Patient Intake Form

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●Today's date _____

●When did your pain begin? _____

● How did you find out about Headache & Pain Center? _____

● Who referred you to us? _____

● Who is your primary care physician (family doctor / PCP)?_____

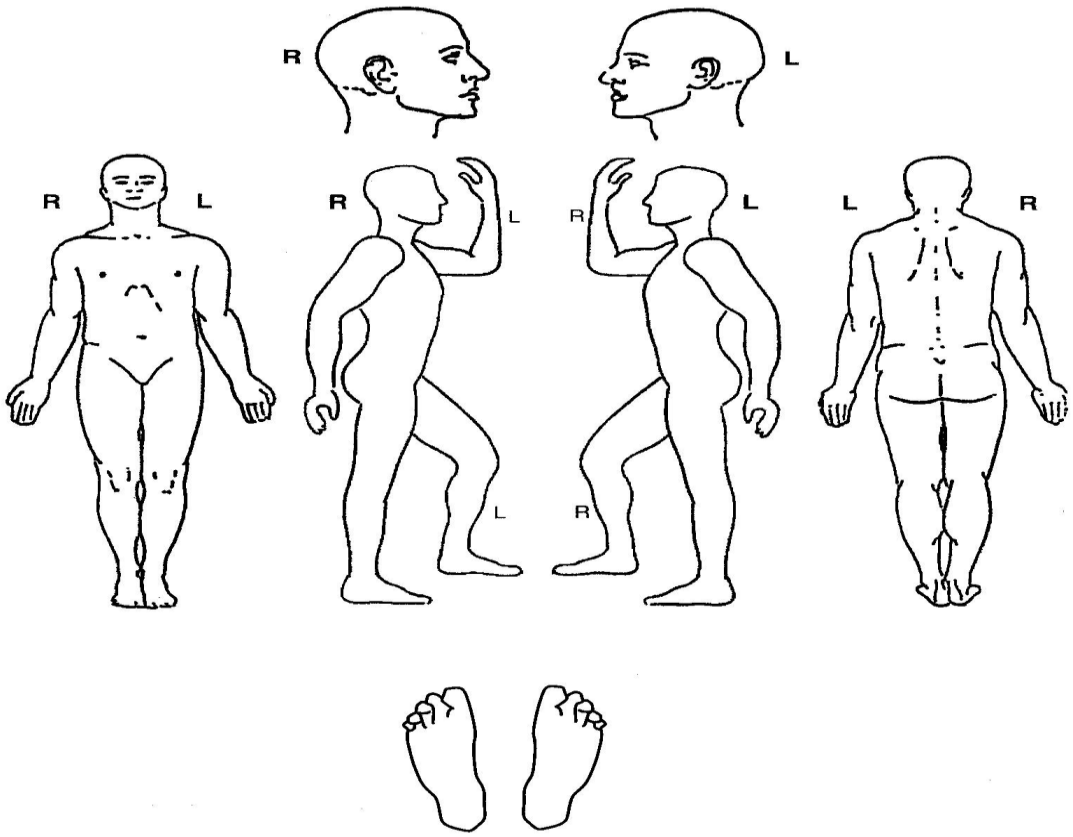
● List your other current doctors:_____

● To which doctors should we send our clinic notes? _____

● Have you seen anyone else for this problem (doctors, therapists, chiropractors)? Who?

_____

PLEASE **SHADE** IN, ON THE DRAWINGS BELOW, THE AREAS WHERE YOU FEEL PAIN.



PLEASE <u>CIRCLE</u> WHICH TREATMENTS YOU HAVE HAD FOR PAIN:

	DATE	HELPFUL	BY WHOM
EPIDURALS / NERVE BLOCKS / Other INJECTIONS (describe)		Yes / No	
Spine or Joint Surgery		Yes / No	
Therapy (Physical, Occupational, other)		Yes / No	
TENS / Neuromuscular Stimulator		Yes / No	
Chiropractor		Yes / No	
Biofeedback / Counseling		Yes / No	
Acupuncture		Yes / No	
Other:		Yes / No	

WHICH OF THE FOLLOWING TESTS HAVE YOU HAD TO EVALUATE YOUR PAIN?

TEST	**DATE DONE***	**WHAT PART OF BODY ***	**WHAT FACILITY ***	**RESULTS IF KNOWN ***
MRI				
CAT (CT) SCAN				
X-RAY				
EMG (TEST FOR NERVE DAMAGE)				
MYELOGRAM				
BONE SCAN				
LABORATORY (BLOOD TEST)				
BONE DENSITY				
EKG				
OTHER:				

***Please answer completely to the best of your knowledge.**

Are you **ALLERGIC** to medications, foods, or latex?_____

What medicine:	What happens? (ie rash, swollen throat, can't breathe etc):	What medicine:	What happens? (ie rash, swollen throat, can't breathe etc):

MEDICATIONS

What **medications** are you taking **now**?

Include prescriptions, vitamins, herbal supplements, & over the counter medications.

