

Freeman Pain Institute

NEW PATIENT INTAKE

PLEASE COMPLETE TO THE BEST OF YOUR ABILITY

Name: _____ Age: _____ Date: ___/___/___ Male Right Handed
 Female Left Handed

HISTORY OF PRESENT COMPLAINT:

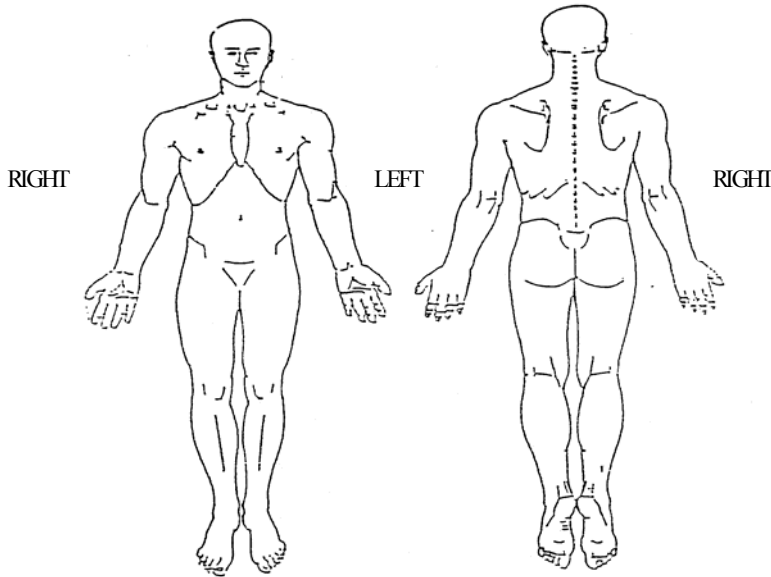
1. What is your primary complaint? _____

2. When and how did this complaint begin? Date ___/___/___

√ Motor Vehicle Accident (Please √ all appropriate boxes)	√ Work Injury	√ Sports Injury	√ Other
Seat belt: <input type="checkbox"/> Yes, <input type="checkbox"/> No <input type="checkbox"/> . Driver, <input type="checkbox"/> Passenger, <input type="checkbox"/> Pedestrian Collision: <input type="checkbox"/> Head on, <input type="checkbox"/> Rear-end, <input type="checkbox"/> Side-impact Your Speed: _____, <input type="checkbox"/> Hit your head, <input type="checkbox"/> Knocked unconscious Went to: <input type="checkbox"/> ER(<input type="checkbox"/> Self, <input type="checkbox"/> Ambulance, <input type="checkbox"/> Helicopter) <input type="checkbox"/> Home Hospital Course: <input type="checkbox"/> Sent home that day, <input type="checkbox"/> Admitted ___ days	<input type="checkbox"/> Fall, <input type="checkbox"/> Restraining, <input type="checkbox"/> Lifting, <input type="checkbox"/> Bending <input type="checkbox"/> Assault, <input type="checkbox"/> Driving <input type="checkbox"/> Notified Supervisor	<input type="checkbox"/> Clip, <input type="checkbox"/> Tackle <input type="checkbox"/> Spear, <input type="checkbox"/> Kick <input type="checkbox"/> Throw, <input type="checkbox"/> Fall <input type="checkbox"/> Hit, <input type="checkbox"/> Pivot <input type="checkbox"/> Fall, <input type="checkbox"/> Lifting	Unknown Fall Bending Lifting <input type="checkbox"/> Assault
Other: _____			

3. Pain / Dysfunction Scale:	1	2	3	4	5	6	7	8	9	10
	No Pain									Worst Pain

4. Please mark the area of your complaint on the diagram below. 5. Neck and Back Pain Description



Please circle the following, if appropriate.

- Is your neck or back pain:
- Always there •Come and go
 - Dull/Achy •Sharp/Stabbing •Both
 - Right side •Left side •Both •Mid-line

- Is your arm or leg discomfort:
- Always there •Come and go
 - Right Side •Left Side •Both
 - Shooting pain •Pins/needles •Numbness
 - Burning •Aching •Cramping •Spasms
 - Fingers or toes involved: _____

- Do you have weakness in your arm or leg?
- Yes •No
 - Why? •Pain •Other: _____

6. Joint Pain Description (Circle): Discomfort, Locking, Popping, Giving way, Swelling, Warmth, Redness, Grinding.

7. Are you experiencing any of the following? Incontinence of the bowel or bladder, Uncontrolled weight loss, Recent fever or chills: Explain _____, Increased pain with lying down

8. How do the following activities influence your current pain level? (Please √ all the appropriate boxes.)

Activity	Better	Worse	Neither
Standing			
Walking			
Bending Backward			
Lying Down			
Movement			

