



# Stony Brook Medicine

## Center for Pain Management New 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 (631) 638-0800 if you have any question on how to complete any section on this form.

### Patient Information

Today's date: \_\_\_\_\_

Your name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

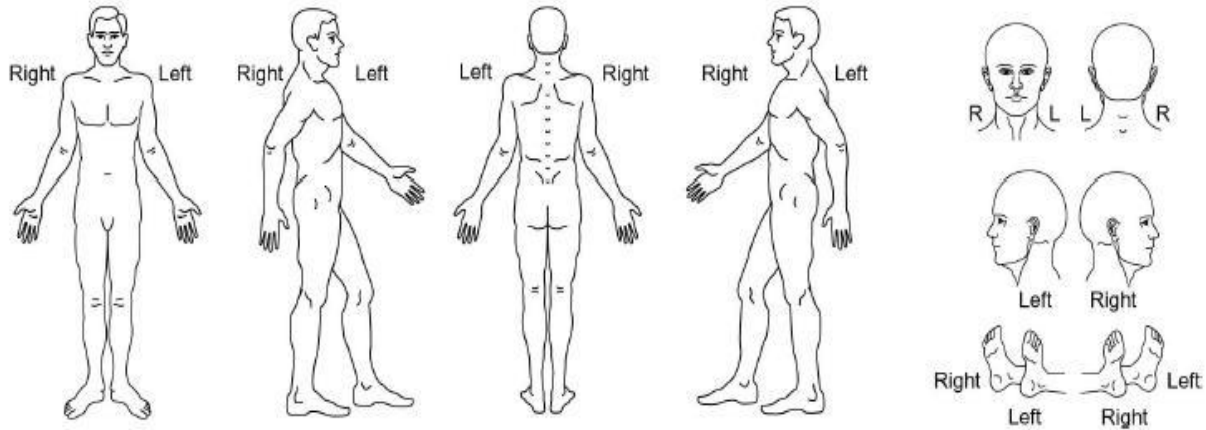
### Pain History

Chief Complaint (Reason for your visit today)? \_\_\_\_\_

Does this pain radiate? If so where? \_\_\_\_\_

Please list any additional areas of pain: \_\_\_\_\_

Use this diagram to indicate the area of your pain. Mark the location with an "X"



### Onset of Symptoms

Approximately when did this pain begin? \_\_\_\_\_

What caused your current pain episode? \_\_\_\_\_

How did your current pain episode begin?  Gradually  Suddenly

Since your pain began how has it changed?  Improved  Worsened  Stayed the same

## Pain Description

Check all of the following that describe your pain:

- |                                      |  |                                   |   |
|--------------------------------------|--|-----------------------------------|---|
| <input type="checkbox"/> Dull/Aching | <input type="checkbox"/> Hot/Burning               | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stabbing/Sharp |
| <input type="checkbox"/> Cramping    | <input type="checkbox"/> Numbness                  | <input type="checkbox"/> Spasming | <input type="checkbox"/> Throbbing      |
| <input type="checkbox"/> Squeezing   | <input type="checkbox"/> Tingling/Pins and Needles |                                   | <input type="checkbox"/> Tightness      |

When is your pain at its worst?

- |  |                                  |                                   |  |
|--|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Mornings        | <input type="checkbox"/> Daytime | <input type="checkbox"/> Evenings | <input type="checkbox"/> Middle of the night |
| <input type="checkbox"/> Always the same |                                  |                                   |  |

How often does the pain occur?

- |  |   |
|--|---|
| <input type="checkbox"/> Constant                      | <input type="checkbox"/> Changes in severity but always present |
| <input type="checkbox"/> Intermittent (comes and goes) |   |

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now \_\_\_\_\_ The Best It Gets \_\_\_\_\_ The Worst It Gets \_\_\_\_\_

Mark the effect each of the following have on your pain level -

	<u>Increases</u>	<u>Decreases</u>	<u>No Change</u>
Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in Weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking upward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking downward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from seated position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What other factors worsen or affect your pain which is not mentioned above?

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### Associated Symptoms

	<b>NO</b>	<b>Yes</b>	<b>Comments</b>
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____
Weakness in the arm/leg	<input type="checkbox"/>	<input type="checkbox"/>	_____
Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fevers/chills	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please mark all of the following treatments you have used for pain relief:

	<b>No Change</b>	<b>Worsened Pain</b>	<b>Helped Pain</b>
Spine Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brace Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot/Cold Packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			

### Interventional Pain Treatment History

- Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
- Joint Injection – Joint(s) \_\_\_\_\_
- Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
- MILD (Minimally Invasive Lumbar Decompression) - \_\_\_\_\_
- Nerve Blocks – Area/Nerve(s) - \_\_\_\_\_
- Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar
- Spinal Cord Stimulator – Trial Only/Permanent Implant \_\_\_\_\_
- Trigger Point Injections – Where? \_\_\_\_\_
- Vertebroplasty/Kyphoplasty – Level(s) \_\_\_\_\_
- Other - \_\_\_\_\_

Which of these procedures listed above have helped with your pain? \_\_\_\_\_

## Diagnostic Tests and Imaging

**Mark all of the following tests that you have related to your current pain complaints:**

- MRI of the: \_\_\_\_\_ Date: \_\_\_\_\_
- X-Ray of the: \_\_\_\_\_ Date: \_\_\_\_\_
- CT Scan of the: \_\_\_\_\_ Date: \_\_\_\_\_
- EMG/NCV study of the: \_\_\_\_\_ Date: \_\_\_\_\_
- Other Diagnostic Testing: \_\_\_\_\_ Date: \_\_\_\_\_
- I have not had ANY diagnostic tests for my current pain complaint

