PrairieShore PAIN CENTER

185 Milwaukee Ave, Ste 230
Lincolnshire, IL 60069

847-883-0077 Phone
847-883-0078 Fax
PrairieShorePainCenter.com

New Patient Intake Form

FOR STAFF USE

CHECK-IN TIME	HEIGHT	WEIGHT	BP	HR	RR	ORT SCORE	UDS	APPT. TIME	ROOM TIME

Please fill out this form so that we can 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 (847) 883-0077 if you have any question about how to complete any section on this form.

Date of First Visit:_____ Name: _____Date of Birth: _____Age: _____

Referring Physician Name: _____Phone: _____

Address:_____ City: _____ State: _____ Zip: _____

Primary Physician Name:_____ Phone: _____

Address:_____ City: _____ State: _____ Zip: _____

Is this visit directly related to Car Accident, Personal Injury or other litigation? ☐ Yes ☐ No

Is this visit directly related to Workman's Compensation case? ☐ Yes ☐ No

PAIN HISTORY

Chief reason for your visit today? _____

_____

_____

_____

_____

Where is your pain located? Does this pain travel? If so where? _____

_____

_____

_____

_____

Please list any additional areas of pain: _____

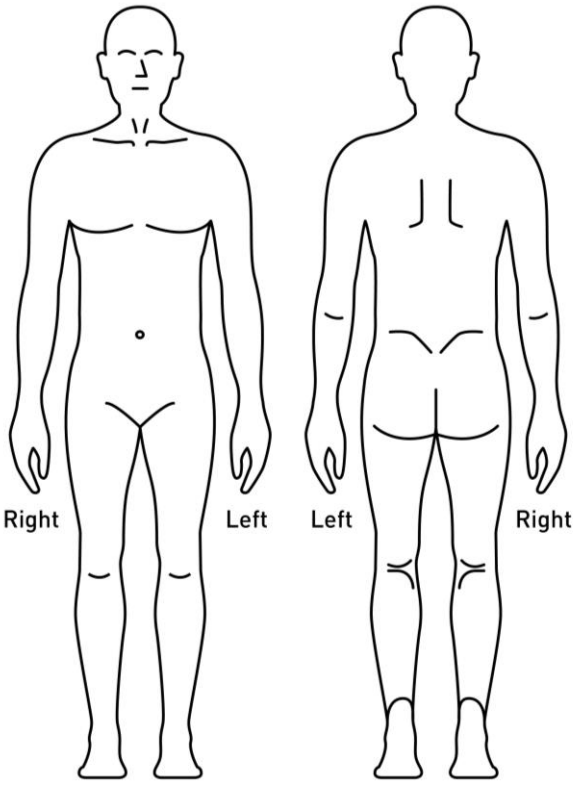
_____

_____

_____

_____

Use the diagram to indicate the area of your pain. Color the location with Red (Severe Pain), Green (Moderate Pain), Blue (Mild Pain) or Black (Numb/Tingly).



Red = Severe Pain **Green** = Moderate Pain
Blue = Mild Pain **Black** = Numb/Tingly

ONSET OF PAIN 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

Have you had this pain before? ☐No ☐Yes

Explain? _____

_____

Check all of the following that describe your pain: ☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp ☐ Cramping ☐ Numb ☐ Spasming ☐ Throbbing ☐ Squeezing ☐ Tingling/Pins and Needles ☐ Heavy

When is your pain at its worst? ☐ Mornings ☐Daytime ☐ Evenings ☐ Middle of the night ☐ Always the same

How often does the pain occur? ☐ Constant ☐ Changes in severity but always present ☐ 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:

ACTIVITY	INCREASES	DECREASES	NO CHANGE
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes In Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking Upward	☐	☐	☐
Looking Downward	☐	☐	☐
Rising From Seated Position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

What other factors worsen or affect your pain, which are not mentioned above? _____

_____

_____

ASSOCIATED SYMPTOMS	NO	YES	COMMENTS
Numbness/Tingling	☐	☐	Where?
Weakness in the Arm/Leg	☐	☐	
Balance Problems	☐	☐	
Bladder Incontinence	☐	☐	
Bowel Incontinence	☐	☐	
Joint Swelling/Stiffness	☐	☐	
Fevers/Chills	☐	☐	
Other	☐	☐	

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

TREATMENT	NO CHANGE	WORSENED PAIN	HELPED PAIN
☐Spine Surgery	☐	☐	☐
☐Physical Therapy	☐	☐	☐
☐Chiropractic Care	☐	☐	☐
☐Psychological Therapy	☐	☐	☐
☐Brace Support	☐	☐	☐
☐Acupuncture	☐	☐	☐
☐Hot/Cold Packs	☐	☐	☐
☐Massage Therapy	☐	☐	☐
☐Medications	☐	☐	☐
☐TENS Unit	☐	☐	☐
☐Other:	☐	☐	☐

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

MEDICATION NAME	DOSE	FREQUENCY
1.		
2.		
3.		
4.		
5.		

INTERVENTIONAL PAIN TREATMENT HISTORY

When and How Many?

