Advanced Interventional Pain Management
New Patient Intake Form

Name: __________________________________________ Age: ______ Date of Birth: ______________ Gender: ______
Height: ______ Weight: ______ Phone Number: __________________________________________
Employer: __________________________ Referring Provider: __________________________ PCP: __________________________

PAIN LOCATION: (Please check only one location you would like to address first)

☐ Head ☐ Neck ☐ Mid-back ☐ Low-back ☐ Shoulder ☐ Hip ☐ Knee ☐ Abdomen
☐ Hand ☐ Foot ☐ Chest wall ☐ Groin ☐ Vagina ☐ Anus ☐ Scrotum

PAIN DESCRIPTION: (check all that apply)

☐ Sharp/Stabbing ☐ Aching ☐ Burning ☐ Throbbing

PAIN ONSET:
☐ <1 month ago ☐ 1 month ago ☐ 3 months ago ☐ 6 months ago ☐ 1 year ago ☐ ___ years ago

ASSOCIATED FEATURES: (check all that apply)

☐ Numbness/Tingling ☐ Worsening Weakness ☐ Unable to control bowel/bladder
☐ Changes in skin color of involved extremity ☐ Change in nail/hair growth of involved extremity

PAIN WORSENED BY: (check all that apply)

☐ Walking ☐ Standing ☐ Sitting ☐ Leaning backward ☐ Leaning forward ☐ Looking down
☐ Looking up ☐ Reaching for objects overhead ☐ Changes in Weather ☐ Touching the area
☐ Loud Noises ☐ Bright Light

FREQUENCY OF SYMPTOMS:

☐ Constant ☐ Intermittent

PAIN SCORE: (over the last week)
Worse Pain Score: ____/10
Average Pain Score: ____/10

0 = no pain 10 = worst pain imaginable

PREVIOUS CONSERVATIVE TREATMENTS TRIED & FAILED:

☐ Physical Therapy x 6 weeks ☐ Unable to tolerate PT ☐ Home Exercises/Stretching
☐ Chiropractor ☐ Acupuncture ☐ TENS Unit ☐ Voltaren Gel ☐ Lidocaine Cream ☐ CBD Oil

PREVIOUS INTERVENTIONAL MANAGEMENT:

☐ Radiofrequency Ablation (Date: __________) ☐ Epidural Steroid Injection (Date: __________)
☐ Joint Injections ☐ Trigger Point Injections
Current Pain Medications: ____________________________

Current (non-pain) Medications: ____________________________

PREVIOUS IMAGING:
(Please list location and year obtained)

☐ MRI

☐ CT

☐ X-RAY

☐ Myelogram

☐ Ultrasound

☐ EMG/NCS

PAST MEDICAL HISTORY:

☐ AIDS
☐ Alcohol Use Disorder
☐ Anemia
☐ Anorexia
☐ Anxiety
☐ Aortic Regurgitation
☐ Aortic Stenosis
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Bipolar Disorder
☐ Breast Cancer
☐ Bulimia
☐ Carpal Tunnel Syndrome
☐ Cervical Cancer
☐ Chronic Kidney Disease
☐ Chronic Pancreatitis
☐ Cirrhosis
☐ Cluster Headaches
☐ Colon Cancer

☐ CRPS
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ Crohn’s Disease
☐ Cubital Tunnel Syndrome
☐ Depression
☐ Diabetes Type I
☐ Diabetes Type II
☐ Diabetic Neuropathy
☐ Enlarged Prostate (BPH)
☐ Epilepsy
☐ Factor V Leiden Mutation
☐ Fibromyalgia
☐ Gastric Reflux
☐ Glaucoma
☐ Gout
☐ Hemophilia
☐ Hepatitis B
☐ Hepatitis C
☐ Herpes Simplex Virus

☐ High Cholesterol
☐ High Blood Pressure
☐ HIV Positive
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Lung cancer
☐ Lupus
☐ Malignant Hyperthermia
☐ Migraines
☐ Mitral Regurgitation
☐ Mitral Stenosis
☐ Myasthenia Gravis
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Ovarian Cancer
☐ Prostate Cancer
☐ Scoliosis
☐ Shingles
☐ Substance Use Disorder
☐ Ulcerative Colitis
☐ Von Willebrand Disease

☐ Other Diagnosis not listed
PAST SURGICAL HISTORY:

- Above Knee Amputation
- ACDF
- Aortic Valve Replacement
- AV Fistula Creation
- Appendectomy
- Below Knee Amputation
- CABG
- Carotid Endarterectomy
- Carpal Tunnel Release
- Cholecystectomy
- Colon Resection
- Other Surgery not listed:

FAMILY HISTORY:

- AIDS
- Alcohol Use Disorder
- Anemia
- Anorexia
- Anxiety
- Aortic Regurgitation
- Aortic Stenosis
- Arthritis
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- Ulcerative Colitis
- Von Willebrand Disease

Social History:

- Current Smoker
- Former Smoker
- Never Smoked
- Alcohol Use
- Illicit Drug Use
- Medical Marijuana Card

Marital Status:

- Single
- Married
- Divorced
- Widowed

Work History:

- Currently Employed
- Unemployed
- Retired
- Disabled
- Short Term Disability

Last Day Worked: _______
# Review of Systems:

<table>
<thead>
<tr>
<th>General</th>
<th>Eyes</th>
<th>ENT</th>
<th>Skin</th>
</tr>
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<tbody>
<tr>
<td>Weight Loss</td>
<td>Vision Loss</td>
<td>Hearing Loss</td>
<td>Itching</td>
</tr>
<tr>
<td>Weakness</td>
<td>Double Vision</td>
<td>Dizziness</td>
<td>Redness</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Pain/Tearing</td>
<td>Runny Nose</td>
<td>Swelling</td>
</tr>
<tr>
<td>Fever</td>
<td>Redness</td>
<td>Sore Throat</td>
<td></td>
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<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th>Respiratory</th>
<th>Musculoskeletal</th>
<th>Hematology</th>
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<tbody>
<tr>
<td>Chest Pain</td>
<td>Cough</td>
<td>Muscle Pain</td>
<td>Easily Bruised</td>
</tr>
<tr>
<td>Irregular Heartbeat</td>
<td>Shortness of Breath</td>
<td>Joint Pain</td>
<td>Prolonged Bleeding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Muscle Spasms</td>
<td>Spontaneous Bleeding</td>
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<table>
<thead>
<tr>
<th>GU</th>
<th>Neurological</th>
<th>Psychological</th>
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</thead>
<tbody>
<tr>
<td>Blood in Urine</td>
<td>Numbness/tingling</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Loss of bladder control</td>
<td>Difficulty holding objects</td>
<td>Depression</td>
</tr>
<tr>
<td>Pain with urination</td>
<td>Frequent falls</td>
<td>Suicidal thoughts</td>
</tr>
<tr>
<td></td>
<td>Headache</td>
<td>Homicidal thoughts</td>
</tr>
<tr>
<td></td>
<td>Seizures</td>
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</table>

<table>
<thead>
<tr>
<th>GI</th>
<th>Endocrine</th>
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</thead>
<tbody>
<tr>
<td>Heart Burn</td>
<td>Sweating</td>
</tr>
<tr>
<td>Constipation</td>
<td>Frequent Thirst</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Always Hot</td>
</tr>
<tr>
<td>Loss of bowel control</td>
<td>Always Cold</td>
</tr>
<tr>
<td>Blood in stool</td>
<td></td>
</tr>
</tbody>
</table>

**Medication Allergies:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________