*North Texas Comprehensive Spine & Pain Center*

*100 Sara Swamy drive Suite 220 / 7700 Lakeview Parkway Suite 100B*
*Sherman Tx, 75090 Rowlett TX 75088*
*Phone#903-892-1999 Fax- 903-892-6999 / Phone# 469-653-0777 Fax# 469-653-0775*

# INTAKE FORM

Referring Physician: _____ Primary Care Physician: _____

**Please list names of other healthcare professionals that have been involved in the management of your pain:**

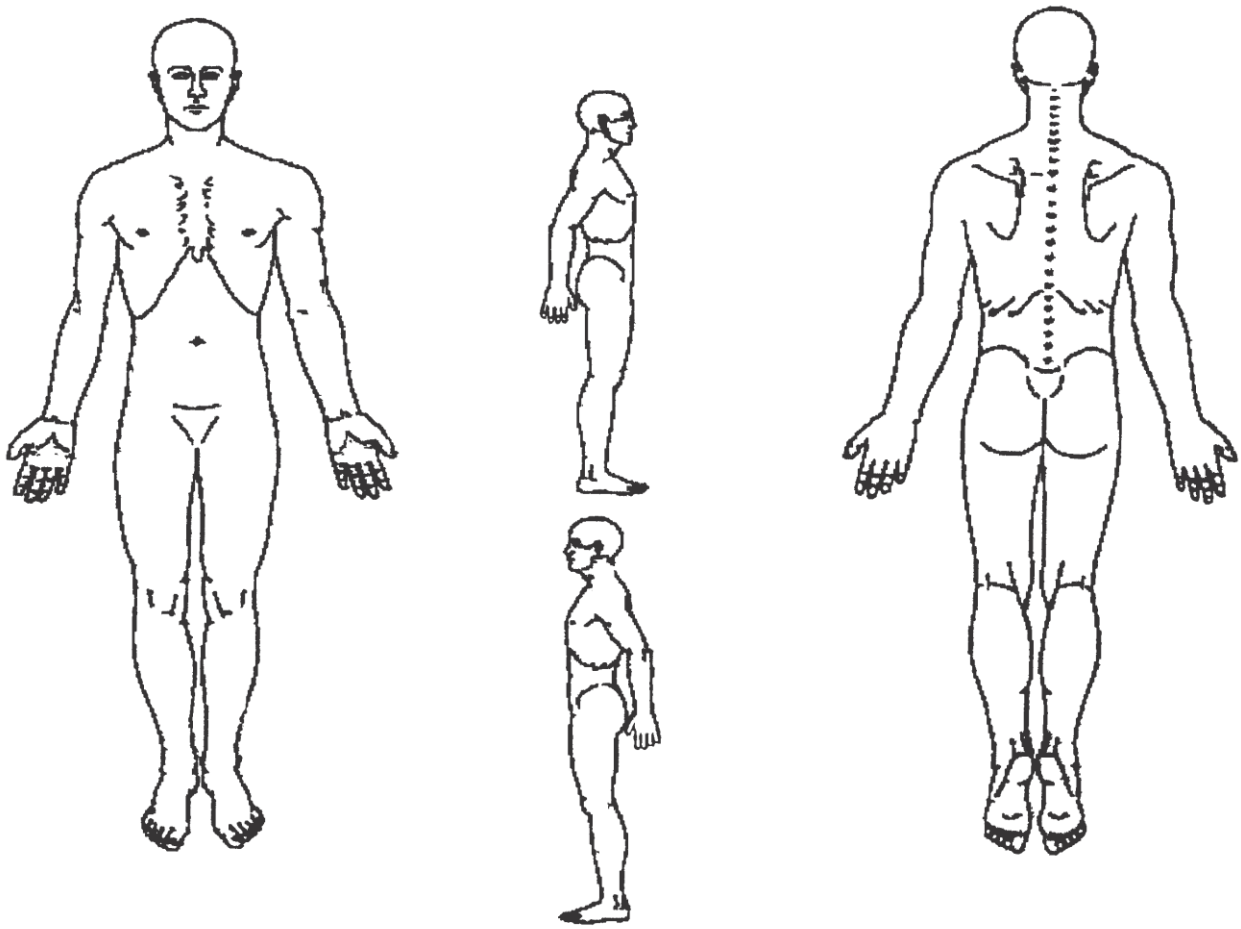
*Pain Specialist:* _____ *Spine(orthopedic or neuro) Surgeon:* _____
*Chiropractor:* _____ *Physical therapist:* _____
*Neurologist:* _____ *Other:* _____

