GCPS
Gulf Coast Pain Specialists

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PATIENT INTAKE FORM

NAME: _____ TODAY'S DATE: _____
FIRST MIDDLE LAST

AGE: _____ RACE: _____ D.O.B.:_____

1. **NAME OF DOCTOR (PERSON) THAT REFERRED YOU TO OUR PRACTICE:** _____
2. **NAME OF YOUR PRIMARY CARE DOCTOR:** _____
3. **WHAT IS THE REASON FOR YOUR VISIT TODAY?** (WHERE DO YOU HURT?) _____
   _____
4. **ONSET OF SYMPTOMS: HOW LONG HAVE YOU HAD THIS PROBLEM?**
   _____
5. **WHAT CAUSED YOUR PROBLEM?** ☐INJURY ☐MOTOR VEHICLE ACCIDENT ☐WORK ACCIDENT ☐UNKNOWN
   EXPLAIN: _____
6. **NURSE'S HISTORY:**_____
   _____
   _____
   _____
   _____
   _____
7. **(A) HAVE YOU PREVIOUSLY BEEN TREATED FOR THE SAME SYMPTOMS BEFORE THIS STARTED?** ☐Y ☐N
   IF YES, WHEN? _____ DIAGNOSIS: _____
   (B) DID YOU FULLY RECOVER? ..... ☐Y ☐N IF YES, WHEN? _____
8. **ARE YOU PRESENTLY BEING TREATED BY A DOCTOR FOR YOUR INJURIES?** ☐Y ☐N
   IF YES, NAME OF DOCTOR: _____ DATE LAST SEEN: _____
9. **CHECK ALL THAT APPLY TO YOUR SYMPTOMS:**

PAIN QUALITY:	INCREASE PAIN:	DECREASE PAIN:	ASSOCIATED SYMPTOMS:	
☐ sharp	☐ sitting	☐ sitting	☐ weakness	☐ insomnia
☐ aching	☐ lying down	☐ lying down	☐ numbness	☐ pain wakes at night
☐ burning	☐ walking	☐ walking	☐ tingling	☐ sexual dysfunction
☐ shooting	☐ bending	☐ bending	☐ fever	☐ other_____
☐ constant	☐ weather	☐ weather	☐ weight loss	_____
☐ intermittent	☐ coughing/sneezing		☐ bowel/bladder problems	

10. **PREVIOUS TREATMENTS FOR PAIN:**

	TREATMENT	HELPFUL?	CURRENTLY ONGOING	COMMENTS
Ten Unit?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	_____
Physical/Occupational Therapy?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	_____
Psychological Evaluation?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	WHO:_____

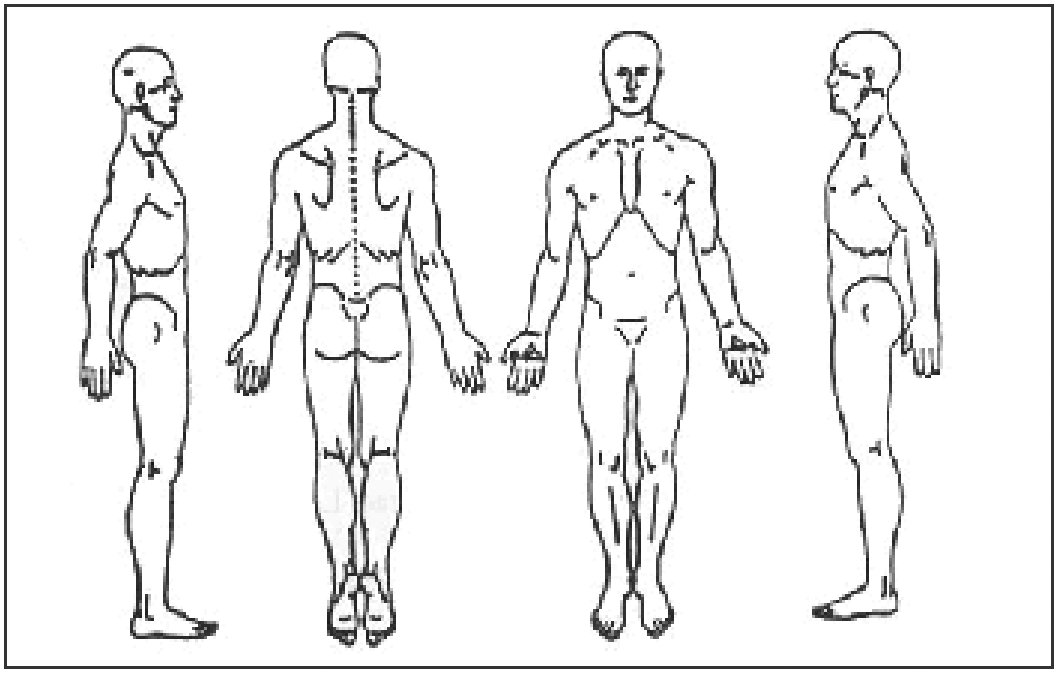
Chiropractic Treatment?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	WHO: _____
Nerve Blocks?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	WHO:_____
Surgeries?	☐ Y ☐ N	☐ Y ☐ N	Type: _____	

11. DIAGNOSTIC INFORMATION:

Radiologic Studies		PART OF BODY	DATE/WHEN	WHERE	RESULTS
X-Rays	☐ Y ☐ N	_____	_____	_____	_____
MRI	☐ Y ☐ N	_____	_____	_____	_____
CT Scan	☐ Y ☐ N	_____	_____	_____	_____
EMG (Nerve Study)	☐ Y ☐ N	_____	_____	_____	_____
Bone Scan	☐ Y ☐ N	_____	_____	_____	_____
Myelogram	☐ Y ☐ N	_____	_____	_____	_____
Other	☐ Y ☐ N	_____	_____	_____	_____

12. PAIN DIAGRAM

MARK AS FOLLOWS: A-ACHE B-BURNING N-NUMBNESS P-PINS & NEEDLES
S-STABBING O-OTHER (Describe):



13. PAIN SCALE (MARK WITH AN X ALONG THE BAR TO INDICATE DEGREE)

(A) HOW DO YOU RATE YOUR PAIN NOW? _____

0	5	10
None	Moderate	Unbearable

14. MEDICATIONS: ☐ NONE ☐ I CURRENTLY TAKE THE FOLLOWING:

NAME OF MEDICATION	AMOUNT PER DAY	REASON	LAST DOSE TAKEN

15. ALLERGIES: IVP Dye: ☐ Y ☐ N Shellfish: ☐ Y ☐ N Morphine: ☐ Y ☐ N Aspirin: ☐ Y ☐ N
Steroids: ☐ Y ☐ N Novocaine: ☐ Y ☐ N Valium: ☐ Y ☐ N Other: ☐ Y ☐ N

WHAT TYPE OF REACTION? _____
_____

16. PAST MEDICAL HISTORY:

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

CNS
☐ Y ