

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 # _____

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 you 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:

<u>Surgery</u>	<u>Date of Surgery</u>
_____	_____
_____	_____
_____	_____
_____	_____

Your Height _____ **Your Weight** _____

Drug Allergies	Reaction
_____	_____
_____	_____

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 _____

HEMATOLOGIC

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.

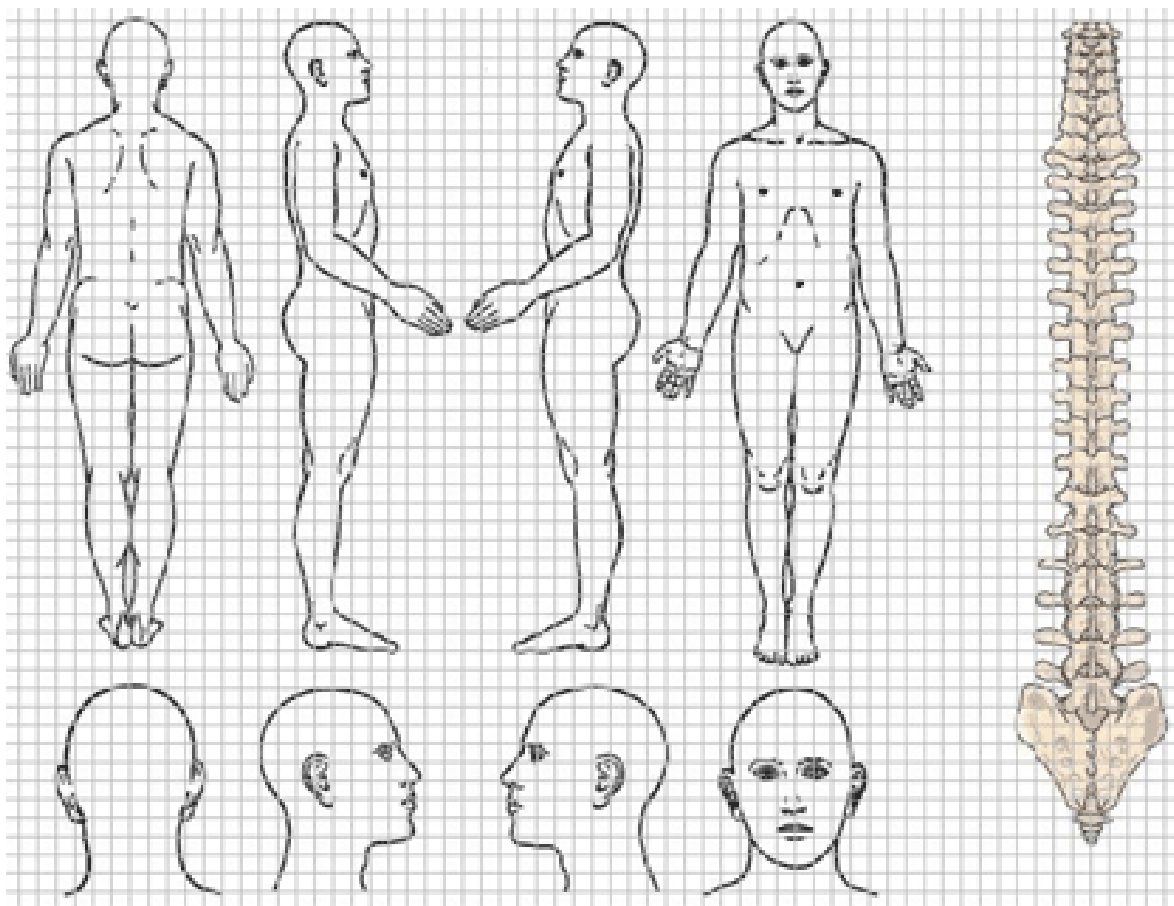
ASA CLASSIFICATION I II III IV V

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** _____