Coastal Spine & Pain

I N T E R V E N T I O N A L P A I N M A N A G E M E N T

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NEW PATIENT INTAKE FORM

Please print clearly and complete all fields. Bring this form with a valid photo ID and insurance card(s) to your appointment.

PATIENT INFORMATION

Patient Name (Last, First, MI):	
Date:	
Referring Physician:	

Are you currently in or anticipate **litigation** for why you are being seen? ☐ **YES** ☐ **NO**	Are you currently in or anticipate filing a **workers' compensation claim**? ☐ **YES** ☐ **NO**

PAIN ASSESSMENT

Today's Pain Score	Average Pain Score	Worst Pain Score
_____ / 10	_____ / 10	_____ / 10

What best describes your pain? *(Check all that apply)*

☐ Aching	☐ Burning	☐ Cramping	☐ Dull
☐ Pins/Needles	☐ Electrical	☐ Stabbing	☐ Stinging
☐ Numb	☐ Tingling	☐ Sharp	☐ Throbbing

Where does your pain START?	
Where does your pain RADIATE to?	
Where is your pain the WORST?	
What TRIGGERS / worsens your pain?	
What DECREASES your pain?	

Pain Frequency: ☐ Constant ☐ Fluctuating but always present ☐ Comes and goes

Under what circumstances did the pain you are being seen for begin? Please give a description with dates:

TREATMENT HISTORY

Have you ever been treated by a pain management clinic or doctor before? ☐ **YES** ☐ **NO**

If yes, Physician Name: _____

Have you received prior injections for your CURRENT pain complaint? ☐ **YES** ☐ **NO**

If yes, what type and how many: _____ Date of Last Injection: _____

What other treatments have you tried for pain? *(Check all that apply)*

☐ Physical Therapy	☐ Water Therapy	☐ TENS
☐ Prescription Medications	☐ Heat / Cold	☐ NSAIDs (OTC)
☐ Chiropractic Care	☐ Yoga / Pilates / Home Exercise	☐ Acupuncture
☐ Massage Therapy	☐ Cognitive Behavioral Therapy	☐ Other: _____

CURRENT PAIN MEDICATIONS

List ALL pain-related medications you currently take (including Ibuprofen, Tylenol, Aleve, Gabapentin, Lyrica, Cymbalta, etc.)

Medication	Dose	Frequency	Improved?	Side Effects

PAST MEDICAL HISTORY

Check all conditions that apply to you:

☐ Addiction	☐ Addiction Treatment	☐ Anxiety	☐ Arthritis (OA/RA)
☐ Asthma / COPD	☐ Cancer	☐ Chronic Joint Pain	☐ Depression
☐ Diabetes	☐ Fibromyalgia	☐ GERD	☐ GI Bleeding
☐ Headaches	☐ Heart Attack	☐ Heart Failure / Disease	☐ High Blood Pressure
☐ Irritable Bowel Syndrome	☐ Kidney Disease	☐ Liver Disease	☐ Lung Disease
☐ Pancreatitis	☐ Prostate Cancer	☐ Prostate Enlargement	☐ Seizure Disorder
☐ Sleep Apnea	☐ Stomach Ulcers	☐ Stroke	☐ Vascular Issues

REVIEW OF SYSTEMS

Check any of the following you have experienced in the past 3 months:

☐ Weight Loss	☐ Weight Gain	☐ Fatigue	☐ Shortness of Breath
☐ Wheezing	☐ Ankle Edema	☐ Chest Pain	☐ Palpitations
☐ Abdominal Pain	☐ Constipation	☐ Reflux	☐ Diarrhea
☐ Vomiting	☐ Blood in Stool	☐ Numbness in Arm/Leg	☐ Loss of Grip Strength
☐ Loss of Leg Strength	☐ Muscle Pain	☐ Joint Swelling	☐ Headaches
☐ Seizures	☐ Balance Issues	☐ Loss of Bowel Control	☐ Loss of Bladder Control
☐ New/Recent Weakness	☐ Itching	☐ Rash	☐ Mass/Lump
☐ Swollen Lymph Nodes	☐ Easy Bruising	☐ Mood Swings	☐ Depression

☐ Anxiety	☐ Agitation	☐ Inability to Sleep	

ADDITIONAL MEDICAL HISTORY

List any other medical problems not listed above:	
Recent hospitalizations (past 6 months) — explain:	
Illnesses that run in your family:	
List ALL allergies:	
List ALL previous surgeries and dates:	
Imaging in the past 2 years related to your pain (MRI, CT, X-ray) — type and location performed:	

Do you smoke? If yes, how many packs per day? _____ ☐ **YES** ☐ **NO**

Do you drink alcohol? If yes, how much per day? _____ ☐ **YES** ☐ **NO**

Have you ever been or are you currently addicted to alcohol or drugs, or been treated for the same? ☐ **YES** ☐ **NO**

Have you ever been diagnosed with depression, treated for depression, or currently feel depressed? ☐ **YES** ☐ **NO**

Are you on a blood thinner? If yes, type: _____ ☐ **YES** ☐ **NO**

FOR OFFICE USE ONLY

Date:	Patient Name:	DOB:

Date of Last UDS (if available):	Consistent / Inconsistent # in past 12 mo: 1 2 3 4
PDMP Checked Today? ☐ Y / ☐ N	Consistent / Inconsistent
Opioid Agreement within 1 year?	☐ YES / ☐ NO Date: ____/____/____
COMM Today?	Score:
ORT-OUD Today?	Score:
Oswestry Today?	Score:
PHQ-9 Today?	Score:
Most Recent Imaging on File?	Results:
Today's Plan:	Action:

Orders / Imaging / Referral	Medications