LONGSTREETCLINIC
Pain Management

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NEW PATIENT - BACK PAIN INTAKE FORM

Name: ______________________________ **Age:** __________

Marital status: ____________________ **Occupation:** ____________________

LIVING ARRANGEMENTS: Who do you live with? ____________________

Home address: ____________________

Home phone or cell phone number: ____________________

Primary care physician: ____________________

Preferred Pharmacy Name and Address: ____________________

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Pain onset (Approximate Date it started. If you don't remember, write unclear): ____________________

Did the pain start gradually or all of sudden? ____________________

Do you have a history of physical trauma around the onset of the pain (Car accident, falls, etc)? ____________________

Where in your specific area in the back do you have pain?____________________

Quality of pain (Please circle): achy shooting sharp tingling numb burning

Variations: The pain is (please circle): constant intermittent episodic/recurring other (specify): __________

Does the pain radiate anywhere? ____________________

What movements, if any, relieves the pain? ____________________

____

What causes or increases the pain (be specific if it's a specific movement)? ____________________

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CHECK if any of the following applies to you

- ❑ Leg/Buttock pain while walking
- ❑ You have to lean forward or flex your back to relieve pain
- ❑ Relief when using a shopping cart or bicycle
- ❑ Weakness or numbness/sensation changes in the legs while walking
- ❑ Leg weakness
- ❑ Low back pain
- ❑ Back pain or radiating pain when coughing or sneezing
- ❑ Back pain worse with bumpy rides
- ❑ Worse back pain with sitting for a long time
- ❑ Worse pain with bending forward
- ❑ Worse back pain with movement
- ❑ Back pain worse with extending back
- ❑ Back pain worse with rotating back
- ❑ Pain worse when going from sitting to standing
- ❑ Pain worse with ALL movements including bending forward, extending back, rotating

Rate your pain: On a 0-10 scale, where 0 is no pain and 10 is the worst pain you can imagine, tell us your level of pain:

Right now: ______________ **On average:** ______________ **Lowest level:** ______________ **Highest level:** ______________

Does this pain limit you in any way? ____

If so, what are the things you were able to do that you cannot do now because of this pain? ________________________________

The pain affects my:

- ❑ Sleep
- ❑ Movement
- ❑ Energy
- ❑ Lifestyle
- ❑ Personal relationships
- ❑ Work
- ❑ Emotions
- ❑ Concentration
- ❑ Appetite
- ❑ Motivation
- ❑ ADLs (Average Daily Life)
- ❑ Other (specify) ____

Sleep: I sleep ___________________ hours a day on average.

Circle if you have the following issues:

1. I have High blood pressure: If yes, what is your home or average blood pressure? ______________________________
2. I snore loud
3. I often feel tired, fatigued, or sleepy during the daytime
4. I had someone observe me stop breathing during sleep

The effects of pain:

- ❑ Nausea/vomiting
- ❑ Shortness of breath
- ❑ Confusion
- ❑ Weakness
- ❑ Numbness
- ❑ Other (specify) ____

Functional History (please check and fill in the blank)

❑ I can walk ____________________ miles

❑ I can run ____________________ mins

❑ I am able to do house chores such as vacuuming, ____ .

❑ My hobbies are ____________________________________ and last time I did them was __________________ .

If it has been a long time since you've done your hobbies, please state the reason why: ____________________________________ .

❑ My job is / was ____________________________________ . ❑ I am retired. ❑ I am disabled. ❑ I am on social security.

Prior Treatments: Please **CHECK** the ones you've tried and **CIRCLE** the ones you've found helpful.

- ❑ Heat/ice pack
- ❑ Physical therapy
- ❑ Occupational therapy
- ❑ Chiropractic
- ❑ Manipulations
- ❑ NSAIDs (ibuprofen, motrin, toradol, meloxicam)
- ❑ Tylenol
- ❑ Gabapentin
- ❑ Lyrica (pregabalin)
- ❑ Amitriptylin, Nortriptylin
- ❑ Duloxetine (cymbalta)
- ❑ Carbamazepin
- ❑ Muscle relaxants: Flexeril (cyclobenzaprine)
- ❑ Voltaren gel (Diclofenac gel)
- ❑ Lidocaine gel (sulponax etc)
- ❑ Trigger point injections
- ❑ Dry needling
- ❑ Theracane
- ❑ TENs Unit
- ❑ Back injection: if yes, please specify

Please CHECK if YES

- ❑ I have an official diagnosis of major depression:
  - ❑ If yes, is this being treated (please circle)? Yes / No
  - ❑ If yes, are you seeing a psychiatrist or psychologist (Please write his/her name)? ________________
- ❑ I think my pain will never get better
- ❑ I have bleeding disorder or my family has bleeding disorder
- ❑ I have contrast allergy
- ❑ I have latex allergy
- ❑ I am allergic to steroids (prednisone, methylprednisolone, dexamethasone, celestone, etc)
- ❑ I am allergic to lidocaine or bupivacaine (numbing medication)
- ❑ I am on chronic immunosuppression: If so, why are you on chronic immunosuppression? ________________
- ❑ I have Diabetes (high glucose or sugar level): If yes, what is your last A1C? ________________
- ❑ I have HIV: If yes, who is your infectious disease physician. When was your last viral load checked ________________
- ❑ I have Hepatitis B or C: if yes, please state if you are getting treated. ________________
- ❑ Thyroid disease: if yes, is it well controlled? (Yes / No)
- ❑ I am on a blood thinner (xarelto, eliquis, coumadin, plavix, aspirin, etc) (Yes / No)
- ❑ Doctor diagnosed me with major depression
- ❑ I have a psychiatric illness. If yes, please list them here: ________________
- ❑ I have sexual trauma history
- ❑ I have lung disease. If yes, do you need oxygen at home? ________________
- ❑ I have sleep apnea (Obstructive sleep apnea): If yes, do you use a CPAP machine? ________________

Medical history: Do you have the following issues? (Please check the boxes)

- ❑ Autoimmune disease
- ❑ Diabetes
- ❑ Cardiac issues
- ❑ Anticoagulants
- ❑ ESRD
- ❑ Vitamin D deficiency
- ❑ B12 deficiency
- ❑ Thyroid problem
- ❑ Other: ________________

Social history: (please check the appropriate answers and answer the question)
Smoking:

- ❑ I smoke ❑ cigar ❑ marijuana ❑ cigarette ________________ times every ❑ day ❑ week ❑ month
- ❑ I smoke e-cigarette ❑ I vape

- ❑ **Alcohol:** I drink ❑ wine ❑ beer ❑ hard liquor ________________ times every ❑ day ❑ week ❑ month

- ❑ **Other drugs:** Cocaine, Marijuana, Heroin, meth, methamphetamine

- ❑ **How often do you exercise and what do you do for exercise?** ❑ Daily ❑ 3-5 times a week ❑ 1-2 times a week

Type of exercise (Ex. yoga, running): ________________ .

Family History:

Autoimmune disease history in the family? ankylosing spondylosis, psoriatic arthritis, rheumatoid arthritis, lupus, sarcoidosis

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Any genetic disorder running in the family? ______________________________

What is your most important question or concern for the visit? ______________________________

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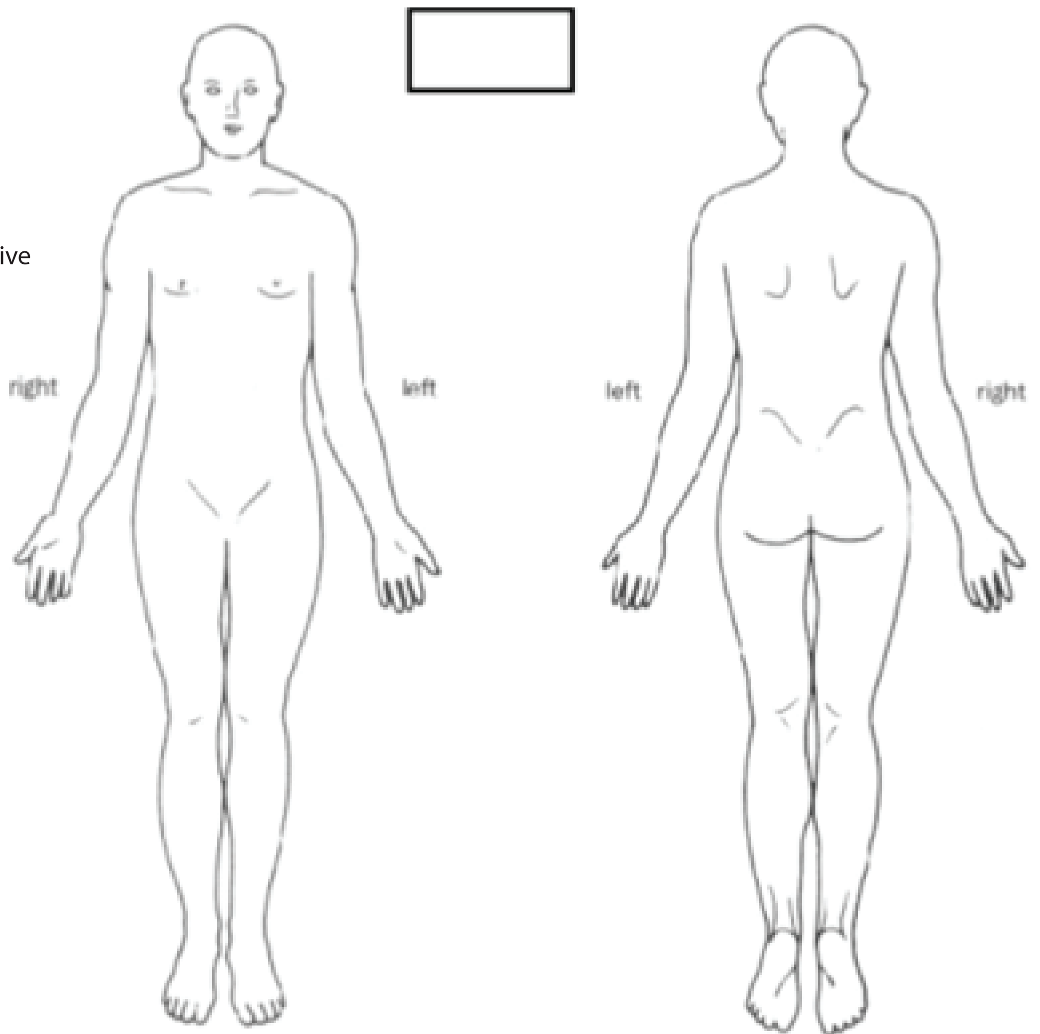
Please use colored markers to indicate location and type of your pain on the diagram below:

Red = Stabbing
Yellow = Aching
Blue = Burning
Black = Numbness
Green = Tingling/ pins & needles
Orange = Hurts to touch / very sensitive

***Draw a star over the most painful point on your body.**



Current Medication List: ______________________________

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