SMPC
SOUTHERN MICHIGAN
PAIN CONSULTANTS

# Patient Intake Information

**Patient Data**

**Name:** _____ **DOB:**_____

**Family Physician:** _____ **Referring Provider:** _____

**SOGI**

**Birth Sex:** O Male O Female O Unknown

**Sexual Orientation:**
O Lesbian, gay, or homosexual
O Straight or heterosexual
O Bisexual
O Do not know
O Choose not to disclose
O Something else, please describe
_____

***This information is now required by governmental programs (CMS) to be documented in each patients chart in order to improve the care provided to each individual person. This information will only be used for your healthcare treatment and will not be shared with anyone.***

**Gender Identity**
O Male
O Female
O Female-to-Male (FTM) / Transgender Male/Trans Man
O Male-to-Female (MTF) / Transgender Female/Trans Woman
O Genderqueer, neither exclusively male nor female
O Choose not to disclose
O Additional gender category or other, please specify
_____

**Allergies/ Medical History**

**Medical History:**

Have you ever, or do you now have, any of the following conditions? Circle all that apply.

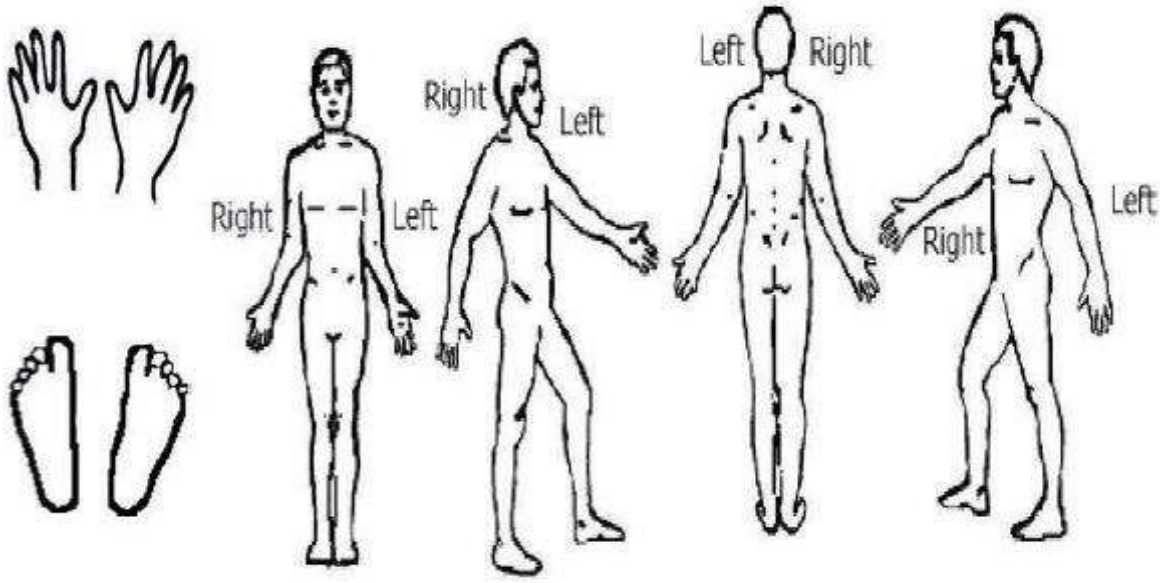
| | | |
|---|---|---|
| Heart Attack/Heart Disease | Bleeding/Bruise Easily | Cancer |
| Irregular Heart Rate | Emphysema | Stroke |
| Chest Pain | Asthma | Kidney Problems |
| High Blood Pressure | Thyroid Problems | Epilepsy/Seizures |
| Stomach/Intestinal Problems | Diabetes Type 1 or Type 2 | Cigarette Use |
| Arthritis | Depression/Psych | Alcohol Use (per week) |
| Substance Abuse/Addiction | | |
| Other, _____ | | |