☐ Epidural Steroid Injection —☐Cervical/☐Thoracic/☐Lumbar _____

☐ Joint Injection — Joint(s) _____

☐ Medial Branch Blocks/Facet Injections —☐Cervical/☐Thoracic/☐Lumbar _____

☐Intrathecal Pump Trial/Implant _____

☐ Nerve Blocks — Area/Nerve(s) _____

☐ Radiofrequency Nerve Ablation —☐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: _____

☐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):

☐ Acupuncturist☐ Neurosurgeon☐ Psychiatrist/Psychologist☐ Chiropractor☐ Orthopedic Surgeon☐ Rheumatologist

☐ Internist☐ Physical Therapist☐ Neurologist ☐ 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

_____

☐ Chemotherapy

☐Radiation Therapy

☐ Diabetes–Type_____

On Insulin? ☐Yes☐No

☐ HIV

Cardiovascular/Hematologic

☐ Anemia

☐ Blood Clots

☐ Heart Attack

☐ Coronary Artery Disease

☐ High Blood Pressure

☐ High Cholesterol

☐ Peripheral Vascular Disease

☐ Stoke/TIA

☐ Heart Valve Disorders

☐ Heart Murmur

☐ Heart Failure

☐ Aneurysm

☐ Dysrhythmia

☐ Pacemaker

☐ Open Heart/Cardiac Bypass Graft Surgery

Gastrointestinal

☐ GERD (Acid Reflux)

☐ Gastrointestinal Bleeding

☐ Stomach Ulcers

☐ Constipation

☐Crohn's Disease/Ulcerative Colitis

☐ Irritable Bowel Syndrome

☐ Chronic Liver Failure/Cirrhosis

☐ Hepatitis Type ___

Urological

☐ Chronic Kidney Disease/Failure

☐ Kidney Stones

☐ Urinary Incontinence

☐ Dialysis

☐ Recurrent urinary tract infection

Neuropsychological

☐ Multiple Sclerosis

☐ Peripheral Neuropathy

☐ Seizures

☐ Depression

☐ Anxiety

☐ Schizophrenia

☐ Bipolar Disorder

☐ ADD/ADHD

☐ Obsessive-Compulsive Disorder

Head/Ears/Eyes/Nose/Throat

☐ Headaches

☐ Migraines

☐ Head Injury

☐ Glaucoma

Endocrine

☐ Hyperthyroidism

☐ Hypothyroidism

Respiratory

☐ Asthma

☐ Bronchitis/Pneumonia

☐ Emphysema/COPD

☐ Sleep Apnea

Musculoskeletal/Rheumatologic

☐ Carpal Tunnel Syndrome

☐ Fibromyalgia

☐ Osteoarthritis

☐ Osteoporosis

☐ Rheumatoid Arthritis

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: _____

☐ 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:

MEDICATION NAME	DOSE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES

Do you have any drug/medication allergies?☐ Yes☐ No

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

MEDICATION NAME	ALLERGIC REACTION
1.	
2.	
3.	
4.	
5.	

Other Allergies:☐ Latex☐ Iodine☐ Tape☐ IV Contrast

FAMILY HISTORY

Mark all appropriate diagnoses as they pertain to your first degree relatives and who it was:

☐Arthritis _____

☐Cancer _____

☐Diabetes _____

☐Heart Disease_____

☐High Blood Pressure _____

☐Kidney Problems _____

☐Liver Problems_____

☐ Substance abuse/addiction _____

☐Other Medical Problems _____

☐ I have no significant family medical history

☐ I am adopted. No Medical History Available

SOCIAL HISTORY

Occupation: _____ ☐Fulltime ☐Part-time

When was the last time you worked outside the home?_____

☐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

Marital Status: ☐Single ☐Married/Common-Law ☐Divorced ☐Separated ☐Widowed

Children: ☐No ☐Yes: How many? _____

Who is in your current household?_____

Alcohol Use:☐ Social Use☐ History of alcoholism☐ Current alcoholism☐Never☐ Daily use of alcohol

☐Amount of alcohol consumed weekly? _____

Tobacco Use:☐ Current user☐ Former use☐ Never used

☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Illegal Drug Use:☐ Denies any illegal drug use☐ Currently uses illegal drugs☐ Marijuana☐Other_____

☐ 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:

Constitutional
☐Difficulty Sleeping
☐Daytime Sleepiness
☐Snoring
☐Fatigue
☐Easy Bruising
☐Night Sweats
☐Chills
☐Fevers
☐Insomnia
☐Low Sex Drive
☐Tremors
☐Weakness
☐Unexplained Weight Gain
☐Unexplained Weight Loss
☐Changes In Appetite

Eyes
☐Recent Visual Changes

Ears/Nose/Throat/Neck
☐Dental Problems
☐Earaches
☐Hearing Problems
☐Nosebleeds
☐Sinus Problems

Cardiovascular
☐Chest Pain
☐Bleeding Disorder
☐Blood Clots
☐Fainting
☐Palpitations/Racing Heart
☐Swelling in Feet

Respiratory
☐Cough
☐Wheezing
☐Shortness Of Breath

Gastrointestinal
☐Constipation
☐Heartburn
☐Tarry Black Stool
☐Diarrhea
☐Nausea/Vomiting
☐Coffee-Ground Vomit
☐Hernia

Musculoskeletal
☐Back Pain
☐Joint Pains
☐Joint Stiffness
☐Joint Swelling
☐Muscle Spasms
☐Neck Pain

Renal
☐Flank Pain
☐Blood In Urine
☐Painful Urination
☐Decreased Urine Flow/Frequency/Volume

Neurological
☐Dizziness
☐Headaches
☐Tremors
☐Numbness/Tingling
☐Seizures
☐Loss Of Balance

Psychiatric
☐Depressed Mood
☐Feeling Anxious
☐Stress Problems
☐Suicidal Thoughts
☐Suicidal Planning
☐Thoughts Of Harming Others

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been made aware of the Privacy Practices for PrairieShore Pain Center.

_____ _____
Name of Patient (Please Print) Signature of Patient or Representative Date

PrairieShore Pain Center reserves the right to modify the privacy practices outlined in the Privacy Policy Notice.