Evan D. Frank, MD PhD

Specialization Pain & Spine Medicine

Intake Form

Name: ____________________________________

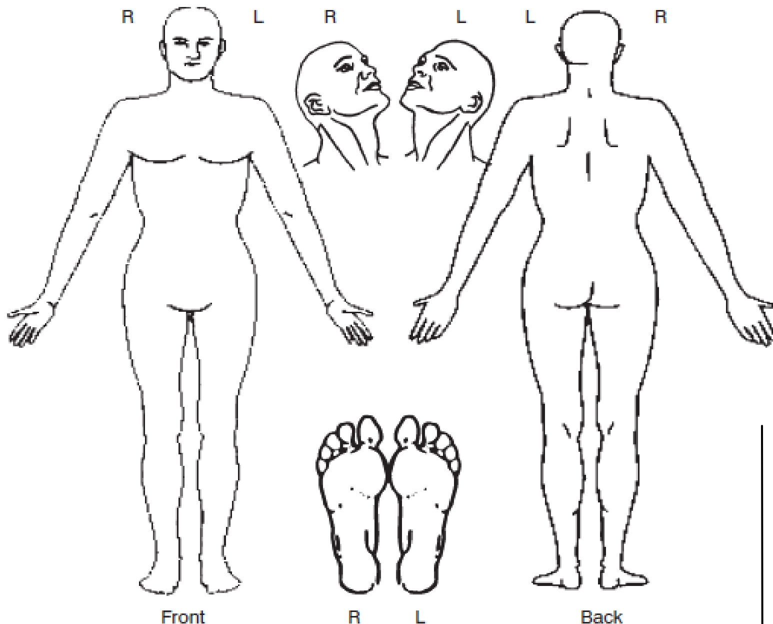
DOB: ______________________________________

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 <u>AVERAGE</u> 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 <u>AT THE CURRENT TIME</u>:**

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 <u>CURRENT</u> 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

<u>PE</u>: Gen'l

Wt ________ Ht

Heent

Neck

Shoulders

Back

Gait

Neuro

SLR

Hips

Pulses

Extremities

Integument

Reflexes

<u>STUDIES</u>:

<u>IMP/PLAN</u>: