

Michigan Advanced Pain & Spine

NEW PATIENT PAIN/SPINE INTAKE FORM

Name: _____ Referring Physician: _____

Date of Birth: _____ Age? _____ Primary Care Physician: _____

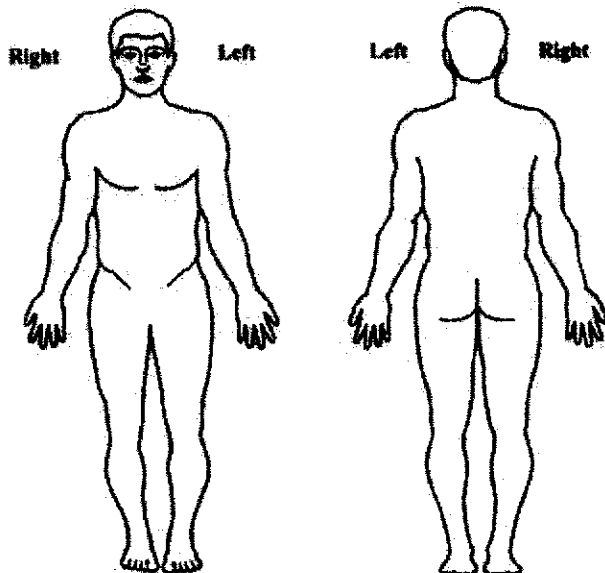
Are you right or left handed? R L

What is the main problem that brings you here today (you may check more than one)?

- | | | | |
|-------------------------------------------------|------------------------------------------|------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Mid Back Pain |
| <input type="checkbox"/> Right Leg Pain | <input type="checkbox"/> Left Leg Pain | <input type="checkbox"/> Right Arm Pain | <input type="checkbox"/> Left Arm Pain |
| <input type="checkbox"/> Widespread Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Other – Specify: _____ | | | |

Which area of pain is the worst? _____

On the drawings below, please shade the area where you currently experience pain.



PAIN HISTORY

When did the pain start (month/day/year)? _____

How did the pain start?

- Spontaneous Onset Gradual Onset

Motor Vehicle Accident – Specify: _____

Fall – Specify: _____

Job related – Specify: _____

Sports/Recreation – Specify: _____

Other Details – Specify: _____

Have you ever been involved in any legal proceedings related to this health matter?

No

Yes – Specify: _____

Do you have any *other* legal issues? _____

Have you had any previous *major* pain issues?

No

Yes

Details: _____

What is the quality of your pain/symptoms?

Sharp

Burning

Numb

Tingling

Aching

Throbbing

Dull

Other – Specify: _____

Since the pain/condition began has it:

Improved

Not changed

Worsened

On a scale from 0 to 10 (where 10 is the worst possible pain) how would you describe the intensity of your pain:

Average level of pain over the last month: _____ Current level of pain: _____

At your worst, what is your pain level: _____ At your best your pain is: _____

Do you have any of the following associated symptoms?

Bowel dysfunction

Bladder dysfunction

Sexual dysfunction

Fevers/chills, night sweats

Arm/leg weakness

Arm/leg numbness

Sedation or confusion

Balance problems

Bruising or bleeding issues

Blood in Stool

Black Tarry Stools

Infection

Loss of Interest in activities

Thoughts of hurting yourself

Difficulty Sleeping

RELIEVING AND AGGRAVATING FACTORS

Check off the following boxes depending on how the position affects your pain:

	Decrease	Increase	No Change
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Backwards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going Upstairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going Downstairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing or Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Details (optional): _____

MEDICAL HISTORY

Current/Past medical problems:

- | | | | |
|-----------------------------------------------|-------------------------------------------|-----------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Ankylosing Spondylitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Inflammatory Bowel Disease |
| <input type="checkbox"/> Bleeding problems | | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Lung disease |
- Cancer: What type: _____

Other Conditions:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Prior spine surgeries:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Prior major surgery not spine related:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

All Current Medications & Supplements/Herbs (name, dose, frequency)

- | | | |
|-----------|-----------|-----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |
| 10. _____ | 11. _____ | 12. _____ |

Do any of your family members (blood relatives) have any of these diseases?

