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ALLIED PAIN & SPINE INSTITUTE

Patient Intake Form

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (408) 528-8833 if you have questions on how to complete any section of this form.

Today's Date: _____

Referring Physician: _____

Primary Care Physician: _____

☐ **Referred by Internet/Website**

First name:	Last name:	Marital status:	
Street:	City:	State:	Zip:
Social Security:	Mobile Number:	Alternative Number:	
Birth Date:	Age:	Sex (circle): Male	Female
Occupation:	Employer:	Employer Phone:	
Email:			

Emergency Contact

Name:	Relationship:	Phone Number:

Insurance Information

Insurance Carrier:	Subscriber ID:	Group Number:
Secondary Insurance:	Subscriber ID:	Group Number:

Occupational Injury (Work Comp)

Date of Injury:	Claim Number:	Insurance Carrier:
Employer:	Adjuster Name:	Adjuster Phone:

Personal Injury

Date of Injury:	Insurance Carrier:	Policy Number:
Claim Number:	Attorney Name:	Attorney Phone:
Att'y Address:	City:	Attorney Fax:

HISTORY (Pain|Spine|Orthopedic|Injury)

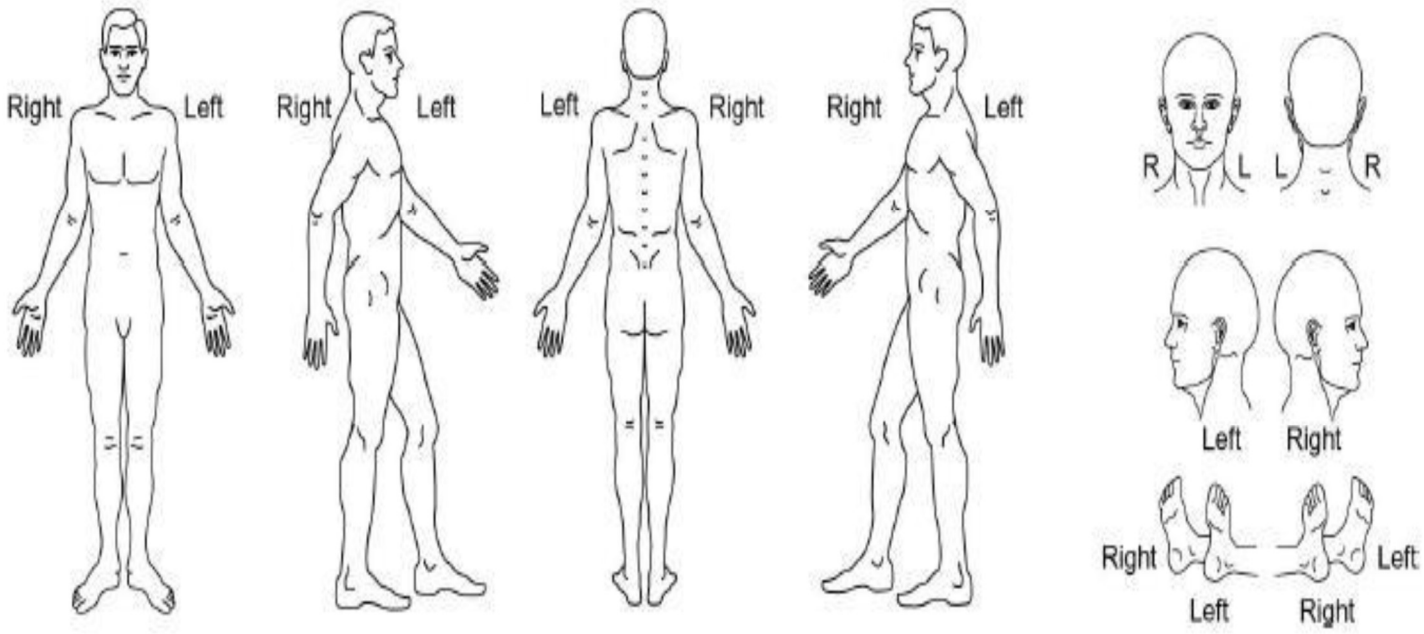
Chief complaint (reason for visit today):

_____

Please list any additional pain issues or involved body part(s):

_____

Use the body outlines below to draw the location(s) of your pain and direction(s) that pain travels (if applicable).



