GULF COAST
PAIN INSTITUTE
"RELIEVING PAIN, RESTORING FUNCTION, RENEWING HOPE"

PATIENT INTAKE FORM

Today's Date: _____
Patient Name: _____ DOB: _____
Social Security: _____ Gender: _____ Marital Status: _____ RACE: ____ AGE: _____
Address: _____
Employer: _____
Employer Address: _____
Home Phone: _____ May we leave a detailed message? ❑Yes ❑ No
Work Phone: _____ May we leave a detailed message? ❑Yes ❑ No
Cell Phone: _____ May we leave a detailed message? ❑Yes ❑ No
E-mail Address: _____
Emergency Contact Name: _____
Emergency Contact Phone Number: _____ Relationship: _____

If work accident or motor vehicle accident please notify front desk

Primary Insurance Information (please be sure to provide a copy of the card)
Carrier Name: _____
Carrier Address: _____
Carrier Phone Number: _____
Insured Name (If other than patient): _____
Patient relationship to insured (if other than insured): _____
Insured ID Number: _____ Group Number: _____
Insured's Employer: _____ Employer Phone: _____

Secondary Insurance Information (please be sure to provide a copy of the card)
Carrier Name: _____
Carrier Address: _____
Carrier Phone Number: _____
Insured Name (If other than patient): _____
Patient relationship to insured (if other than insured): _____
Insured ID Number: _____ Group Number: _____
Insured's Employer: _____ Employer Phone: _____

Please complete the following section IF PATIENT IS A MINOR/DEPENDENT ONLY
Guarantor Name: _____
Relationship to Patient: _____ DOB: _____
Address: _____
Home Phone: _____ May we leave a detailed message? ❑Yes ❑ No
Work Phone: _____ May we leave a detailed message? ❑Yes ❑ No
Cell Phone: _____ May we leave a detailed message? ❑Yes ❑ No
E-mail Address: _____

PLEASE NOTE: If a Motor Vehicle Accident or Work Accident has brought you to our office today please notify our front desk as additional paperwork may be needed.

1. Name of Doctor that's referred you: _____ ❑None
2. Name of Primary Care Physician: _____
3. What is the reason for your visit today? Where do you hurt? _____
4. How long have you had this problem? _____
5. What caused your problem?❑Injury ❑Motor Vehicle Accident ❑Work Accident ❑Unknown
6. Give a brief history of what caused your pain to start. If accident, date_____:

   _____

   _____

   _____
7. Have you previously been treated for the same symptoms before this started? ❑Yes ❑No
   a. If yes, When? _____ Diagnosis: _____
   b. Did you fully recover? ❑Yes ❑No If yes, When?_____
8. Check all that apply to your symptoms:
   a. Pain Quality: ❑Sharp ❑Aching ❑Burning ❑Shooting ❑Constant ❑Intermittent
   b. Increase Pain: ❑Sitting ❑Laying Down ❑Walking ❑Bending ❑Weather ❑Coughing/Sneezing
   c. Decrease Pain: ❑Sitting ❑Laying Down ❑Walking ❑Bending ❑Weather ❑Stretching
   d. Associated Symptoms: ❑Weakness ❑Numbness ❑Tingling ❑Fever ❑Pain Wakes At Night ❑Insomnia ❑Sexual Dysfunction ❑Bowel/Bladder Problems ❑Weight loss : _____ ❑Other: _____
9. Previous Treatment For:

	Treatment	Helpful	On Going	Comments:
Back Brace?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	_____
Neck Brace?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	_____
Tens Unit?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	_____
Physical/Occupational Therapy?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	_____
Psychological Evaluation?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	WHO?_____
Chiropractic Care?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	WHO?_____
Nerve Blocks?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	WHO?_____
Surgeries?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	WHO?_____

10. Radiological Studies

		Part of Body	Date	Where	Results
X-Rays	❑Yes ❑No	_____	_____	_____	_____
MRI	❑Yes ❑No	_____	_____	_____	_____
CT Scan	❑Yes ❑No	_____	_____	_____	_____
EMG (Nerve Study)	❑Yes ❑No	_____	_____	_____	_____
Bone Scan	❑Yes ❑No	_____	_____	_____	_____
Myleogram	❑Yes ❑No	_____	_____	_____	_____
Other	❑Yes ❑No	_____	_____	_____	_____