- | | | | |
|--------------------------------------------------|-----------------------------------------------------|------------------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Back/ neck problems | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Psychiatric Issues | <input type="checkbox"/> Alcohol or Drug Issues | <input type="checkbox"/> Chronic Pain (type?): _____ | |

Marital status: Single Married Separated Divorced Widowed Other

Have you experienced significant stress in the past year? _____

What is your living situation?(family, friends alone, etc.) _____

If you have children, what are their ages? _____

What is your current work status?

- Full Time Part Time Light-Duty Worker's Compensation Disabled Retired

What is the highest grade you completed or degree you received? _____

Tobacco Use Yes No Date Quit _____ If yes, #Packs/Day _____

Alcohol Use Yes No Date Quit _____ If yes, #Drinks/Day _____

Other Drug Use Yes No Date Quit _____ If yes, what type: _____

Caffeinated Drinks Yes No Date Quit _____ If yes, #/Day _____

OTHER THERAPIES FOR PAIN

Please check all of the treatment you have tried for ***this*** pain condition and indicate whether the treatment provided you with any relief.

Treatment	No Relief	Moderate Relief	Excellent Relief
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biofeedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery (type?): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injections (type?): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Exercise: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Therapy: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS YOU HAVE TAKEN IN THE PAST FOR PAIN OR MOOD

Using the list below, please indicate the prescription medication(s) that you have tried ***in the past***. If you have not taken these medications, you can skip this section.

Opioids

- Tylenol w/codeine Vicodin/Lortab Percocet/Endocet Oxycodone Dilaudid Demerol
 MSContin Oxycontin Fentanyl Patch Methadone Other: _____

Antiinflammatories (NSAIDs)

- Ibuprofen (Motrin, Advil) Naprosyn (Naproxen, Aleve) Relafen (Nabumetone) Other: _____

Muscle Relaxants

- Flexeril (Cyclobenzaprine) Soma (Carisoprodol) Baclofen (Lioresal) Zanaflex (Tizanidine)
 Norflex (Orphenadrine) Robaxin (Methocarbamol) Other _____

Antidepressants

- Elavil (Amitriptyline) Nortriptyline Desipramine Doxepin
 Cymbalta (Duloxetine) Effexor (Venlafaxine) Savella (Milnacipran) Other _____

Antianxiety Agents

- Ativan (Lorazepam) Klonopin Valium Xanax (Alprazolam) Other _____

Other Agents

- Ultram (Tramadol) Prednisone Suboxone (Buprenorphine)
 Neurontin (Gabapentin) Lyrica (Pregabalin) Topomax (Topiramate) Other _____

ALLERGIES

- Are you allergic to latex? Yes No
 Are you allergic to IV Contrast? Yes No
 Do you have any other allergies? No Yes, please list below:

1. _____	2. _____	3. _____
2. _____	5. _____	6. _____

REVIEW OF SYMPTOMS (Please mark all of the following that apply to you)

Constitutional

- Fever/Chills Fatigue Swollen Glands Loss of Appetite Difficulty Sleeping

Comments: _____

Eyes

- Blurred Vision Double Vision Abnormal Vision

Comments: _____

Ears, Nose, Mouth, Throat

- Dizziness Room Spinning Sinus Pain Dental Issues Sore Throat

Comments: _____

Cardiovascular

- Chest Pain Palpitations Leg/ankle Swelling Fainting

Comments: _____

Respiratory

- Cough Asthma Shortness of Breath

Comments: _____

Neurologic

- Seizures Numbness in Arms/Legs Weakness in Arms/Legs Memory Problems
 Headaches Speech Problems Comments: _____

Gastrointestinal

- Nausea/Vomiting Constipation Diarrhea Change in Stools

Comments: _____

Genitourinary

- Blood in Urine Change in Bladder Habits Change in Sexual Function

Comments: _____

Musculoskeletal

- Painful joints Swollen joints Joint Redness Bone infection

Comments: _____

Integumentary/Skin

- Sores Rash Easy Bruising Skin Cancer Psoriasis

Psychiatric

- Depressed Anxious Loss of interest in activities Thoughts of hurting yourself

Comments: _____

Endocrine

- Excessive urination Poor energy Weight loss

Comments: _____