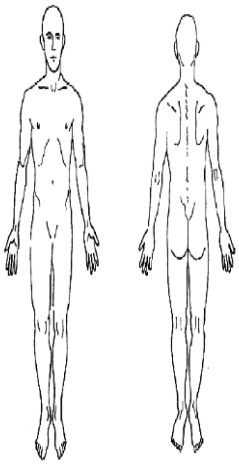
PAIN INSTACARE

PATIENT INTAKE FORM

Please fill this form for us to understand your pain and treat it effectively.

CHIEF COMPLAINTS: (Headaches / Neck Pain / Upper Extremity Pain (L / R)/ Upper Back Pain / Chest Pain / Low back Pain/Pelvic Pain / lower tremity Pain (L / R) / Foot Pain L/R) /Facial Pain / Whole body pain Hip Pain (L / R) Shoulder Pain (L/R) Elbow pain (L/R) Wrist pain(L/R) Multiple joints pain)



List your symptoms :

Pain characteristics are:
Intensity: _____10 (Today) **Duration**: (How Long ago it started) / **Quality:** Dull / Sharp / Shooting / Burning / Throbbing / Stabbing / Aching / knife like / Other _____/ **Aggravating factors**: □ Physical activity □ Bending □ Twisting □ Lifting □ Walking Sitting □ Standing
Relieving factors: □ laying down □ Physical Activity □ Medications /**Associated Issues**: □ Numbness □ Tingling

Describe characteristics : (Intensity / duration / quality / aggravating factors/relieving factors / associated factors)

HISTORY OF PRESENT ILLNESS: How and when did your pain start? (Please describe) If it is related to any injury please describe in detail. Also please tell us if there were any previous injuries t account for your symptoms.

Describe your pain

PREVIOUS TESTS PERFORMED: Describe in detail what tests (like Xrays, MRI, CT, EMG etc has been done previously for your symptoms . Also report any diagnosis if you know

PREVIOUS TREATMENTS: Please list any treatment you received with name and type of doctors and their treatments (Physical Therapy / Medications/ Chiropractic Care / Acupuncture / Pain Management / Ortho/ Spine **)**

ALLERGIES: Describe any allergies you may have.

CURRENT MEDICATIONS: List your current medications including any blood thinners

PAST MEDICAL HISTORY : Describe all your medical problems in the past

PAST SURGICAL HISTORY: Please list all surgeries you have had

SOCIAL HISTORY: Please state your marital status, also if you smoke, use alcohol or any illicit drugs
Also discuss your occupational status currently whether you are working or disabled

FUNCTIONAL HISTORY: describe if you are independent or independent with ADLs and ambulation

Activity of Daily Living □ Independent □ Dependent **Ambulation** □ Independent □ Dependent with _____

FAMILY HISTORY: Please tell us about any family medical history , age, disease suffering, alive or diseased
Father: Alive / Deceased / _____ Mother: Alive / Deceased_____

REVIEW OF SYSTEM: If you are experiencing any other symptoms besides your pain please mention here