



**NEW PATIENT
INTAKE ASSESSMENT**

BEACHES LASER SPINE & PAIN

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?

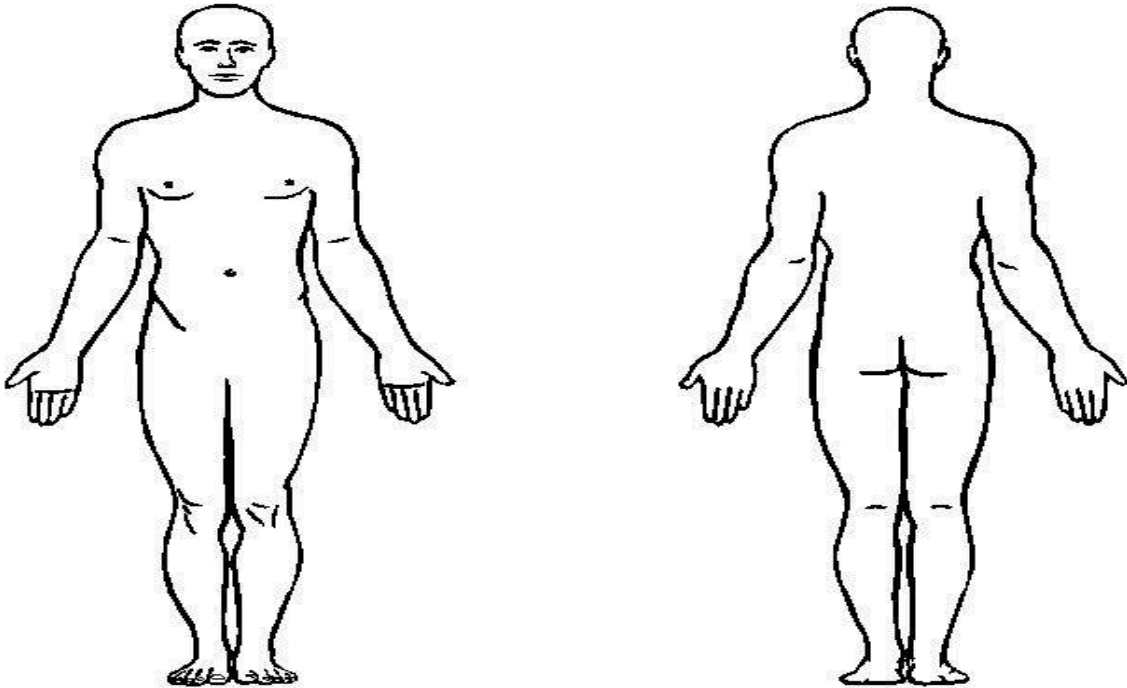
Is your pain constant or intermittent?

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

Gastrointestinal / 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

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.