INTERVENTIONAL PAIN MANAGEMENT
DWAYNE E. JONES, MD, LLC

PATIENT INTAKE FORM

Date ___________

Name ______________________________ Date of Birth _______________ Age ________

Address ____ Sex ________

Home Phone ________________________ Primary Care Physician ___________________

Address ____ Phone # ____________________

Referring Physician ____

Address ____ Phone # ____________________

Email Address ____

CHIEF COMPLAINT:
Describe in your own words why you came to the Pain Clinic today:

____

What are your expectations from your visit to the Pain Clinic today?

____

HISTORY OF PRESENT ILLNESS:
When did you first notice your pain/problem?

____

What do you think caused your pain/problem?

____

____

Where is your pain: (Please draw on figure on the last page)___________________________

Is your pain worse on one side than the other, if so, which side? ______________________

Describe your pain) for example, dull, sharp, burning, achy, etc.)

____

Does your pain migrate or radiate to other parts of your body, if so, where?

____

Please use the following scale to rate your pain below: 0-10

0 meaning no pain and 10 meaning severely painful..
My pain at BEST is ______ My pain NOW is _______ My pain at its WORST is ________

List the things that make your pain better

____

____

List the things that make your pain worse

____

____

How is your sleeping?

____

Have there been any changes in your mood? (for example, irritable, sad, not eating, etc.)

____

If so please explain

____

____

What have other physicians told you is causing your pain?

____

____

Has your physician prescribed or have your tried any of the following forms of treatments for pain relief? If so, please note the date/s you tried or began treatment, the effectiveness (for example, good, bad, very, etc.) and the percentage of pain relief, if any.

	DATES	EFFECTIVENESS	%PAIN DECREASED
Restricting activity			0% -- 100% _______%
Medication/s			0% -- 100% _______%
Ice/Heat			0% -- 100% _______%
Physical/occupational therapy			0% -- 100% _______%
Tens unit			0% -- 100% _______%
Chiropractic			0% -- 100% _______%
Biofeedback/counseling			0% -- 100% _______%
Nerve Blocks/Injections			0% -- 100% _______%
Surgery			0% -- 100% _______%

Is this pain the result of a work related accident:

____

If yes, is legal action or an insurance settlement pending?

____

If yes, describe the current status of such action

____

If no, do you plan to pursue legal action or insurance settlement in the future?

____

Have you had any of the following pain related evaluations and if so please give the date/s and the facility in which you had the evaluations.

	DATES	FACILITY(S)
X-rays		
Cat scans		
MRI		
Myelogram		
Bone Scan		
Nerve and Muscle tests) EMG's		

Previous Medical History:
Have you ever been diagnosed with any of the following medical conditions, and if so, when?

	DATE DIAGNOSED		DATE DIAGNOSED
Asthma/COPD		**High Blood Pressure**	
Heart Disease		**Ulcers/GERD**	
Kidney problems		**Hepatitis**	
Bleeding tendencies		**Cancer**	
Diabetes		**Other**	

Previous Surgical History:

Please list any surgeries, that you have had and the dates of those surgeries below:

Surgery	Date of Surgery

Your Height ________________________ **Your Weight** _________________

Drug Allergies ____ **Reduction** ________________

____

____

Medications ____ **Dose** _________________

____

____

____

If you are currently taking a blood thinner please CIRCLE which one you are taking:
LOVENOX PLAVIX COUMADIN REFLUDAN HEPARIN TICLID

Social History:
I work at ______________________________________ **I am retired from** ________________

I have missed work in the month ___________ **(Y/N) If yes, how many days?** ___________

Tobacco use Y/N _____ **packs per day** _______**# years** ______ **Quit** _______ **Date** _______

Alcohol use Y/N _____ **amount/day** _________________ **History of abuse?** _________**Y/N**

Single __________ **Married** ___________ **Divorced** __________ **Widowed** _______________

I am: Pregnant ________________ **Planning to become pregnant** __________________**Y/N**

Does anyone live with you? ___________ **If so, who?** ________________________________

Education background: (circle all that applies)
GED High School College Technical School Other
____

Family History: **Does any of your immediate family members have a history of a major disease:**
(For example: heart disease, lung disease, bone disease) if so, please list here:

Mother ____

Father ____

Sister ____

Brother ____

Review of Systems:

Do you have any of the following symptoms: Please list all symptoms that apply.