**Mark the following physicians or specialists you have consulted for your current pain problem(s):**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Neurosurgeon       | <input type="checkbox"/> Psychiatrist/Psychologist |
| <input type="checkbox"/> Chiropractor  | <input type="checkbox"/> Orthopedic Surgeon | <input type="checkbox"/> Rheumatologist            |
| <input type="checkbox"/> Internist     | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Neurologist               |
| <input type="checkbox"/> Other _____   |   |  |

## Past Medical History

Please list the names of other Pain Physicians you have seen in the past? \_\_\_\_\_

Mark the following conditions/diseases that you have been treated for in the past:

### General Medical

- Cancer - Type \_\_\_\_\_
- Diabetes - Type \_\_\_\_\_

### Cardiovascular/Hematologic

- Anemia
- Heart Attack
- Coronary Artery Disease
- High Blood Pressure
- Peripheral Vascular Disease
- Stroke/TIA
- Heart Valve Disorders

### Gastrointestinal

- GERD (Acid Reflux)
- Gastrointestinal Bleeding
- Stomach Ulcers
- Constipation

### Urological

- Chronic Kidney Disease
- Kidney Stones
- Urinary Incontinence
- Dialysis

### Neuropsychological

- Multiple Sclerosis
- Peripheral Neuropathy
- Seizures
- Depression
- Anxiety
- Schizophrenia
- Bipolar Disorder

### Head/Ears/Eyes/Nose/Throat

- Headaches
- Migraines
- Head Injury
- Hyperthyroidism
- Hypothyroidism
- Glaucoma

### Respiratory

- Asthma
- Bronchitis/Pneumonia
- Emphysema/COPD

### Musculoskeletal/Rheumatologic

- Bursitis
- Carpal Tunnel Syndrome
- Fibromyalgia
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Chronic Joint Pains

### Other Diagnosed Conditions

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Past Surgical History

Please list any surgical procedures you have had done in the past including date:

- 1) \_\_\_\_\_ Date? \_\_\_\_\_
- 2) \_\_\_\_\_ Date? \_\_\_\_\_
- 3) \_\_\_\_\_ Date? \_\_\_\_\_
- 4) \_\_\_\_\_ Date? \_\_\_\_\_
- 5) \_\_\_\_\_ Date? \_\_\_\_\_

I have **NEVER** had any surgical procedures performed.

## Current Medications

Are you currently taking any blood thinners or anti-coagulants?  YES  No

If **YES**, which ones?  Aspirin  Plavix  Coumadin  Lovenox  Other \_\_\_\_\_

**Please list all medications you are currently taking including vitamins. Attach additional sheet if required:**

	<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____
10)	_____	_____	_____

**Please list all past pain medications that you have been on at any point for your current pain complaints?**

	<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

## Allergies

Do you have any drug/medication allergies?

Yes

No

If so, please list all medications you are allergic to:

<u>Medication Name</u>	<u>Allergic Reaction</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Topical Allergies:

Latex

Iodine

Tape

IV Contrast

## Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

Arthritis

Cancer

Diabetes

Headaches/Migraines

High Blood Pressure

Kidney Problems

Liver Problems

Osteoporosis

Rheumatoid arthritis

Seizures

Stroke

Other Medical Problems: \_\_\_\_\_

I have no significant family medical history

## Social History

Occupation: \_\_\_\_\_ When was the last time you worked? \_\_\_\_\_

Who is in your current household? \_\_\_\_\_

Are there any stairs in your current home? \_\_\_\_\_ If so how many? \_\_\_\_\_

Temporary Disability

Permanent Disability

Retired

Unemployed

Are you currently under worker's compensation?

No

Yes

Is there an ongoing lawsuit related to your visit today?

No

Yes

**Alcohol Use:**

Social Use

History of alcoholism

Current alcoholism

Never

Daily use of alcohol

**Tobacco Use:**

Current user

Former user

Never used

Packs per day? \_\_\_\_\_

How many years? \_\_\_\_\_

Quit Date: \_\_\_\_\_

**Illegal Drug Use:**

Denies any illegal drug use

Currently uses illegal drugs

Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications?

Yes

No

## Review of Systems

Mark the following symptoms that you currently suffer from:

<b>Constitutional:</b>	<input type="checkbox"/> Chills	<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Easy bruising
	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fevers
	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Low sex drive	<input type="checkbox"/> Tremors
	<input type="checkbox"/> Unexplained Weight Gain		<input type="checkbox"/> Weakness
	<input type="checkbox"/> Unexplained Weight Loss		

<b>Eyes:</b>	<input type="checkbox"/> Recent Visual changes
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<b>Ears/Nose/Throat/Neck:</b>	<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Earaches	<input type="checkbox"/> Hearing Problems
	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sinus problems	

<b>Cardiovascular:</b>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Blood Clots
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Swelling in feet
	<input type="checkbox"/> Shortness of breath during sleep		

<b>Respiratory:</b>	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of breath
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<b>Gastrointestinal:</b>	<input type="checkbox"/> Constipation	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Abdominal Cramps
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Hernia

<b>Musculoskeletal:</b>	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Joint Pains	<input type="checkbox"/> Joint Stiffness
	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> muscle spasms	<input type="checkbox"/> Neck Pain

<b>Genitourinary/Nephrology:</b>	<input type="checkbox"/> Flank Pain	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Painful Urination
	<input type="checkbox"/> Decreased Urine Flow/Frequency/Volume		

<b>Neurological:</b>	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Tremors
	<input type="checkbox"/> Numbness/Tingling		<input type="checkbox"/> Seizures

<b>Psychiatric:</b>	<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Feeling Anxious	<input type="checkbox"/> Stress Problems
	<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Suicidal Planning	
	<input type="checkbox"/> Thoughts of Harming Others		

All other review of systems negative

Reviewer \_\_\_\_\_