Activity	Better	Worse	Neither
Sitting			
Coughing/Sneezing			
Bending Forward			
Squatting			
Other			

9. Have you consulted any prior doctors for this problem? **None**

Name	Specialty	Date	Treatment

10. Have you had any recent treatments for this problem? **None**

Treatment	Month/Year
Physical Therapy	
Epidural Injection	

Treatment	Month/Year
Sacroiliac Injection	
Trigger Point Injection	

Treatment	Month/Year
Facet Injection	
Chiropractic	

11. Have you had any of the following diagnostic tests for your problem? **None**

Test	Month/Year
X-ray	
MRI	

Test	Month/Year
CT-Scan	
Bone Scan	

Test	Month/Year
Bone Density	
Blood Work	

Test	Month/Year
EMG	

12. Do you have any previous symptoms, injury or surgery to your primary complaint

- No previous history
- Yes; _____

13. PAST MEDICAL HISTORY: (Please \checkmark all the appropriate boxes) **None**

\checkmark	Illness
	Asthma
	Diabetes
	Hepatitis
	Ulcers
	Osteoporosis
	Prostate Problem

\checkmark	Illness
	Seizures
	Depression
	High Blood Pressure
	Pacemaker
	Stroke
	Glaucoma

\checkmark	Illness
	Cancer _____
	Heart Disorder _____
	Blood Disorder _____
	Thyroid Disorder _____
	Lung Disorder _____
	Other _____

14. PAST SURGICAL HISTORY: **None**

Procedure	Date	Outcome

Procedure	Date	Outcome

15. ALLERGIES: **None**

Drug Name	Reaction

Drug Name	Reaction

Drug Name	Reaction

16. CURRENT MEDICATIONS: (Include vitamin, herbal, etc) **None**

Name	Dose	How Often	Name	Dose	How Often

17. PLEASE LIST ALL PAST PAIN MEDICATIONS AND REACTIONS

Drug Name	Reaction	Drug Name	Reaction	Drug Name	Reaction

18. SOCIAL HISTORY:

1. Occupation: _____ . If you are on disability give the date it began ___/___/___
2. Who put you out on disability? _____
3. Please circle your **current** work status **and** plans for **return** to work.
 - **Current Work Status:** Full duty Light duty Off Duty Unemployed Retired
 - Do you plan to return to work at your similar position? Yes No
4. Job Lifting: Heavy (Over 60 pounds), Medium (30-50), Light (10-20), Sedentary
5. Who changed your work status if you are **not at full duty**? _____
6. What date do they plan to return you to full duty? ___/___/___
7. Do you smoke cigarettes? No Yes, number of packs per day _____, for _____ years.
8. Have you ever been treated for alcohol or drug addiction? No Yes
9. Have your ever had any problems with pain medications? If so, what? _____

FAMILY HISTORY: (Please fill in the following, if appropriate) **Unknown**

Relative	Medical Illness
Father	
Mother	
Sibling 1	
Sibling 2	

REVIEW OF SYSTEMS: (Please check the appropriate boxes) **None**

- Constitutional:** Weight loss, Fever, Chills, Night sweats, Other _____
- Skin:** Bleeding, Bruising, Rashes, Moles, Sores _____, Other _____
- Eyes, Ears, Nose, Throat:** Recent changes in: Vision, Hearing, Smell, Taste, Other _____
- Respiratory:** Shortness of breath, Wheezing, Productive cough, Other _____
- Cardiovascular:** Chest pain, Palpitations, Murmur, Feet edema, Other _____
- Gastrointestinal:** Nausea/Vomiting, Diarrhea, Constipation, Abdominal pain, Other _____
- Genito-Urinary:** Bloody urine, Urinary discomfort, Abnormal discharge, Other _____
- Musculoskeletal:** Cramps, Joint Pain / Swelling, Morning stiffness Weakness, Other _____
- Central Nervous System:** Convulsions, Dizziness, Problem sleeping, Other _____
- Female:** Are you pregnant? No, Yes, Last menstrual period – Date _____, Other _____
- Male:** Last prostate exam – Date _____, PSA – Date _____, Results _____, Other _____
- Other:** _____

HOW WERE YOU REFERRED TO THIS OFFICE?

Doctor Patient, Friend, Yellow pages Advertisement Other: _____

• **Patient’s Rights:** We are dedicated to your health and well being. Please complete the entire form to aid in the most effective management of your condition. **Treatment can not begin until all information is obtained.** Work restrictions can only be addressed if specifically placed by this office. Medication use must be specifically followed according to the doctor’s recommendations and Controlled Substance Agreement. No refills will be given before proper expiration date and will only be given at according to our guidelines. We thank you for the opportunity to participate in your care.
 Patient’s Signature: _____

Office Use: _____