## PAIN HISTORY

**PLEASE DESCRIBE YOUR PAIN PROBLEM – Mark where your pain located – including any spreading/radiation – please state R for right, L for left or B for both if both sides are involved.**

*Head____ Face_____ Neck_____ Mid Back _____*
*Shoulder _____ Arm_____ Hand_____*
*Chest wall_____ Abdomen_____ Pelvis_____*
*Lower back _____ Hip_____ Buttocks_____ Thighs_____ Knee_____ Calf____ Foot_____*
*Other*_____

Please use the diagram below to demonstrate where your pain is located by shading the painful areas:



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- **WHEN did your pain first begin? _____**

- **HOW did your pain begin? (Please choose one option)**
  *No particular event_____ After an accident_____ Date of accident_____*
  *Work related? Yes ____ No____ Pending litigation? Yes_____ No_____*
  *After surgery_____ Date of Surgery_____*
  *Other_____*

- **WHAT DOES YOUR PAIN FEEL LIKE? Please circle choices**
  - **Sharp Shooting**
  - **Tingling Cramping**
  - **Dull Aching**

- **HOW DOES YOUR PAIN CHANGE WITH TIME? Please circle choices**
  - **Constant**
  - **Intermittent**

- **What makes your pain BETTER?**
  **_____**
  **_____**

- **Which makes your pain WORSE?**
  **_____**
  **_____**

- **How does pain affect your lifestyle? (What can you no longer do because of your pain?)**
  **_____**

**PAST MEDICAL HISTORY**

*HIGH BLOOD PRESSURE CARDIAC DISEASE PREVIOUS HEART ATTACK*

*COPD/ASTHMA OTHER LUNG DISEASE*

*ACID REFLUX STOMACH ULCERS HEPATITIS CIRRHOSIS*

*KIDNEY DISEASE DIABETES*

*STROKE SEIZURES CANCER*

OTHER PROBLEMS_____

**SURGICAL HISTORY**

**Please list any operation(s) or surgeries you have had in the past:**

- Type of surgery _____Year _____ Type of surgery _____ ____Year _____
- Type of surgery _____Year _____ Type of surgery _____ ____Year _____
- Type of surgery _____Year _____ Type of surgery _____ ____Year _____
- Type of surgery _____Year _____ Type of surgery _____ ____Year _____

**FAMILY HISTORY**

**Please list any medical conditions that run in your family including chronic pain, substance use or back/neck surgeries – _____**
**_____**

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**ALLERGIES:**

- **Please list your ALLERGIES TO MEDICATIONS/SUBSTANCES:**

Name of Medication Adverse Reaction Experienced When was the last time this happened?

_____

_____

- **Are you allergic to Iodine Contrast Dye (e.g. IVP Dye)?** __Yes __No

If you answered yes, what type of reaction did you have and when?

_____

- **Are you allergic to Aspirin or Anti-Inflammatory Medications (e.g. Ibuprofen)?**

__Yes __No If you answered yes, what type of reaction did you have?

_____

**CURRENT MEDICATIONS:**

- Bring all current medications including prescription bottles to office visit

**Please list the PAIN MEDICATIONS you currently take:**

Name of Pain Medication Dosage How often do you take it? Who prescribed it for you?

_____ _____
_____ _____
_____ _____
_____ _____

**Please list the medications you currently take FOR OTHER MEDICAL CONDITIONS:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please review and mark **ALL** items that have applied to you **within the last month** (including today)

