character of your pain i.e. sharp, dull, electric?

_____
Is your pain constant or intermittent?

_____
What makes your pain better?
_____
What makes your pain worse?
_____

What would you rate your pain on a scale of 0-10? _____

Please indicate your worst area of pain on the diagram below (picture of front and back of body for patient's to color in)



PREVIOUS DIAGNOSTICS FOR PAINFUL CONDITION:

When and where was your last MRI, CT, EMG performed?

_____
_____
_____
_____

Please list any previous: **surgeries, injections, or procedures for painful conditions, the physician, and the procedure dates**? Please also say whether the procedure was effective and for how long. For Example: "PRP Stem Cell injection 3/5/12 with 3 years full relief by Dr. Spooner"

_____
_____
_____
_____
_____
_____
_____
_____

Have you participated in physical therapy? When and Where?

_____
_____
_____
_____

Review of Systems:
* General: Do you have low energy? YES / NO
* Do you feel sick most days? YES / NO
* Are you able to walk 100 yards? YES / NO

Psychiatry and Neurology:
* Have you ever had a seizure? YES / NO
* Do you feel depressed more often than not? YES / NO
* Do you feel Anxious or do other people say you are anxious? YES / NO
* Do you have panic attacks? YES / NO
* Do you have unwanted intrusive thoughts or perform certain behaviors excessively such as washing your hands? YES / NO
* Do you have difficulty falling asleep? why? YES / NO

_____

Endocrine:
* Do you get too cold/ warm when other people are comfortable? YES / NO
* Is your appetite increased? YES / NO
* Is your appetite decreased? YES / NO
* Did you lose/ gain more than 10 pounds in the past 2 months? YES / NO

Gastrointenstinal / Genito-urinary:
* Do you have frequent constipation? YES / NO
* Do you have unintentional loss of urine or stool during the day? YES / NO
* Do you have irritable bowel syndrome? YES / NO
* Do you have Crohn's disease? YES / NO

Sexual:
* Are you able to obtain and maintain an erection? YES / NO N/A
* Is sexual intercourse painful? YES / NO

Pulmonary:
* Have you been diagnosed with Sleep Apnea? YES / NO
* Do you use a CPAP? Yes / NO
* Do you have asthma, COPD, or become short of breath often? YES / NO

Cardiac:
* Do you have chest pain? YES / NO
* Do you have an arrhythmia or irregular heart beat? YES / NO
* Do you have a pacemaker or IED? YES / NO

Hematology:
* Do you take any blood thinners such as Aspirin, Warfarin, Coumadin, or Plavix? YES / NO
* What dose do you take: _____
* Do you bruise easily? YES / NO
* When cut do you bleed for a longer time than others? YES / NO

INFECTION / IMMUNE DISEASE:
* Do you have or have you had Cancer? Please list all cancer treatments and dates:

_____
_____
_____

* Do you have any immune disease? YES / NO
If yes, which? _____

* Have you received a tetanus vaccine in the past five years? YES / NO

PAST MEDICAL HISTORY: Please list any medical diagnoses that you have received:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list all **CURRENT MEDICATION**: Medication Dose Frequency/ Indication /How long taking.
For example: Aspirin 81mg once daily Heart 10 years

Please list all **PREVIOUS MEDICATIONS TAKEN FOR PAIN** and why they were discontinued. For example: "MS Contin 15mg Three times daily was ineffective and caused nausea"

PLEASE LIST ANY **ALLERGIES OR SENSITIVITIES** TO MEDICATION, LATEX, or FOOD and what the reaction was.
For example: Penicillin causes Hives

PAST SURGICAL HISTORY: Please list any previous surgeries and the date of surgery.

_____
_____
_____
_____
_____
_____

PAST PSYCHIATRIC HISTORY: Please list all prior psychiatric diagnoses:

_____
_____
_____

FAMILY HISTORY: Has anyone in your family had chronic pain or chemical addiction? What was their condition and what is your relation to them?

_____
_____
_____
_____

How old is your father? _____ Please list their medical conditions

_____
_____

How old is your mother?_____ Please list their medical conditions

_____
_____

Any other illnesses in your family (i.e. seizure, cancer, diabetes)?

_____
_____
_____

SOCIAL HISTORY:

* How many people do you live with? _____
* Are you married YES / NO
* How many children do you have? _____
* Do you feel safe in your home? YES / NO
* Do you smoke? YES / NO

If so, how many packs per day?

_____

* Have you ever been diagnosed with chemical addiction or dependence? YES / NO

What substances?

_____

* Have you ever attended a substance rehab program or AA? YES / NO
* Have you ever had a DUI? YES / NO

Have you seen a dentist in the last 6 months? YES / NO

Please list any dental problems:

_____

* Do you currently see a psychiatrist or counselor? YES / NO

GOALS FOR PAIN MANAGEMENT:

Please list 3 reasonable goals tor activities that you would like to accomplish but are currently unable to due to pain (i.e. sit comfortably while driving, be able to lay flat while sleeping, being happier and less irritable):

1)_____

2)_____

3)_____

Thank you for your responses, this form will be added to your electronic medical file.