CONSTITUTIONAL

Fever/chills/sweats/weight change ______________________________

EYES,EARS, NOSE

Headaches/eye, ear or nose problems ______________________________

CARDIOVASCULAR

Chest pains/murmur/fluttering in chest ______________________________

RESPIRATORY

Short of breath/productive cough ______________________________

GASTROINTESTIONAL

Diarrhea/constipation/incontinence ______________________________

NEUROLOGIC

Weakness/loss of balance/falls ______________________________

SKIN

Skin rash/hives/ulcers ______________________________

PSYCHIATRIC

Depression/anxiety ______________________________

ENDOCRINE

Diabetes/thyroid ______________________________

HEMATALOGIC

Bleeding problems/anemia/swollen nodes ______________________________

ALLERGY/IMMUNOLOGIC

Seasonal allergies/asthma/hay fever ______________________________

LATEX ALLERGY

Have you ever been tested for a Latex Allergy? Y/N ______________________

If so, what were the results? (Negative/Positive) ______________________

Do you have eczema or problems with rashes: (Y/N) ______________________

Do you have swelling, itching, hives or other symptoms after contact with:

- **Balloons (Y/N)** ____________
- **Dental Examinations or Procedure (Y/N)** ______________
- **Vaginal or Rectal Exam (Y/N)** _____________
- **Using a Diaphragm or Condom (Y/N)** ______________
- **Wearing Rubber Gloves (Y/N)** ________________

Have you experienced an unexplained anaphylactic episode? (For example: rapid heart, swelling of your throat and respiratory distress all at the same time) (Y/N) ______________

If yes, which one? ______________________________

FOOD ALLERGY

Are you allergic to any of the following? IF so, indicate which ones and the reaction.

Bananas/Avocados ______________________________

Kiwi Fruit/Chestnuts ______________________________

**** Nursing** If patients answers yes to BOTH a LATEX ALLERGY and ANY of the above questions were answered yes-note LATEX ALLERGY on the front of the chart.**

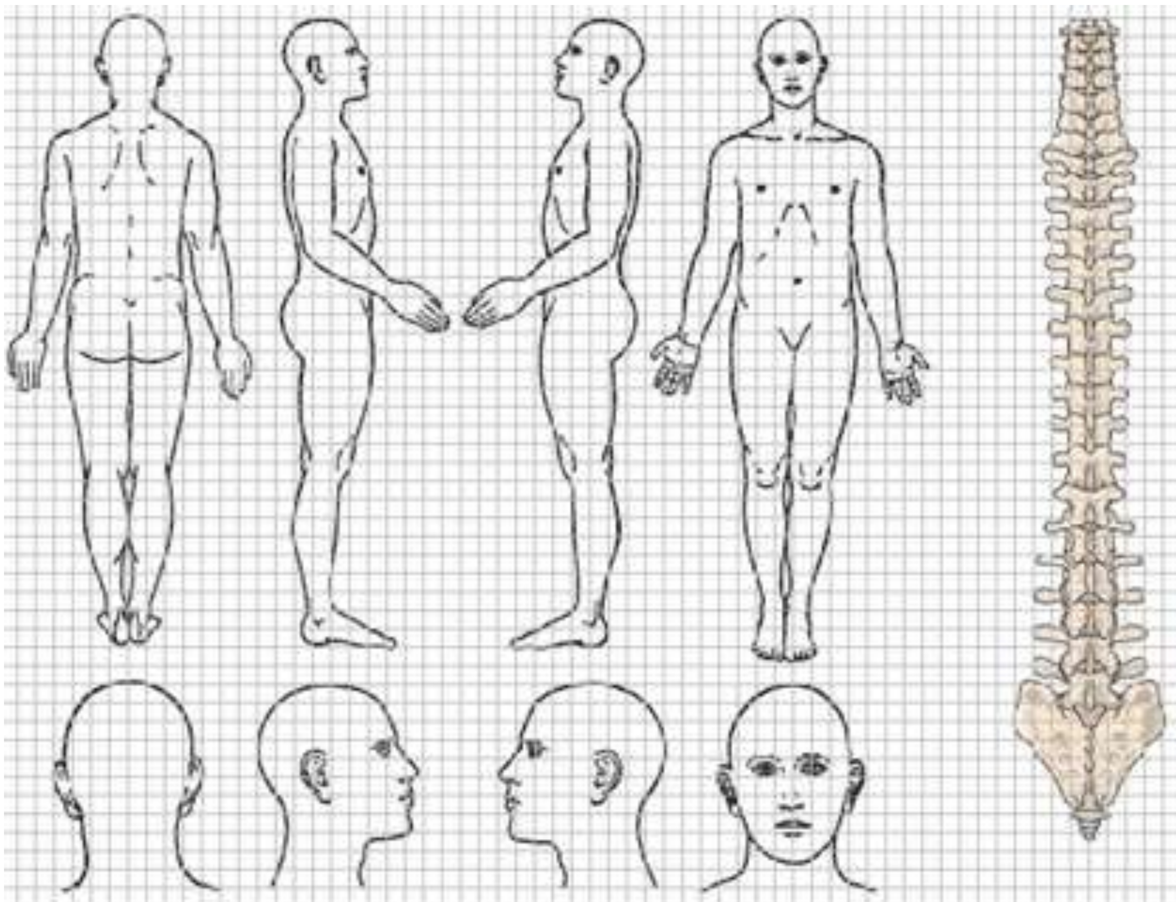
ASA CLASSIFICATION I II III IV V

PHYSICIAN SIGNATURE ______________________ **DATE** ____________

PLAN OF TREATMENT

Pain Clinic – Patient Intake Form

Please Shade on the drawing below where you feel pain.



Intake Form Completed Per Patient Responses

Date: ____________________Nurse Signature_____________________