Using the **following** "key" to describe quality of pain (mark on diagrams):

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
///	BBB	NNN	XXX	+++	OOO

How did your symptoms begin?

☐ Suddenly ☐ Gradually ☐ Combination

Approximately how long ago did your pain/symptoms begin?

☐ Days ☐ Weeks ☐ Months ☐Years ☐ Date: _____

Describe onset of injury or symptoms: *(If related to injury, please indicate location or setting and describe mechanism)*

_____

_____

Since onset, your symptoms have:

☐ Improved ☐ Stayed same or worsened

How often does your pain and/or associated symptoms occur?

☐ Constant/Daily ☐ Intermittent (comes and goes)

Circle your level of pain intensity:

Least Pain___0____1____2____3____4____5____6____7____8____9____10____Worst Pain

Associated symptoms:

☐ NONE

☐ Numbness/Tingling Location(s): _____

☐ Weakness Location(s): _____

☐ Bowel/Bladder Incontinence Location(s): _____

☐ Other _____

Which of the following increase your pain/symptoms:

☐ Pushing ☐ Pulling ☐ Lifting ☐ Sitting ☐ Standing

☐ Walking ☐ Stairs ☐ Bending ☐ Work ☐ Weather

☐ Cough ☐ Exercise ☐ Sleep ☐ Other: _____

Which of the following decrease your pain/symptoms:

☐ Heat/Ice ☐ Medication ☐ Sitting ☐ Standing ☐ Exercise

☐ Rest ☐ Chiropractic ☐ Acupuncture ☐Physical Therapy

☐ Brace ☐ TENS ☐ Steroid Injection/ Procedure ☐ Cognitive Therapy

☐ Other: _____

Please mark all treatments you have used for pain relief:

☐ NONE

☐ Medication(s): _____

☐ Physical therapy ☐ Chiropractic therapy ☐ Acupuncture ☐ Psychological therapy

☐ Massage therapy ☐ Brace support ☐ Hot/cold packs ☐ TENS unit

Please mark all interventional treatments you have received for pain relief:

☐ NONE

☐ Trigger point injection(s):
Location: _____
Date(s): _____

☐ Joint injection(s):
Location: _____
Date(s): _____

☐ Spinal cord stimulator
Area involved: _____
Date(s): _____

☐ Spine/Orthopedic surgery
Area involved: _____
Date(s): _____

☐ Other: _____

Mark diagnostic studies you have had related to current complaints:

☐ NONE

☐ MRI Body Part: _____ Date: _____

☐ X-ray Body Part: _____ Date: _____

☐ CT scan Body Part: _____ Date: _____

☐ EMG/NCS Body Part: _____ Date: _____

CURRENT MEDICATION(S)

Are you taking any medication? ☐ Yes ☐ No

(*If you have a written list we can copy it for you.)*

Medication_____ Strength/Dose_____

Medication_____ Strength/Dose_____

Medication_____ Strength/Dose_____

Medication_____ Strength/Dose_____

Medication_____ Strength/Dose_____

Medication_____ Strength/Dose_____

Medication_____ Strength/Dose_____

PAST MEDICAL HISTORY

☐ NONE

☐ Anemia	☐ Anxiety	☐ Asthma	☐ Atrial Fibrillation
☐ Bipolar Disorder	☐ Blood Clot/DVT	☐ Bronchitis/Pneumonia	☐ Cancer: _____
☐ Carpal Tunnel Syndrome	☐ Cataracts	☐ Chronic Join Pain	☐ Constipation
☐ Coronary Artery Disease	☐ Depression	☐ Diabetes Mellitus	☐ Diverticulosis
☐ Emphysema/COPD	☐ Endometriosis	☐ Fibromyalgia	☐ Gastrointestinal Bleeding
☐ GERD (Acid Reflux)	☐ Glaucoma	☐ Gout	☐ Head/Brain Injury
☐ Headaches	☐ Heart Attack	☐ Heart Valve Disorder	☐ Hepatitis B
☐ Hepatitis C	☐ High Blood Pressure	☐ HIV	☐ High Cholesterol
☐ Hyperthyroidism	☐ Hypothyroidism	☐ Insomnia	☐ Kidney Stone(s)
☐ Lupus (SLE)	☐ Migraines	☐ Multiple Sclerosis	☐ Osteoarthritis
☐ Osteoporosis	☐ Overactive Bladder	☐ Parkinson's	☐ Peripheral Neuropathy
☐ Peripheral Vascular Disease	☐ Rheumatoid Arthritis	☐ Sciatica	☐ Seizures
☐ Sleep Apnea	☐ Stomach Ulcer	☐ Stroke/TIA	☐ Tuberculosis

