ADVANCED PAIN MANAGEMENT
& SPINAL INTERVENTION

New Patient Intake Form

Patient Information

Today's date: _____

Your name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

Pain History

Cause of Injury:

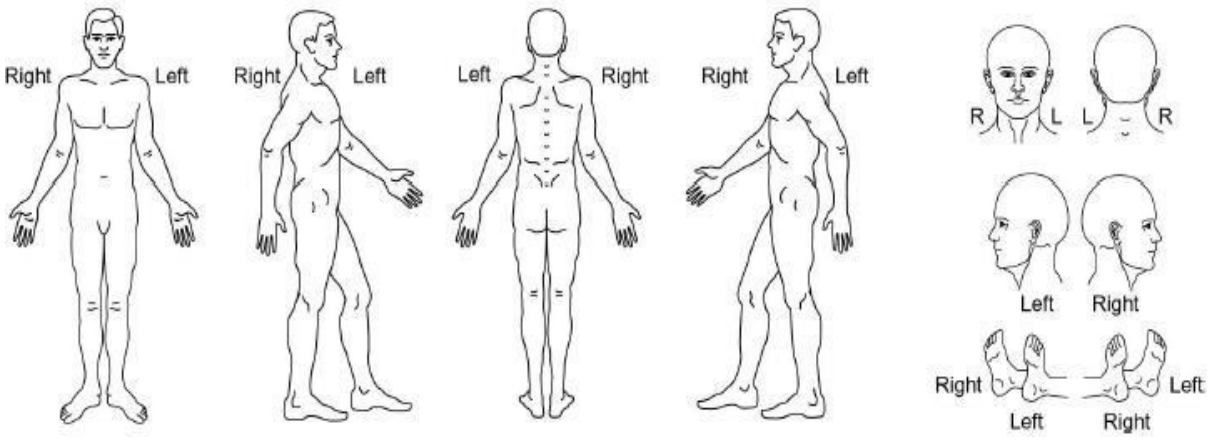
☐ Work related
☐ Auto Accident
☐ Sport Injury
☐ Slip/fall or other accident
☐ Not injury- related
☐ Other _____

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

Quality of pain: Please circle the following term to describe your pain

Throbbing	Cramping	Heavy Dull	Annoying
Shooting	Gnawing	Tender	Sickening
Stabbing	Burning	Splitting	Fearful
Sharp	Aching	Tiring exhausting	Punishing, Cruel

Pain Rating: Please rate your pain by circling the appropriate numbers.

CURRENT PAIN LEVEL

1	2	3	4	5	6	7	8	9	10

PAIN SCORE WITHOUT MEDICATIONS

1	2	3	4	5	6	7	8	9	10

PAIN SCORE WHEN TAKING MEDICATION

1	2	3	4	5	6	7	8	9	10

WORSE PAIN IN THE PAST WEEK

1	2	3	4	5	6	7	8	9	10

Associated Symptoms: Please circle ALL terms that apply as a result of the pain.

Numbness	Frequent falls/Poor coordination	Locking of knees	Changes in hair distribution/quality
Tingling	Difficulty walking/running	Loss of range of motion	Muscle wasting
Weakness of limbs	Difficulty with balance	Differences in limbs temperature	Painful to light/air blowing
Loss of sensation in the limbs	Dropping objects frequently	Changes in skin color	Alternate swelling/shrinking
Loss of bowel/bladder control	Difficulty swallowing	Changes in tissue texture	Difficulty with activities of daily living
Headache	Poor concentration	Visual Changes	Loss of memory

What time of day is your pain at its worst? ☐ Morning ☐ Daytime ☐ Evening ☐Always the same

How often does the pain occur?

☐ Constant ☐Changes in severity but always present ☐Intermittent (comes and goes)

If pain "1" 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_____

What other factors worsen or affect your pain?

_____

What other factors relieve your pain?

_____

Are there any associated symptoms? (eg: numbness/tingling/weakness/incontinence, etc.)

_____

What are the goals you wish to achieve with Pain Management? _____

Diagnostic Tests and Imaging

Mark all of the following tests that you have had 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):

☐ Acupuncturist	☐Neurosurgeon	☐Psychiatrist/Psychologist
☐ Chiropractor	☐Orthopedic Surgeon	☐Rheumatologist
☐ Internist	☐Physical Therapist	☐Neurologist

☐ Other _____

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

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
TENS Unit	☐	☐	☐

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

☐ 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?

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) _____	_____

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

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:

Cancer/Oncology
- ☐ Cancer – Type _____
- ☐ Cancer – Type_____
- ☐ Cancer – Type_____

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders
- ☐ Presence of stent/pacemaker/ defibrillator

Gastrointestinal
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ IBS/Crohns Disease

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

Neurological
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Balance Disorder
- ☐ Head Injury
- ☐ Headaches
- ☐ Migraines

ENT
- ☐ Glaucoma
- ☐ Vertigo
- ☐ Hearing Problems
- ☐ Nosebleeds

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ ADD/ADHD
- ☐ PTSD

Endocrinology
- ☐ Diabetes – Type_____
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

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.

Family History

Mark all appropriate diagnoses as they pertain to your parents and siblings:

☐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 ☐Daily use of alcohol ☐Never ☐History of alcoholism ☐Current alcoholism

Tobacco Use:

☐ Current user ☐Former user ☐Never used

☐ Packs per day? ☐ Quit Date: _____

Cannabis (marijuana) Use:

Do you use cannabis (marijuana)? ☐No ☐Yes
If yes: Use type: ☐Medical (prescription/recommendation) ☐Recreational

Frequency: ☐Daily ☐ Weekly ☐ Occasionally / Date of Last Use: _____

Other Illegal Drug Use: ☐Denies any illegal drug use ☐Currently uses illegal drugs ☐Formerly used illegal drugs (not currently Have you ever abused narcotic or prescription medications? ☐Yes ☐No

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)			

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)			

Only if any of your medications cause constipation, please answer these questions. If not,skip this section.
On average, how often do you have a bowel movement?(Please check one)

☐ **More than 3 times per day** ☐ **2 to 3 times per day**
☐ Once per day ☐ 2 to 3 times per week
Less than once per week

Think back to when you started pain medicine. Did your bowel habits change? If so how?

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional: ☐Fevers ☐Chills ☐Sweats ☐Weakness ☐Fatigue ☐Decreased Activity ☐Malaise ☐Unexplained weight gain ☐Unexplained weight loss ☐Low sex drive ☐Difficulty sleeping

Eyes: ☐Blurriness ☐Double vision ☐Visual disturbance ☐Pain

Ears/Nose/Throat/Neck: ☐Hearing problems ☐Ear pain ☐Sinus problems ☐Sore throat ☐Nosebleeds

Respiratory: ☐Shortness of breath ☐Cough ☐Sputum production ☐Wheezing

Cardiovascular: ☐Chest pain ☐Palpitations ☐Swelling in feet ☐Shortness of breath during sleep ☐Bleeding disorder ☐Blood clots ☐Fainting

Gastrointestinal: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Heartburn ☐Abdominal pain

Genitourinary/Nephrology: ☐Painful urination ☐Blood in urine ☐Change in urine stream ☐Unusual discharge ☐Flank pain ☐Urinary incontinence

Musculoskeletal: ☐Back pain ☐Neck pain ☐Joint pain ☐Muscle pain ☐Muscle cramp ☐ Muscle spasm ☐Gait disturbances ☐Joint stiffness ☐Joint swelling ☐Trauma

Integumentary: ☐Rash ☐Itching ☐Lesions ☐Bruising

Neurological: ☐Abnormal balance ☐Confusion ☐Numbness ☐Tingling ☐Dizziness ☐Headaches ☐Loss of coordination ☐Memory loss ☐Seizures ☐Tinnitus ☐Tremors ☐Vertigo

Psychiatric: ☐Feeling anxious ☐Depressed mood ☐Suicidal thoughts ☐Hallucinations ☐Stress problems ☐Suicidal planning ☐Thoughts of harming other

Consent To Treat

I, _____, (patient name) give permission for PainX- Dr. Raul Calderon to provide me medical treatment.

I agree to allow PainX to file for insurance benefits to pay for the care I receive I understand that:

- PainX will send my medical record information to my insurance company.
- I must pay for the cost of these services in the event that my insurance does not cover the cost.
- I have read and understand the patient financial responsibilities policy.
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

Patient Signature: _____ Date: _____

Print Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

PAIN X ADVANCED PAIN MANAGEMENT & SPINAL INTERVENTION

PainX Advanced Pain Management & Spinal Intervention

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This authorization allows PainX Advanced Pain Management & Spinal Intervention to use or disclose your protected health information as described below. **You may revoke this authorization at any time** by writing to our Privacy Officer at the address listed below.

1. PATIENT INFORMATION

Patient's Name (Last, First, MI)	Date of Birth (MM/DD/YYYY)	Phone Number

2. AUTHORIZATION

☐ **I authorize PainX Advanced Pain Management & Spinal Intervention** to obtain my protected health information from any physician, hospital, health care provider, imaging center, laboratory, pharmacy, or other entity that has provided me medical care.

Provider(s), if known (optional): _____

3. INFORMATION TO BE USED OR DISCLOSED (Check all that apply)

☐ All Health Information (All Records) ☐ Office / Consultation Notes ☐ Imaging Reports

☐ Procedure / Operative Notes ☐ Medication List ☐ Billing / Claims Information

☐ Other (please specify): _____

4. DATES OF SERVICE

☐ All Dates

☐ Specific Dates: From _____

To _____

5. HOW SHOULD THE INFORMATION BE SENT?

☐ Fax to: _____

☐ Secure Email to: _____

☐ Mail

☐ Pick Up

☐ Other: _____

6. PURPOSE OF DISCLOSURE (Check one)

☐ Continued Medical Care ☐ Personal Use ☐ Attorney / Legal ☐ Insurance ☐ Other: _____

NOTICE OF RIGHTS

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address listed below. My revocation will be effective upon receipt, but will not be effective to the extent that PainX Advanced Pain Management & Spinal Intervention has already taken action in reliance upon this authorization.

I have a right to receive a copy of this authorization. I understand that information used or disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

This authorization expires one (1) year from the date signed below unless otherwise specified.

7. SIGNATURE

Signature of Patient or Legal Representative	Printed Name	Relationship (if not patient)	Date (MM/DD/YYYY)

4955 Van Nuys Blvd., Ste 505
Sherman Oaks, CA 91403 | (818) 444-4242 | (800) 448-2507 (fax) | PainXDoctors.com | painx@painxdoctors.com