**Allergies:** _____

_____

**Complaints:**

**Please mark where your pain is.**



**Current Medications:**

**List all Medication you are currently using and how often you use them. Please indicate below:**

**1.**_____ **6.**_____

**2.**_____ **7.**_____

**3.**_____ **8.**_____

**4.**_____ **9.**_____

**Vitals:**

**Nurse Use Only**

BP: _____ HR: _____ RR: _____

Temp: _____ O2: _____ Ht: _____ Wt: _____

**HPI Pain Details:**

**Where is the pain located for today's visit?** _____

**The pain is described as: (Circle all that apply)**

Dull Aching Throbbing Cramping Sharp

Burning Shooting Stabbing Tingling

**The pain is** Acute (Less than 3 months) Chronic (More than 3 months)

**The acuity is described as: (Circle the one that applies)**

Stable Exacerbated Worsening Progressing New Onset

**How often is your pain? (Circle the one the applies)**

Constant Intermittent Frequent Occasional Infrequent

**The pain is worse in: (Circle the one that applies)**

Morning Afternoon Evening Morning & Afternoon

Morning & Evening All Day

**This pain had been present since: _____**

**The cause of pain is the result of: (Circle the one that applies)**

A gradual onset and it is not the result of injury or accident

An auto accident A work accident An injury at home outside the workplace Other

**Pain rating at PRESENT on a scale of 0-10: _____**

**Pain rating at BEST on a scale of 0-10**: _____

**Pain rating at WORST on a scale of 0-10: _____**

**Aggravating elements include: (Circle all that apply)**

Heat Cold Physical Activity Sitting Standing

Walking Running Stairs Bending Twisting

Stress Light Touch Sexual Active Weather All the Above

**Additional Pain Location(s): _____**

**Additional Details:**

Circle the correct choice:

| | | |
|---|---|---|
| **Any Changes to bowel or bladder function?** | **Yes** | **No** |
| **Are medications being taken as prescribed?** | **Yes** | **No** |
| **Do you have any numbness or tingling?** | **Yes** | **No** |
| **Do you have any muscle weakness?** | **Yes** | **No** |
| **Any swelling in the affected area?** | **Yes** | **No** |
| **Any muscle spasms or cramps?** | **Yes** | **No** |

**Diagnostic Studies:**

| Test | Date & Place Done | Results | Test | Date & Place Done | Results |
|---|---|---|---|---|---|
| X-ray | | | X-ray | | |
| MRI | | | MRI | | |
| CT scan | | | CT scan | | |

**Family History**

**Mother:** _____

**Father:** _____

**Other family members:** _____

**Social History**

**Conservative Care:**

**Have you tried physical therapy?** Yes No

**If Yes What area? _____ When? _____**

**Have you tried chiropractic care?** Yes No

**If yes, what area? _____ When? _____**

**Are you engaged in a prescribed home exercise program related to your pain complaint?**

Yes No **Where did you learn it from? _____**

**When did you start the home exercise program? _____**

**How many times a week do you complete your home exercise?**

0 1 2 3 4 5 6 7

**How much time is spent doing your home exercise?**

5-10 Minutes 15-30 minutes Greater than 30 minutes

**Have you tried osteopathic manipulation treatment (OMT)?** Yes No

**What medications are you actively taking for pain?**

NSAIDS Over the counter Muscle Relaxers Topical pain medications

Prescribed pain medications Other: _____

**Please list what medication(s) you are taking for pain:**

_____

**Have you been able to decrease use in the last 3 months?** Yes No

**If not, why?** Not tolerated Only provided temporary relief Increased pain

**Do you use Ice or Heat?** Yes No

**If yes, how often do you use it?**

Daily Weekly A few times a week Monthly As needed

**Do you currently attend acupuncture or have you in the past?** Yes No

**If yes, When?** _____

**How often?**

Daily Weekly A few times a week Monthly As needed

**Do you use a TENS unit or have you in the past?** Yes No

**If yes, When?** _____

**How often?**

Daily Weekly A few times a week Monthly As needed

**Are you actively enrolled in Behavior Health Counseling?** Yes No

**If yes, when did you last attend Behavior Health Counseling?** _____

**Other conservative care treatments?**

_____

**Tobacco Use: (Circle the one that applies)**

Current Smoker Former Smoker Non-Smoker

**If Current smoker**

**When did you start smoking?** _____

**How often do you smoke cigarettes?** Everyday Some days, but not everyday

**How many cigarettes a day do you smoke?** 5 or less 5-10 11-20 21-30 31 or more

**How soon after you wake up do you smoke your first cigarette?**

Within 5 minutes 6-30 minutes 31-60 minutes after 60 minutes

**Are you interested in quitting?**

Ready to quit Thinking about quitting Not ready to quit

**Are you an other tobacco user? (Such as snuff, pouches, chew?)** Yes No

**Drug/Alcohol- Alcohol Screen:**

**Did you have a drink containing alcohol in the past year?** Yes No

**If yes, how often have you had a drink containing alcohol in the past year?**

Never Monthly or less 2-4 times a month 2-3 times a week

4 or more times a week

**How many drinks did you have on a typical day when you were drinking in the past year?**

1-2 drinks 3-4 drinks 5-6 drinks 7-9 drinks 10 or more

**How often did you have 6 or more drinks on one occasion in the past year?**

Never Less than monthly Monthly Weekly Daily or almost daily

**Drug Use: Do you use any recreational drugs?** Yes No

**Have you ever used needles to inject drugs?** Yes No

**Caffeine: Caffeine Intake**

None 1-2 cups per day 2-3 cups per day 3-4 cups per day

more than 4 cups per day

**Do you use marijuana?** Yes No

**If yes, do you have a medical marijuana card?** Yes No

**Surgical History**

| Type of Surgery | Date | Type of Surgery | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Recent Hospitalization?** Yes No

**If yes, please explain:** _____

_____

**Review Of Systems**

**Cardiovascular**

__ Shortness of Breath

__ Chest Pain/ Discomfort

__ Palpitations/ Irregular Heartbeat

**Ear/Nose/Throat/Mouth**

__ Difficulty Hearing/ Ringing in Ears

__ Hay Fever/ Allergies/ Congestion

__ Trouble Swallowing

__ Loss of Sense of Smell

**Constitutional**

__ Recent Fever/ Sweats

__ Unexplained Weight Loss/ Gain

__ Unexplained Fatigue/ Weakness

**Endocrine**

__ Cold/ Heat Intolerance

__ Increased Thirst

__ Increased Appetite

**Eyes**

__ Change in Vision

**Gastrointestinal**

__ Changes in Bowel Movement

__ Nausea/ Vomiting

__ Diarrhea

**Genitourinary**

__ Nighttime Urination

__ Concern with Sexual Function

__ Painful/ Bloody Urination

__ Leaking Urine

__ Discharge of the Vagina

__ Unusual Vaginal Bleeding

**Musculoskeletal**

__ Muscle Pain

__ Joint Pain

__ Muscle Weakness

__ Back Pain

**Respiratory**

__ Cough/ Wheeze

__ Coughing up Blood

**Lymphatic**

__ Easy Bruising/ Bleeding

__ Unexplained Lumps

**Neurological**

__ Headaches

__ Numbness

__ Tremors

__ Poor Balance

**Psychiatric**

__ Anxiety/ Stress

__ Sleep Problems

__ Depression

**Skin**

__ Rash

__ Sores

__ Asthma

**Procedures**

**Pre-Procedure Checklist**

**Any active infection or antibiotics?** Yes No

**Any chance of pregnancy?** Yes No

**Any anticoagulant (blood thinner) use?** Yes No

**If yes, what anticoagulant? _____**

**Last used date: _____**

**Taking NSAIDS?** Yes No

**If yes, what NSAID(S)? _____**

**Last used date: _____**

**Taking aspirin?** Yes No

**If yes, last used date: _____**

**Known diabetes?** Yes No

**If yes: Type I Type II**

**Last Blood Sugar: _____**

**Last A1C: _____**

**Do you have any implants? If yes, please list below:**

_____

_____

**Do you have a driver?** Yes No

**If yes,**

**Name: _____** **Phone number _____**