11. How would you rate your pain today (circle one)? ❑0 - No Pain ❑1-3 Mild __ ❑4-6 Moderate __ ❑7-10 Severe __
12. Currently taking medications? ❑Yes ❑No If yes, please list below:

Name of Medication	Amount Daily	Reason	Date Last Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. Are you currently taking any blood thinners? ❑Yes ❑ No If yes, what? _____

Doctors Notes:

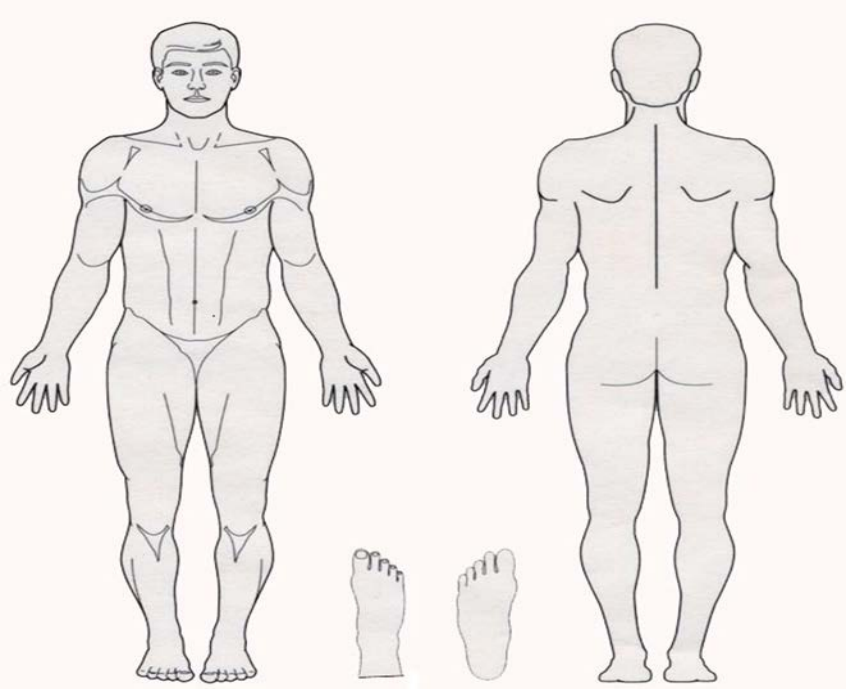
_____

_____

_____

_____

14. Mark the diagram below as follows: A= Ache B= Burning N= Numbness P= Pins & Needles S= Stabbing O= Other



NURSE / DOCTOR NOTES

15. Do you have any of the following **allergies**?

❑IVP Dye ❑Steroids ❑Shellfish ❑Novocaine ❑Morphine ❑Valium ❑Aspirin ❑Other:_____

If yes, what type of reaction: _____

16. Do you have a **Past Medical History** of any of the following?

CNS

Cerebral Aneurysm	❑Yes	❑No
Stroke	❑Yes	❑No
Brain Tumor	❑Yes	❑No
Seizure Disorder	❑Yes	❑No
Neuropathy	❑Yes	❑No

GASTROINTESTINAL

Hiatal Hernia	❑Yes	❑No
Ulcer	❑Yes	❑No

Other: _____

BONE/MUSCLE

Arthritis	❑Yes	❑No
Fibromyalgia	❑Yes	❑No

GENITOURINARY

Kidney Disease	❑Yes	❑No
Are you pregnant?	❑Yes	❑No

CARDIOVASCULAR

Hypertension	❑Yes	❑No
Valve Disease	❑Yes	❑No
Heart Attack	❑Yes	❑No

Date:_____

Irregular Heartbeat	❑Yes	❑No
Pacemaker	❑Yes	❑No

RESPIRATORY

Asthma	❑Yes	❑No
Emphysema	❑Yes	❑No
Bronchitis	❑Yes	❑No

PSYCHIATRIC

Depression?	❑Yes	❑No

Date:_____

Anxiety	❑Yes	❑No

METABOLIC

Liver Disease	❑Yes	❑No
Diabetes/Types _____	❑Yes	❑No
Thyroid	❑Yes	❑No
Bleeding Disorder?	❑Yes	❑No

What:_____

Other weight?	❑Yes	❑No

INFECTIOUS

Hepatitis/Types _____	❑Yes	❑No
HIV/AIDS	❑Yes	❑No
Cancer	❑Yes	❑No

Types/Treatment:

_____

17. Review of Symptoms

CONSTITUTIONAL			RESPIRATORY			UROLOGY		
Fever	❑Yes	❑No	Shortness of Breathe	❑Yes	❑No	Frequent Urination	❑Yes	❑No
Weight Loss	❑Yes	❑No	Cough	❑Yes	❑No	Recurrent UTI	❑Yes	❑No
Insomnia	❑Yes	❑No						
MUSCULOSKELETAL			**CARDIOLOGY**			**ENDOCRINOLOGY**		
Joint Pain	❑Yes	❑No	Chest Pain	❑Yes	❑No	Osteoporosis	❑Yes	❑No
Joint Swelling	❑Yes	❑No	Congestive Heart Failure	❑Yes	❑No	Diabetes	❑Yes	❑No
			Leg Swelling	❑Yes	❑No			
ENT			**GASTROENTEROLOGY**			**PSYCHOLOGY**		
Sinus Headaches	❑Yes	❑No	Heartburn	❑Yes	❑No	Depression	❑Yes	❑No
			Vomiting	❑Yes	❑No	Sleep Disturbances	❑Yes	❑No
						High Stress Level	❑Yes	❑No
OPTHALMOLOGY			**NEUROLOGY**					
Loss of Vision	❑Yes	❑No	Headache	❑Yes	❑No			
Blurring of Vision	❑Yes	❑No	Dizziness	❑Yes	❑No			
			Seizures	❑Yes	❑No			

18. Surgical Procedure History

Procedure | Date

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

19. Have any of your family had the following:

		If Yes, Who?				If Yes, Who?	
Diabetes	❑Yes ❑No	_____	❑Deceased	Alcoholism	❑Yes ❑No	_____	❑Deceased
Heart Disease	❑Yes ❑No	_____	❑Deceased	Cancer	❑Yes ❑No	_____	❑Deceased
Suicide	❑Yes ❑No	_____	❑Deceased	Neck/Back Problems	❑Yes ❑No	_____	❑Deceased
Psychiatric Disorders	❑Yes ❑No	_____	❑Deceased	Drug use	❑Yes ❑No	_____	❑Deceased

SOCIAL HISTORY

20. Are you ❑Married ❑Divorced ❑Separated ❑Windowed ❑Single
21. Do you have children: ❑Yes ❑No If Yes, How many? _____
22. What is your highest level of school? _____
23. Do you smoke? ❑Yes ❑No If Yes, How many? _____
24. Do you drink alcohol? ❑ Never ❑Social ❑Light ❑Moderate ❑Heavy
25. Do you use drugs? ❑Never ❑Occasionally ❑Frequently ❑What Kind? _____
26. Do you use intravenous drugs? ❑Yes ❑No

EMPLOYEMENT INFORMATION

27. Occupation at time of injury? _____ ❑Unemployed ❑Retired
28. Type of work at time of injury? ❑Office/Clerical ❑Light Labor ❑Moderate Labor ❑Heavy Labor
29. Current occupation? _____ ❑Unemployed ❑Retired
30. Current type of work? ❑Office/Clerical ❑Light Labor ❑Moderate Labor ❑Heavy Labor
31. If you are unemployed are you receiving ❑Disability Income ❑Workman's Comp ❑Retirement
32. When did you last work? _____
33. Number of hours worked per week? _____
34. If on disability, who put you on it? _____
35. Have you ever been put on work restriction? ❑Yes ❑No If Yes, what kind?

    _____
36. Are you currently on work restriction? ❑Yes ❑No If Yes, what kind?

    _____
37. Doctors Notes:

    _____

    _____

    _____

All of the above information is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____