Medication & Dose	How do you take it?	Why Prescribed?	**Doctor** who prescribed it

Pharmacy name and location: _____**Phone #:**(___)_____

Are you on any of the following over the counter medications? (*Circle*) Aspirin, Angelica, Cloves, Danshen, Dong Quai, Feverfew, Garlic, Ginger, Gingko Biloba, Ginseng, Glucosamine, Green Tea, Horse Chestnut, Red Clover, St. John's Wort, Turmeric, Vitamin E.

Are you taking any **BLOOD THINNERS**? *Circle all that apply* **(Aggrenox, Persantine–Dipyridamole; Coumadin, Jantoven-Warfarin; Plavix-Clopidogrel; Ticlid-Ticlopidine, Pletal-Cilostazol, Effient-Prasugrel, Brilinta-Ticagrelor, Xarelto-Rivaroxaban, Trental (Pentoxifylline), Pradaxa (Dibigatran, Etexilate). Why?**_____

LIST medications tried in the past for pain or headaches that **did not** work:

_____

MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD OR PRESENTLY HAVE:

- ☐ Pacemaker
- ☐ Diabetes
  - Diet Controlled? Y/N
  - Do you take insulin? Y/N
  - Oral Medications? Y/N
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Irregular Heart Beat (explain type_____)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Easy Bleeding
- ☐ Claustrophobic
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Cancer Type:_____
  - Has it spread? Y / N
  - Where? _____
- ☐ Sleep Apnea
- ☐ Ulcers/Gastric Reflux
- ☐ Kidney Problems (Describe:_____)
- ☐ Lung Problems (COPD, Emphysema, Asthma)
- ☐ Current /Recent Infection
- ☐ Other Medical Problems or Diseases:_____ _____
- ☐ Seizures

Are you pregnant or plan to become pregnant? Y / N

Do you have any metal implants, orthodontic braces, metal piercings, or tattoos? Y / N

If yes, explain:_____

HEADACHE QUESTIONS

PLEASE FILL OUT IF YOU HAVE HEADACHES.

1._____ Is this the worst headache of your life?

2._____ How frequently do you have headaches; has the severity or frequency increased?

3._____ Was this a sudden headache that woke you from sleep?

4._____ Where are your headaches located?

5._____ Have you or a loved one noticed disorientation, memory problems, etc? Explain_____

6._____ What time of day do your headaches start?

7._____ Does it start with exertion (i.e. bowel movement, straining, exercise)?

8._____ From the beginning of the headache, how long does it take to reach maximum intensity (minutes, hours, etc.)?

9._____ How long do your headaches last?

10._____ Do you notice any symptoms before the headache begins ("aura")? Please explain "aura"._____

11._____ How would you characterize the headache pain? Is it burning, shooting, sharp, dull, pounding or other?

12._____ Does anything help the headache?

13._____ List of medications you are (if not yet listed) presently taking or have taken for headaches: _____

14._____ List other therapies for your headaches: _____

16._____ Do you have family members who experience headaches:_____

17._____ Are the headaches a sudden onset after the age of 50?

15._____ Do you experience any of the symptoms listed below during your headache?

	(Please Circle)			(Please Circle)	
Neck Stiffness	Yes	No	Tingling	Yes	No
Dizziness	Yes	No	Sensitivity to Light	Yes	No
Vomiting	Yes	No	Sensitivity to Noise	Yes	No
Numbness	Yes	No	Need to Walk or Move Around	Yes	No
Confusion	Yes	No	Disorientation	Yes	No

Headache & PAIN CENTER amc
answertopain.com
Expert Pain Relief Since 1994

Patient's Demographic Information

Today's Date: _____

Patient's Name: _____

Spouse's Name: _____

Mailing Address: _____
Street City State Zip

Sex: _____ Date of Birth: _____ Age: _____ S.S. #: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

(We use appropriate security measure to protect against loss, misuse, and alteration of data used by our system. We will never share, sell, or rent individual personal information with anyone for their promotional use. Information submitted to us is only available to employees managing this information for purposes of contacting you or sending emails based on your request for information, and to contracted service providers for purposes of providing services related to our communications with you.)

This form was read and completed by whom? _____

Patient's Employer: _____ Phone #: _____

Self Employed: Yes / No Occupation: _____

Primary Insurance: _____ Secondary Insurance: _____

Guarantor's Name: _____ S.S. #: _____
(if different from patient)

Guarantor's Employer: _____ Phone #: _____

Notify in case of emergency: Name: _____ Relationship:_____

Phone #: _____ Address: _____

Relative or Neighbor not living with you: _____ Phone #:_____

Personal Physician: _____

Was this condition due to an accident? Yes / No Date of Accident: _____

Do you currently have any open claims? (If yes, please give detailed information): Yes / No

_____

Workers' Compensation? Yes / No Through Whom: _____

Attorney or Liability Insurance? Yes / No Through Whom: _____

Signature of Patient / Guardian: _____