

Evan D. Frank, MD PhD

Specialization Pain & Spine Medicine

Intake Form

Name: _____

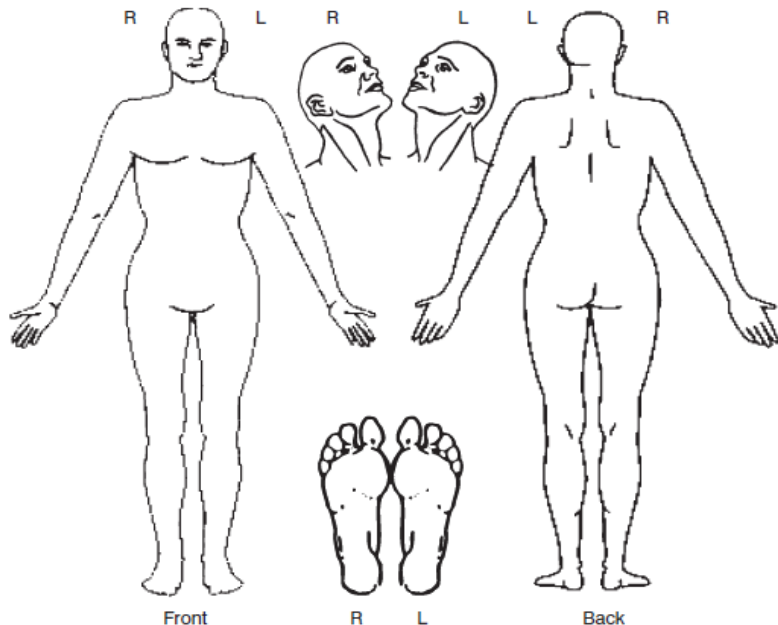
DOB: _____

Age: _____

Sex: _____

Today's Date: _____

1. On diagram, please SHADE IN the location of your pain. Please CIRCLE the one most painful area.



2. Please circle words that describe pain:

- | | | | |
|---------|----------|-----------|-----------|
| Sharp | Shooting | Throbbing | Stabbing |
| Burning | Aching | Sickening | Punishing |

3. Please CIRCLE the number below which matches the AVERAGE level of pain you have every day:

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

4. How long have you had the present pain?

5. What do you think started your pain?

6. Please circle if you've had any of the following treatments:

- | | |
|---------------------|---------------------|
| Acupuncture | Injections |
| Chiropractor | Anti-depressants |
| Biofeedback | Sedatives/Narcotics |
| Anti-inflammatories | Physical therapy |

7. Circle any of the symptoms listed below that you are having AT THE CURRENT TIME:

- Weight loss _____
- Loss of appetite _____
- Fever/chills _____
- Double/blurred vision _____
- Ringing in ears _____
- Bloody nose/gums _____
- Sore throat _____
- Chest pain _____
- Palpitations _____
- Shortness of breath _____
- Cough _____
- Speech _____
- Leg/arm weakness _____
- Blood in stool _____
- Constipation/diarrhea _____
- Blood in urine _____
- Abdominal pain _____
- Change in bladder habits _____
- Rashes _____
- Bruises _____
- Headache _____
- Dizziness _____
- Blackouts _____
- Numbness/tingling _____
- Seizures _____
- Pain in other joints _____
- Sexual difficulties _____
- Depression _____
- Anxiety _____
- Anger _____
- Sleep _____
- Other _____

Evan D. Frank, MD PhD

Intake Form

Pt. Name: _____

8. Please circle all your medical illnesses below:

- High blood pressure
- Peptic ulcer
- Frequent infections
- Bleeding problems
- Stroke
- Anesthesia problems
- Liver disease
- Rheumatoid arthritis
- Cardiac disease
- Angina
- Thyroid
- Diabetes
- Sleep apnea/c-pap
- Blot clot
- Cancer
- Emphysema
- Depression/anxiety
- Asthma
- Kidney disease
- Acid reflux
- Seizure
- Other _____

9. Please list all surgeries

10. Please list names of all CURRENT medications:

11. PLEASE LIST ALL ALLERGIES TO MEDICATIONS

12. Please answer the following questions concerning social history:

- Have you ever had problems with alcohol? No Yes
- Have you ever smoked cigarettes? No Yes
- Have you ever used illicit drugs? No Yes

- Are you on disability? No Yes
- Any litigation in process? No Yes

Current or recent occupation _____

With whom do you live? _____

13. Please circle any medical conditions that afflict your family members:

- Rheumatoid arthritis Diabetes
- Cancer Heart disease
- Stroke Hypertension

PE: Gen'l

| | |
|----------|----------|
| Wt _____ | Ht _____ |
|----------|----------|

Heent

Neck

Shoulders

Back

Gait

Neuro

SLR

Hips

Pulses

Extremities

Integument

Reflexes

STUDIES:

IMP/PLAN: