Center for Neuromodulation
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INITIAL PAIN INTAKE FORM

Name_____ Date___/___/___

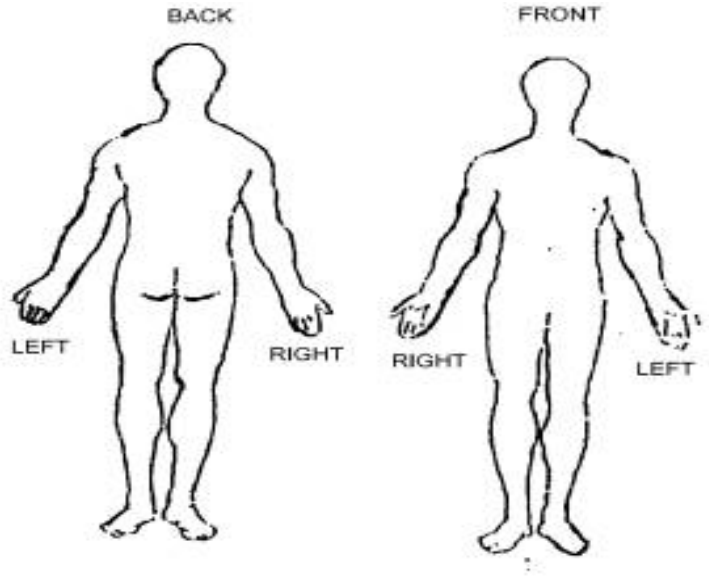
Date of Birth ___/___/___ Age____

Referring Doctor/Source_____ Tel. Number_____

Primary Care Doctor_____ Tel. Number_____

When and how did your pain begin?

Please mark with an "X" on the diagrams below where you feel pain.



NYU Langone MEDICAL CENTER

What is your pain score? (0=No Pain; 10=Worst Pain Possible)

No Pain 0 1 2 3 4 5 6 7 8 9 10 *Worst Pain Possible*

Mild *Moderate* *Severe*

Pain score today _____ Pain score on your best day _____ Pain score on your worst day _____

√							
Check the words that describe your pain	burning	throbbing	sharp	dull	aching	shooting	squeezing

What makes your pain better? _____

_____

_____

What makes your pain worse? _____

_____

_____

Have you ever seen a pain management specialist? ___ Yes ____ No

List the names of the doctors who have treated you for your pain condition and provide approximate dates.

Doctor_____ Date_____

Doctor_____ Date_____

Doctor_____ Date_____

Please check if you ever had any of the following:

Epidural Steroid injections ____ Facet Blocks _____ Physical Therapy _____ Acupuncture ____

Botox Injections ____ TENS Unit _____ Spinal Cord Stimulator _____

Your medical history (please check and describe if appropriate):

Condition	X	Details
Heart Disease		
High Blood Pressure		
Asthma		
High Cholesterol		
Emphysema		
Bronchitis		
Cancer		
Epilepsy/Seizures		
Stroke		
Ulcers		
GI Reflux		
Hepatitis		
Kidney Stones		
Kidney/Renal problems		
Prostate Problems		
Endocrine/Hormonal Problems		
Diabetes		
Other:		

Please List all of your current medications including herbs and supplements: (or attach a copy)

Medication	Dose	Times per day

Surgical History

Please list all the surgeries that you have had and the approximate dates they were done:

Surgeries	Dates

Please check if you take any of the following medications:
Aspirin ___
Plavix ___
Coumadin ___
Any other blood thinner: _____

Do you have a bleeding disorder? ___ Yes ____ No
If "yes", please describe:

Do you have any allergies to any medications? Yes___ No___
If you answered "Yes", please write down the name of the medication and the allergic reaction:

Medication	Allergic Reaction

Please record any other non-medication allergies you have (food, seasonal allergies, etc).

Are you : (please check) _right handed __left handed __ambidextrous

<u>Family History</u> (please check if present in any family members):
High Blood Pressure ___ Cardiac Disease _____
Parkinson's Disease _____ Pulmonary Disease _____
Other:

<u>Social History</u>

Marital status:
Number of Children:_____
Whom do you live with?:_____

Do you smoke cigarettes? _____
For how long have you smoked? _____
How many packs per day do/did you smoke? _____
Have you tried or thought of quitting? _____
Have you abused substances? _____
Do you drink alcohol? _____
How much? _____
Do you use street drugs? _____
Have you been treated in a drug rehab? _____
Have you had any sexually transmitted diseases? _____
Are you employed? _____
What's your occupation? _____
Date of your last employment? _____
Are you being treated for depression? _____Yes _____No

Review of Systems Please circle all that apply to you:

General	Fever Malaise Fatigue Generalized weakness Chronic Pain
Eyes	Blurriness of vision Pain or pressure in the eyes Blindness Cataracts Glaucoma Double vision
Eyes/ears/nose/mouth	Nose bleeding runny nose difficulty hearing ringing in the ears ulcers in the mouth difficulty chewing difficulty or pain when swallowing Ear infection Polyps Sinusitis
Heart	Chest pain angina irregular heartbeat fainting stroke Heart attack Pacemaker
Lungs	Difficulty breathing shortness of breath coughing wheezing Asthma Emphysema
Gastrointestinal	Loss of appetite vomiting nausea constipation diarrhea bleeding or blood in the stool loss of bowel control
Genitourinary	Difficulty urinating painful urination urinary frequency blood in the urine frequency at night Stress incontinence Loss of bladder control Enlarged prostate or BPH
Musculoskeletal	Arthritic pain stiffness flaccidity contractures rigidity joint pains muscle aches/pains fractures osteoporosis osteoarthritis Gout
Skin	Rash Itching Keloids Pressure ulcers wounds Melanoma Basal cell carcinoma Lumps warts moles
Neurological	Seizures Epilepsy Numbness or tingling sensations headaches dizziness Balance problems gait disorder
Psychiatric	Depression Sadness Mania Withdrawals Drug addiction suicidal thoughts Schizophrenia
Endocrine	Palpitations weight loss intolerance to cold or heat urinating a lot Loss or thinning of hair insomnia rapid heart rate insomnia
Blood and Lymphatics	Bleeding or bruising Swollen glands
Allergic / Immunologic	Drug /food/latex allergy arthritis prior transplant hay fever Lupus Gets sick easily allergic rhinitis

PLEASE SIGN AND DATE:

Patient's Signature _____ Date___/___/___

Physical Examination

Height ___ ft. ___in. Weight ____lbs.

BP _____/_____ HR_____ RR_____Temp._____