The Pain Center of Central Florida, P.A.
Intake Evaluation form

Date: _____

Name: _____
Last **First** **Middle Initial**

Date of Birth: _____

Chief Complaint(s):

1) **Your chief complaint(s) are: (Circle all that apply) Neck pain Mid-back pain Low-back pain Right arm pain Left arm pain Right leg pain Left leg pain Headache Other** _____
2) **Do you currently have a headache? ___Yes ___ No**
   a. **If " Yes" are they: (Circle the one that applies) Mild Moderate Severe**
3) **Your worst pain is in the following areas: Neck Mid-back Low-back Right arm Left arm Right leg Left leg Other**_____
4) **Do you currently have a fracture? ___ Yes ___No**
   a. **If "Yes" Please indicate what type of fracture:** _____
5) **Do you currently have tingling? ___ Yes ___ No**
6) **If "Yes" Please indicate which of the following areas: (Circle all that apply) Neck Mid-back Low-back Right arm Left arm Right leg Left leg Other** _____
7) **Do you currently have weakness in any of the following areas? (Circle all that apply) Neck Mid-back Low-back Right arm Left arm Right leg Left leg Other**_____
8) **Do you currently have stiffness of the joints in any of the following areas? (Circle all that apply) Neck Mid-back Low-back Right arm Left arm Right leg Left leg Other** _____
9) **Do you currently have numbness in any of the following areas? (Circle all that apply) Neck Mid-back Low-back Right arm Left arm Right leg Left leg Other** _____

History of Present Illness:

10) **Please indicate the area where you have the worst pain. Neck Mid-back Low-back Right arm Left arm Right leg left leg Other**_____
11) **Please indicate the actual date you started with this pain. If you cannot give exact date how long have you had the pain:** _____
12) **Please indicate your age when this pain started:** _____
13) **Please indicate the way your pain started: (Circle all that apply) Sudden Gradual Delayed**
14) **Please indicate the frequency of the pain: (Circle all that apply) Constant Intermittent**
15) **Please indicate how you pain has changed over the course of time: (Circle all that apply) Slowly improving Progressively worsening Fluctuating Decreasing in intensity Increasing in intensity**
16) **What led to the precipitating event? (Circle all that apply) Lifting (what)** _____ **Bending over Twisting Kneeling Pushing heavy objects Pulling a load Climbing Reaching Fall Trip MVA Throwing Catching Job with repetitive lifting Job with repetitive motion Job with tonic posture/position Other**_____
17) **Please indicate the location of the incident: Workplace Home Commercial Facility Parking lot While driving Company Sponsored event Traveling for work Vacation Church School Other** _____

If No MVA (Motor Vehicle Accident): Please proceed to question 38

18) If MVA, Please indicate the date of accident: _____
19) If MVA, Please indicate if the vehicle was: Totaled or $_____Amount of damage
20) If MVA, Please describe if the accident was: (Circle all that apply) From behind Head on From the left side From the right side
21) If MVA, Please indicate the cause of the accident: (Circle all that apply)
Patient's vehicle lost control Other vehicle lost control Other vehicle hit patient
Patient struck by a vehicle Other _____
22) If MVA, Please indicate if your vehicle was: (Circle all that apply)
Stopped Moving at constant speed Accelerating Slowing down
23) If MVA, Please indicate how fast your vehicle was moving. _____ MPH
24) Please indicate the type of vehicle: (Circle all that apply) Compact Mid-size Motorcycle Sedan SUV Truck Van Other _____
25) Please give the make, model and year of the vehicle:_____
26) If MVA, Please indicate the patient's status during the accident: (Circle all that apply)
Driving with seatbelt Driving without seatbelt Back passage with seatbelt Back passage without seatbelt Front passage with seatbelt Front passage without seatbelt A pedestrian
27) Please indicate the place of incident: (Circle all that apply) Intersection Interstate Exit ramp On ramp Parking Lot City street Other _____
28) If MVA, Please indicate if the vehicle was rolled over? ___ Yes ___ No
29) If MVA, Please indicate if the vehicle had airbags? ___ Yes ___ No
30) If MVA, Please indicate if the vehicle had headrest? ___ Yes ___ No
31) If MVA, Please indicate if the vehicle airbags deployed? ___ Yes ___ No
32) If MVA, Please indicate the following IF you suffered a head injury: (Circle all that apply)
Brief loss of consciousness Remained conscious
33) Please indicate if you were able to walk: ___ Yes ___ No
34) Please indicate if you went to the ER? ___ Yes ___ No
35) If you went to the ER how did you get there? By ambulance By family member By friend By self Other _____
36) Please indicate when your pain began after MVA: Immediately ____ hours later ____ days later
37) Please indicate who you saw after the MVA and when: Chiropractor ____ days later Injury care physician ____ days later Primary care physician ____ days later

38) Please score your pain now: (scale 1-10 with 1 being minimum and 10 being maximum) _____
39) Please score your pain when at its worst:(scale 1-10 with 1 being minimum and 10 being maximum)____
40) Please score your pain when at its least:(scale 1-10 with 1 being minimum and 10 being maximum) ____
41) Please describe your pain: (Circle all that apply) Achy Burning Dull Sharp Shooting Stabbing Throbbing Other _____
42) Please indicate the location if the pain radiates: Neck Mid-back Low-back Right arm Left arm Right leg Left leg Other _____
43) Please indicate if you have of the following symptoms associated with your pain: (Circle all that apply)
Blurry Vision Dizziness Memory Loss Numbness Vomiting Weakness Weight Loss
Other _____

44) Please indicate any aggravating factors you have due to the pain: (Circle all that apply)
Any Activity or Movement Bending Over Carrying Climbing Stairs Driving Exercise Lying Down Medications Overhead Movement Prolonged Sitting Walking Weight Bearing Working Other _____

45) Please indicate any relieving factors of the pain: (Circle all that apply) Activity Application of Cold Application of Heat Exercise Medication Movement Physical therapy Rest Sitting Standing TENS Other _____

46) If you are currently on medications for the pain are they: (Circle all that apply)
Effective Less Effective Not Effective Working Well

47) If you are currently on medications for the pain are you having any side effects such as: (Circle all that apply) Constipation Dizziness Drowsiness Insomnia Itching Loss of Balance Myalgia Nausea Vomiting Weakness Other _____

48) If you are currently on medications for the pain do you feel a tolerance for the medication?
___Yes ___No

49) If you are currently on medications for the pain are you: (Circle all that apply) Needing more Stable Weaning down

50) Please indicate medications you are using now: (Circle all that apply) Actiq Advil Aleve/naproxen Butrans Carisoprodol Celebrex Dilaudid/hydromorphone Exalgo Fentanyl patch Flexeril Hydrocodone Kadian Meloxicam Methadone Morphine sulfate ER Morphine sulfate IR Nupren/ibuprofen Opana ER Oxyodone ER Oxyodone IR Oxycontin Robaxin Tramadol Other _____

51) Do you want to change medications? ___ Yes ___No

52) Please indicate if you have tried these medictions: (Circle all that apply)
NSAIDs (which ones) _____ Cymbalta Lyrica
Muscle relaxers (which ones) _____ Neurontin/gabapentin
Opiates (which ones) _____

53) Do the medications help with any of the following? (Circle all that apply) Daily activities
Family activities Mood Sleep pattern Social activities Overall physical function

54) Have you tried any of the following treatments? (Circle all that apply)
Prescription Medication (what year) _____ Helpful? ___ Yes ___No
Biofeedback (what year) _____ Helpful? ___ Yes ___No

55) Epidural Injections (what year) _____ Helpful? ___ Yes ___No
Pain Management Program (what year) _____ Helpful? ___ Yes ___No
Physical Therapy (what year) _____ Helpful? ___ Yes ___No
Facet injection (what year) _____ Helpful? ___ Yes ___No
Spinal Cord Stimulator (what year) _____ Spine Surgery (what year) _____
TENS Unit (what year) _____
Acupuncture (what year) _____ Helpful? ___ Yes ___No
Chiropractic Therapy (what year) _____ Helpful? ___ Yes ___No
Psychological Therapy (what year) _____ Helpful? ___ Yes ___No
Counseling (what year) _____ Helpful? ___ Yes ___No
Massage (what year) _____ Helpful? ___ Yes ___No
Other (what year) _____ Helpful? ___ Yes ___No

