

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 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:

Surgery

Date of Surgery

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.

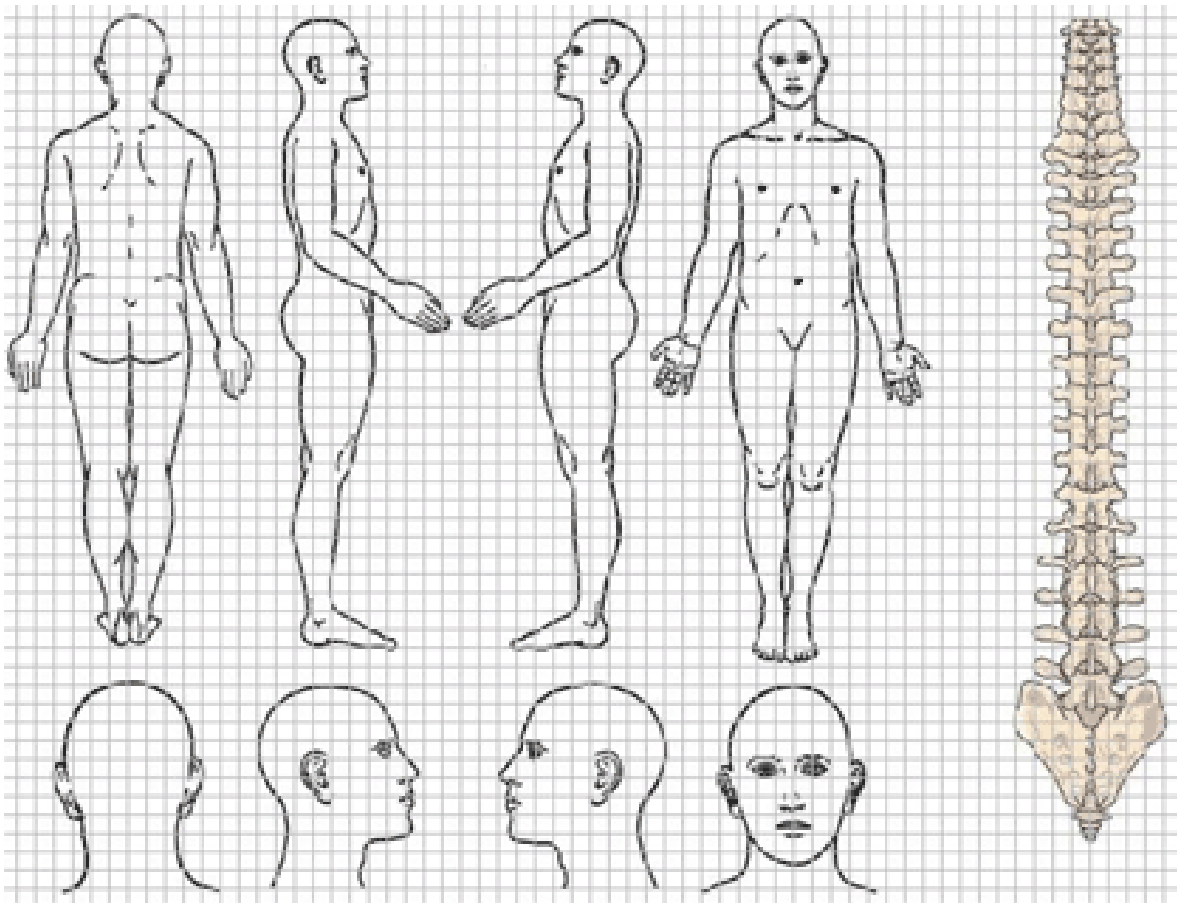
ASA CLASSIFICATION I II III IV V

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** _____