***GENERAL HEALTH:*** *Weight loss Weight gain Fatigue Loss of appetite*
***FEMALES:*** *Pregnant*
***EYES:*** *Eye pain Double vision*
***EARS/NOSE:*** *Ear pain Hearing loss Ringing in ears Sinus Pressure*
***MOUTH/THROAT:*** *Sore throat Problems Swallowing Hoarseness*
***CHEST/HEART:*** *Chest pain Racing/pounding heart Problems breathing w/ lying down*
***RESPIRATORY:*** *Cough Wheezing Shortness of breath*
***GASTROINTESTINAL:*** *Heartburn Nausea/vomiting Diarrhea/Constipation Abdominal pain*
***URINARY TRACT:*** *Blood in urine Increased urination Pain w/urination*
***MUSCULOSKELETAL:*** *Back pain Pain in muscles/joints Stiff joints*
***SKIN:*** *Rash Skin infections MRSA*
***NEUROLOGIC:*** *Seizures Memory issues Weakness/numbness/tingling*
***ENDOCRINE:*** *Increased sensitivity to cold Increased sensitivity to heat*
***HEMATOLOGY:*** *Easy Bruising Easy Bleeding*
***IMMUNE:*** *Frequent infections*
***MENTAL HEALTH:*** *Anxiety/Depression Thoughts of hurting self or others*

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- **Do you take Aspirin?** __ Yes __ No **If you answered yes, when was your last dose?** _____
- **Do you take blood thinners (Coumadin, Plavix, Eliquis, Pletal, Aggrenox, or Ticlid)?** __ Yes __ No
  **If you answered yes, when was your last dose?** _____
  **If you answered yes, will the prescribing physician allow you to discontinue this blood thinner medication for any length of time? ___ Yes** ___ No**

** Please note that you MUST have permission from the physician who prescribes or manages the blood thinner in order to stop this medication.

- **Do you take? (please circle):**
  - **Herbal medications? List** _____
  - **Vitamin E**
  - **Fish Oil**
  - **Other Supplements? List** _____

**SOCIAL HISTORY**

- **What is your current marital status?**
  __ *Single* __ *Married* __ *Divorced* __ *Widowed*

- **With whom do you live?**
  __ *I Live Alone*
  __ *With My Parents*
  __ *With Spouse*
  __ *With Children*
  __ *With Others (Significant Other, friends, Roommate, etc.)*

- **How far did you get in school?** _____
- **Do you currently smoke cigarettes?** ____ Yes ____ No
  **If no and you are a former smoker, when did you quit for good?** _____
  **If yes, packs per day?** _____ For **how many years have you smoked?** _____

- **Do you currently drink alcoholic beverages?** ___ Yes ___ No
  **If yes, how many drinks do you have in a week?** _____

- **Have you ever been diagnosed with or treated for drug or alcohol abuse?** __ Yes __ No
  **If yes, when?** _____ **Please describe** _____

- Do you currently use **illicit drugs?** ___ Yes ___ No
- Have you ever used **illicit drugs?** ___ Yes ___ No
  - If yes, what drugs and when? _____

- **Do you exercise? Y/N What kind of exercise?** _____
- **How often?** _____

**WORK HISTORY**

- **What is your employment status? (please check one)**
  ___ *Retired* ___ *Able to work but currently unemployed* __ *Homemaker* __ *Student*
  ___ *Not working, on Workers' Comp. leave from my job since* _____
  ___*Working Full Time*
  ___ *Not working, on Disability since (date)* _____
  ___ *Working Part Time*

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- **What is (was) your occupation or job title? (please describe)**
  _____
- **Please use the following space to describe any other issues related to your pain condition that has not been covered in the above questions. Your comments and concerns are welcome:**

_____
_____

**WHICH DIAGNOSTIC STUDIES HAVE BEEN DONE TO EVALUATE YOUR PAIN PROBLEM?**

- If you have had any of the imaging done please bring copies of the reports or films including EMG/NCS, MRI, CT-scan, or X-rays to office visit **(Please check all that apply)**
  Ordered by Whom?
  __ *Blood Tests* _____ *X-Rays* _____
  __ *MRI Scan* _____ *CT scan* _____
  __ *EMG / Nerve Conduction Studies* _____ *Bone Scan* _____
  __ *other?* _____ _____

**WHICH TREATMENTS HAVE YOU DONE FOR YOUR PAIN PROBLEM?**

*Injection Treatments*_____*Chiropractor Treatments*_____
*Acupuncture*_____*Surgical Treatments*_____
*Physical Therapy*_____*Psychological Treatments*_____
*Other*_____

**I certify that I have answered all of the above questions truthfully and to the best of my ability**

Patient Name (Pls. Print)_____Patient Signature_____Date_____