☐ Other: _____

ALLERGIES/INTOLERANCE

☐ NONE

List drug/substance and associated reactions for all allergies:

1) _____
2) _____
3) _____
4) _____

SURGICAL HISTORY

☐ NONE

☐ Abdominal Hernia Repair	☐ Aneurysm Repair: Type_____	☐ Angioplasty w/Stent
☐ Ankle/Foot Surgery: Type_____	☐ Appendectomy	☐ Bladder Surgery
☐ Bowel Surgery	☐ Brain Tumor Resection	☐ Breast Biopsy
☐ Bunionectomy	☐ Cardiac Pacemaker	☐ Carpal Tunnel Release (LEFT)
☐ Carpal Tunnel Release (RIGHT)	☐ Cataract Removal	☐ Cesarean Section (C-section)
☐ Deviated Septum Repair	☐ Elbow Surgery: Type_____	☐ Fibroid Removal
☐ Fracture/Pins/ORIF: Location:_____	☐ Gallbladder Removal (Cholecystectomy)	☐ Gastric Bypass or Stapling
☐ Gout Tophus Removal	☐ Heart Valve Surgery	☐ Hip: Type_____
☐ Hysterectomy	☐ Inguinal Hernia Repair	☐ Kidney Stone Removal
☐ Knee: Type_____	☐ Kyphoplasty	☐ Lasik
☐ Low back/Lumbar Spine: Type_____	☐ Mastectomy	☐ Neck/Cervical Spine: Type_____
☐ Open Heart Surgery (Bypass)	☐ Pilonidal Cyst Excision	☐ Shoulder: Type_____
☐ Spleen Removal (Splenectomy)	☐ Thyroidectomy	☐ Tonsillectomy
☐Trigger Finger Release: _____	☐ Tubal Ligation	☐ Wisdom Teeth Extraction
☐ Other: _____		

FAMILY HISTORY

List significant medical disease in 1st degree relatives:

1) _____
2) _____
3) _____

SOCIAL HISTORY

Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widowed
Children:	☐ Yes	☐ No		
Tobacco Use:	☐ No	☐ Yes:	Packs per day_____	
Alcohol Use:	☐ Never	☐ Occasionally/Socially		☐ Daily
Illegal Drug Use:	☐ Never	☐ Yes	Type: _____	Last Use: _____

Exercise: ☐ Never ☐ 1-2 times/ week ☐ 3+ times/week

WORK HISTORY (Required for all WORK COMP cases)

☐ Retired

Current Occupation: _____

Employer: _____

Work Duties: _____

How long have you worked at current position: _____

Work Status:

☐ Full Duty ☐ Temporary Disability ☐ Permanent Disability ☐ Unemployed

☐ Modified----------→ Restrictions: _____

REVIEW OF SYSTEMS (Please check all that apply)

General

☐ Change in appetite
☐ Chills
☐ Fevers
☐ Lightheadedness
☐ Weight gain
☐ Weight loss
☐ Sleep disturbance

Gastrointestinal

☐ Abdominal pain
☐ Blood in stool
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Nausea/Vomiting
☐ Bowel incontinence

Head/Eyes/Ears/Nose/Throat

☐ Decreased hearing
☐ Decreased sense of smell
☐ Difficulty swallowing
☐ Ringing in ears
☐ Sinus pain
☐ Sore throat
☐ Double vision

Urologic

☐ Painful urination
☐ Blood in urine
☐ Increased urinary frequency
☐ Increased urinary urgency

Neurologic

☐ Balance difficulty
☐ Headaches
☐ Dizziness
☐ Seizures

Respiratory

☐ Cough
☐ Shortness of breath
☐ Wheezing
☐ Chest congestion

Cardiovascular

☐ Chest pain
☐ Fluid accumulation in legs
☐ Palpitations (heart fluttering)
☐ Cold blue hands/feet

Skin

☐ Discoloration
☐ Rash
☐ Skin lesion(s)
☐ Excessive sweating

Psychiatric

☐ Depressed mood
☐ Anxiety
☐ Irritability
☐ Suicidality