Harvard Vanguard Medical Associates
Atrius Health

NEW PATIENT PAIN/SPINE INTAKE FORM

Name: ______________________ **Referring Physician:** ______________________

Date of Birth: ____________ **Age?** ________ **Primary Care Physician:** ______________________

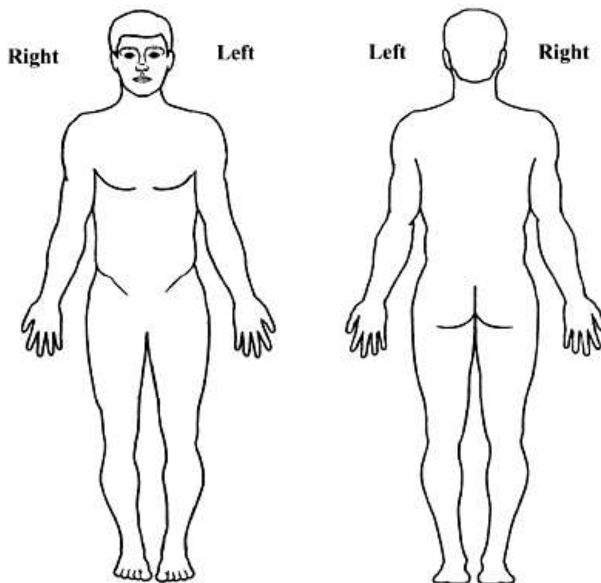
Are you right or left handed? R ☐ L ☐

What is the main problem that brings you here today (you may check more than one)?

☐ Neck Pain ☐ Lower Back Pain ☐ Upper Back Pain ☐ Mid Back Pain
☐ Right Leg Pain ☐ Left Leg Pain ☐ Right Arm Pain ☐ Left Arm Pain
☐ Widespread Pain ☐ Shoulder Pain ☐ Hip Pain ☐ Abdominal Pain
☐ Other – Specify: ______________________

Which area of pain is the worst? ______________________

On the drawings below, please shade the area where you currently experience pain.



PAIN HISTORY

When did the pain start (month/day/year)? ______________________

How did the pain start?

☐ Spontaneous Onset ☐ Gradual Onset
☐ Motor Vehicle Accident – Specify: ______________________
☐ Fall – Specify: ______________________
☐ Job related – Specify: ______________________
☐ Sports/Recreation – Specify: ______________________
☐ Other Details – Specify: ______________________

____

Have you ever been involved in any legal proceedings related to *this* health matter?

☐ No

☐ Yes – Specify: ____

Do you have any ***other*** legal issues? ______________________________________

Have you had any previous *major* pain issues?

☐ No ☐ Yes

Details: ____

What is the quality of your pain/symptoms?

☐ Sharp ☐ Burning ☐ Numb ☐ Tingling

☐ Aching ☐ Throbbing ☐ Dull ☐ Other – Specify: ________________

Since the pain/condition began has it:

☐ Improved ☐ Not changed ☐ Worsened

On a **scale from 0 to 10 (where 10 is the worst possible pain)** how would you describe the intensity of your pain:

Average level of pain over the **last month**: _____ **Current** level of pain: _____

At your **worst,** what is your pain level: _____ At your **best** your pain is: _____

Do you have any of the following associated symptoms?

☐ Bowel dysfunction
☐ Fevers/chills, night sweats
☐ Sedation or confusion
☐ Blood in Stool
☐ Loss of Interest in activities
☐ Bladder dysfunction
☐ Arm/leg weakness
☐ Balance problems
☐ Black Tarry Stools
☐ Thoughts of hurting yourself
☐ Sexual dysfunction
☐ Arm/leg numbness
☐ Bruising or bleeding issues
☐ Infection
☐ Difficulty Sleeping

RELIEVING AND AGGRAVATING FACTORS

Check off the following boxes depending on how the position affects your pain:

	Decrease	**Increase**	**No Change**
Lying Down	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Bending Forward	☐	☐	☐
Bending Backwards	☐	☐	☐
Twisting	☐	☐	☐
Lifting	☐	☐	☐
Going Upstairs	☐	☐	☐
Going Downstairs	☐	☐	☐
Sneezing or Coughing	☐	☐	☐
Bowel Movements	☐	☐	☐

☐ Other Details (optional): ____

____

____

OTHER THERAPIES FOR PAIN

Please check all of the treatment you have tried for ***this*** pain condition and indicate whether the treatment provided you with any relief.

Treatment	**No Relief**	**Moderate Relief**	**Excellent Relief**
Physical Therapy	☐	☐	☐
Occupational Therapy	☐	☐	☐
Psychotherapy	☐	☐	☐
TENS	☐	☐	☐
Acupuncture	☐	☐	☐
Chiropractic	☐	☐	☐
Brace	☐	☐	☐
Meditation	☐	☐	☐
Biofeedback	☐	☐	☐
Massage	☐	☐	☐
Surgery (type?): ______________________	☐	☐	☐
Injections (type?): ____________________	☐	☐	☐
Other Exercise:________________________	☐	☐	☐
Other Therapy:________________________	☐	☐	☐

MEDICATIONS YOU HAVE TAKEN IN *THE PAST* FOR PAIN OR MOOD

Using the list below, please indicate the prescription medication(s) that you have tried ***in the past***. If you have not taken these medications, you can skip this section.

Opioids

☐ Tylenol w/codeine ☐ Vicodin/Lortab ☐ Percocet/Endocet ☐ Oxycodone ☐ Dilaudid ☐ Demerol

☐ MSContin ☐ Oxycontin ☐ Fentanyl Patch ☐ Methadone ☐ Other: ______

Antiinflammatories (NSAIDs)

☐ Ibuprofen (Motrin, Advil) ☐ Naprosyn (Naproxen, Aleve) ☐ Relafen (Nabumetone) ☐ Other: ______

Muscle Relaxants

☐ Flexeril (Cyclobenzaprine) ☐ Soma (Carisoprodol) ☐ Baclofen (Lioresal) ☐ Zanaflex (Tizanidine)

☐ Norflex (Orphenadrine) ☐ Robaxin (Methocarbamol) ☐ Other ______

Antidepressants

☐ Elavil (Amitriptyline) ☐ Nortriptyline ☐ Desipramine ☐ Doxepin

☐ Cymbalta (Duloxetine) ☐ Effexor (Venlafaxine) ☐ Savella (Milnacipran) ☐ Other ______

Antianxiety Agents

☐ Ativan (Lorazepam) ☐ Klonopin ☐ Valium ☐ Xanax (Alprazolam) ☐ Other ______

Other Agents

☐ Ultram (Tramadol) ☐ Prednisone ☐ Suboxone (Buprenorphine)

☐ Neurontin (Gabapentin) ☐ Lyrica (Pregabalin) ☐ Topomax (Topiramate) ☐ Other ______

ALLERGIES

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to IV Contrast? ☐ Yes ☐ No

Do you have any other allergies? ☐ No ☐ Yes, please list below:

1. ______ 2. ______ 3. ______

2. ______ 5. ______ 6. ______

MEDICAL HISTORY

Current/Past medical problems:

☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Ankylosing Spondylitis
☐ Diabetes ☐ Kidney Disease ☐ Heart disease ☐ High Blood Pressure
☐ Sleep Apnea ☐ Thyroid Disorder ☐ Osteoporosis ☐ Inflammatory Bowel Disease
☐ Bleeding problems ☐ HIV/AIDS ☐ Liver disease ☐ Lung disease
☐ Cancer: What type: ______________________________

Other Conditions:

1.______________________ **2.**______________________
3.______________________ **4.**______________________
5.______________________ **6.**______________________

Prior spine surgeries:

1.______________________ **2.**______________________
3.______________________ **4.**______________________
5.______________________ **6.**______________________

Prior *major* surgerie not spine related:

1.______________________ **2.**______________________
3.______________________ **4.**______________________

All Current Medications & Supplements/Herbs (name, dose, frequency)

1.________________ **2.**________________ **3.** ________________
4.________________ **5.**________________ **6.** ________________
7.________________ **8.**________________ **9.** ________________
10.________________ **11.**________________ **12.**________________

Do any of your family members (blood relatives) have any of these diseases?

☐ Back/ neck problems ☐ Rheumatoid arthritis ☐ Gout ☐ Seizures
☐ Ankylosing spondylitis ☐ Inflammatory bowel disease ☐ Cancer
☐ Coronary artery disease ☐ High blood pressure ☐ Anemia ☐ Diabetes
☐ Psychiatric Issues ☐ Alcohol or Drug Issues ☐ Chronic Pain (type?): ____________

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Have you experienced significant stress in the past year?______________________

What is your living situation?(family, friends alone, etc.) ______________________

If you have children, what are their ages? ______________________

What is your current work status?

☐ Full Time ☐ Part Time ☐ Light-Duty ☐ Worker's Compensation ☐Disabled ☐Retired

What is the highest grade you completed or degree you received?______________________

Tobacco Use ☐ Yes ☐ No Date Quit __________ If yes, #Packs/Day __________

Alcohol Use ☐ Yes ☐ No Date Quit __________ If yes, #Drinks/Day __________

Other Drug Use ☐ Yes ☐ No Date Quit __________ If yes, what type: __________

Caffeinated Drinks ☐ Yes ☐ No Date Quit __________ If yes, #/Day __________

REVIEW OF SYMPTOMS (Please mark all of the following that apply to you)

Constitutional

☐ Fever/Chills ☐ Fatigue ☐ Swollen Glands ☐ Loss of Appetite ☐ Difficulty Sleeping

Comments: ______________________________

Eyes

☐ Blurred Vision ☐ Double Vision ☐ Abnormal Vision

Comments: ______________________________

Ears, Nose, Mouth, Throat

☐ Dizziness ☐ Room Spinning ☐ Sinus Pain ☐ Dental Issues ☐ Sore Throat

Comments: ______________________________

Cardiovascular

☐ Chest Pain ☐ Palpitations ☐ Leg/ankle Swelling ☐ Fainting

Comments: ______________________________

Respiratory

☐ Cough ☐ Asthma ☐ Shortness of Breath

Comments: ______________________________

Neurologic

☐ Seizures ☐ Numbness in Arms/Legs ☐ Weakness in Arms/Legs ☐ Memory Problems

☐ Headaches ☐ Speech Problems Comments: ______________________________

Gastrointestinal

☐ Nausea/Vomiting ☐ Constipation ☐ Diarrhea ☐ Change in Stools

Comments: ______________________________

Genitourinary

☐ Blood in Urine ☐ Change in Bladder Habits ☐ Change in Sexual Function

Comments: ______________________________

Musculoskeletal

☐ Painful joints ☐ Swollen joints ☐ Joint Redness ☐ Bone infection

Comments: ______________________________

Integumentary/Skin

☐ Sores ☐ Rash ☐ Easy Bruising ☐ Skin Cancer ☐ Psoriasis

Psychiatric

☐ Depressed ☐ Anxious ☐ Loss of interest in activities ☐ Thoughts of hurting yourself

Comments: ______________________________

Endocrine

☐ Excessive urination ☐ Poor energy ☐ Weight loss

Comments: ______________________________