Interventional Pain Wellness Center

Return Patient Intake Form

Name:_____ **Cell Number**_____ **Email Address**_____

Primary Care Physician (PCP) Name:_____ Contact information: _____

Referring Physician Name:_____ Contact information: _____

Preferred Pharmacy: _____

What is your primary Insurance? _____ **Secondary Insurance**:_____

How is your pain? SAME BETTER WORSE

Any changes in your health? New Tests or New Medications? YES NO

_____

Are you taking your medications as prescribed? YES NO

What Pain medicines are you taking?

_____ _____ _____ _____

Any side effects? YES NO

Where is your Pain? _____

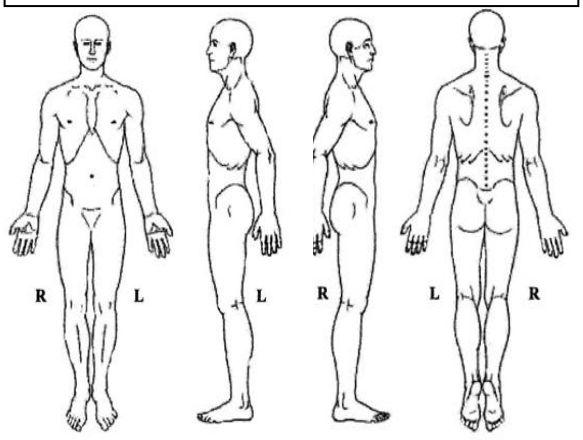
Describe your Pain ? _____

Aching Cramping Dull Sore Stiffness Swelling Tender

Throbbing Burning Numbness Pins/Needles

Sharp Shooting Stabbing Weakness

Circle Location of Pain



Rate your pain (0 is no pain, 10 is worst):

LEAST: 0 1 2 3 4 5 6 7 8 9 10

WORST: 0 1 2 3 4 5 6 7 8 9 10

AVERAGE: 0 1 2 3 4 5 6 7 8 9 10

What makes the pain worse?

Sitting Standing Leaning backward Laying down Walking Exercise Lifting
Weather Other_____

What makes the pain better?

Heat Ice Massage Brace Medication

Interventional Pain Wellness Center

Does your pain affect your Daily Activities? YES ☐ NO ☐
Does your pain affect your sleep? YES ☐ NO ☐
Does your pain affect your mood or anxiety? YES ☐ NO ☐

Review of System (ROS): (Circle any that apply)

General	Weight changes	Fever/Chills	Sweating	Other-
Neurologic	Headaches	Dizziness	Numbness	Other-
Psychiatric	Memory problems	Depressed Mood	Suicidal thoughts	Anxiety
	Stress	Delayed thinking	Fogginess	Other-
Cardiovascular	Chest pain	Irregular heart beat	Leg swelling	Other-
Respiratory	Shortness of breath	Breathing difficulty	Cough	Other-
Gastrointestinal	Nausea/Vomiting	Diarrhea	Constipation	Other-
Urinary/Sexual	Urinary retention	Loss of libido	Loss of orgasm	Other-
Musculoskeletal	Weakness	Back pain	Joint pain	Other-
Hematology	Bleeding	Bruising	Cancer	Other-
Dermatology	Skin Rash	Color Changes	Swelling	Other-