56) If surgery to spine? By whom _____

57) Please indicate if any of the following apply: (Circle all that apply) Cancer Chronic Corticosteroid Use Coronary Artery Disease Diabetes Mellitus Injury Herniated Disk Obesity Osteoarthirtis Osteoporois Peripheral Vascular Disease Pulmonary Disease Rheumatoid Arthritis Spinal Stenosis Spondylolisthesis Other _____

58) Please indicate your level of sleep since the pain started: (Circle all that apply) Increased Decreased Stayed the same Other _____

59) Please indicate the quality of sleep you receive since the pain started: (Circle all that apply) Good Normal Poor Other _____

60) Do you have snoring episodes? ___ Yes ___ No

61) Do you wake up gasping at night? ___ Yes ___ No

62) Do you have sleep apnea? ___ Yes ___ No

63) If yes to question 61 do you wear a CPAP device? ___ Yes ___ No

64) Please indicate if you were adopted. ___ Yes ___ NO

65)

FAMILY HISTORY (Fill in health history about your family)

Relationship	Illnesses	Habits	Date of Birth	Age at Death/ Cause of Death
Father				
Mother				
Brother				
Brother				
Sister				
Sister				

Past Medical history

Have you ever had or currently have:

66) A malignancy, please give the diagnosis and date of diagnosis: _____

67) A skin condition, please give the diagnosis and date of diagnosis: _____

68) An eyes, ears, nose and throat condition, please give the diagnosis and date of diagnosis: _____

69) A respiratory condition, please give the diagnosis and date of diagnosis: _____

70) A cardiovascular condition, please give the diagnosis and date of diagnosis: _____

71) A genitourinary condition, please give the diagnosis and date of diagnosis: _____

72) A musculoskeletal condition, please give the diagnosis and date of diagnosis: _____

73) A neurologic condition, please give the diagnosis and date of diagnosis: _____

74) A psychiatric condition, please give the diagnosis and date of diagnosis: _____

75) A hematologic/lymphatic condition, please give the diagnosis and date of diagnosis: _____

76) An endocrine condition, please give the diagnosis and date of diagnosis: _____

77) An infectious disease, please give the diagnosis and date of diagnosis: _____

78) An allergic/immunologic condition, please give the diagnosis and date of diagnosis: _____

79) A rheumatologic condition, please give the diagnosis and date of diagnosis: _____

80) Any trauma or toxin exposure, please give the diagnosis and date of diagnosis: _____

81) Please list any allergies you have to anesthesia: _____

82) Please list any allergies you have to medications: _____

83) Please list any other allergies you have: _____

84) Please list any surgical procedure you have had: _____
_____
_____

85) Please indicate your marital status: (Circle all that apply) Single Married Married (common law) Domestic partner Separated Divorced Divorced and remarried Widowed Widowed and remarried Other _____
86) Are you an active smoker? ___ Yes ___ No
87) If "yes" to question 86, how many cigarettes/packs do you smoke a day? _____
88) If "yes" to question 86, when did you started smoking and at what age? _____
89) Are you an inactive smoker? ___ Yes ___ No
90) If "yes" to question 89, how many cigarettes/packs did you smoke a day? _____
91) If "yes" to question 89, when did you stop smoking and at what age? _____
92) If you drink alcohol please list the type you drink and how much daily: _____
93) If you drink alcohol please indicate at what age you started to drink and the actual date: _____
94) If you no longer drink alcohol please indicate the actual date you stopped: _____
95) If you have or currently use illicit/recreational drugs, please list the type: _____
96) If you have or currently use illicit/recreational drugs, please list the method you used: _____
97) If you have or currently use illicit/recreational drugs, please list the age and actual date you started:
_____
98) If you have used recreational drugs, please list the age and actual date you stopped: _____
99) Please indicate the highest level of education you have received: (Circle all that apply) High school College Graduate school Trade school MD JD Masters PhD Other _____
100) Please indicate if you are currently: Employed Unemployed Retired Disabled Other _____
101) If you are employed are you: ___ Full time ___ Part time
102) If you are employed please indicate your job title or profession: _____
103) If employed please give the name of your company: _____
104) If unemployed please indicate your last date of employment:_____
105) If retired how long have you been retired? (days, weeks, months, or years) _____
106) If disabled please list the actual age and date you became disabled: _____
107) If disabled please indicate the cause: Accident Congenital anomaly Illness Medical condition Inability to work because of work restrictions Other _____
108) Within your work environment are you or have you been exposed to any of the following hazards: (Circle all that apply) Infectious diseases Inorganic dust Organic dust Radiation Toxic chemicals Other _____
109) Please list any hobbies and activities you are currently involved in: _____

Review of System:

110) Please indicate if you have any of the following: (Circle all that apply) Anorexia Change in appetite Chills Exercise tolerance Fatigue Fever Malaise Night sweats Weakness Weight changes Other _____
111) If you indicated change in appetite is it? ___ Decreased ___ Increased
112) If you indicated fatigue is it: Mild Moderate Severe
113) If you indicated fever is it: Low grade High grade ____ Degrees
114) If you indicate night sweats is it: Head and shoulder Mild Soaking sheets Other _____
115) If you indicate weight change is it: (Circle all that apply) Weight gain Weight loss How many____ lbs Over how long ____ months/years

116) Please indicate if you have any of the following musculoskeletal conditions: (Circle all that apply)
Arthritis Atrophy Deformity Gout Limitation of motion Muscle cramps Pain, back Pain, bone Pain, joints Pain, muscle Stiffness

117) Do you have any of the following skin conditions: (Circle all that apply) Change in hair or nails
Dry skin Excessive sweating Hives Hyperpigmentation Hypopigmentation Infection Itching Jaundice Lesions or sores Loss of hair Lumps Mole, changes Moles, new Rash

118) Please indicate if you have any of the following: (Circle all that apply) Bleeding gums Blurred vision
Difficulty swallowing Double vision Earaches Ear discharge Ear ringing Hay fever
Hearing loss Hoarseness Nose bleeds Sinus trouble Vision loss Visual flashes

119) Please indicate if you have any of the following neck conditions: (Circle all that apply) Enlarged thyroid
Neck mass Neck pain Stiffness Swelling Swollen glands

120) Please indicate if you have any of the following respiratory conditions: (Circle all that apply)
Chest wall pain Clubbing of fingers Cough Cyanosis Exposure to tuberculosis Hempytsis
Nocturnal gasping Shortness of breath Snoring Stridor Tuberculosis Wheezing

121) Please indicate when your last PPD was: _____

122) Please indicate if you have any of the following cardiac conditions: (Circle all that apply)
Chest pain or tightness that is brought on by exertion Chest pain that is not associated with exertion
Palpitations Rapid heartbeat Varicose veins

123) Please indicate if you have any of the following gastrointestinal conditions: (Circle all that apply)
Loss of appetite Bowel habit changes Constipation Nausea Hemorrhoids Incontinence, stool
Indigestion Diarrhea Heartburn Abdominal pain Rectal bleeding Vomiting

124) Please indicate if you have any of the following genitourinary conditions: (Circle all that apply)
Blood in urine Frequent urination Incontinence, urine Painful urination Urgency

*** FEMALES ONLY *** (go to 130 if male)

125) Please indicate if you have any of the following symptoms: (Circle all that apply) Amenorrhea
Decreased libido Intermenstrual bleeding Menorrhagia Metrorrhagia Painful sex Pelvic pain
Postcoital bleeding Postmenopausal bleeding Sexual difficulties Vaginal dryness Vaginal itching
Other _____

*** MALES ONLY *** (go to 129 if female)

126) Please indicate if you have any of the following symptoms: (Circle all that apply) Decreased libido
Erectile dysfunction Hernia Impotence Reduced urinary stream Sexual difficulties Testicular mass Testicular pain Other _____

127) Please indicate if you have any of the following neurological conditions: (Circle all that apply) Muscle weakness Numbness/tingling Gait disturbance Mental status changes Forgetfulness Seizure
Dizziness Fainting episodes

128) Please circle any of the following endocrinological conditions: (Circle all that apply) Brittle hair
Brittle nails Hypoglycemia Hyperglycemia Heat/cold intolerance Hypercalcemia
If diabetic, please list your average blood sugar number: _____

129) Please circle any of the following psychiatric conditions: (Circle all that apply) Anxiety Binge eating
crying or near crying episodes Delusions Depression Irritability Mood swing
Poor concentration Poor memory Suicidal thoughts and ideation Useless feelings

CURRENT MEDICATONS

Medication	Dose	Directions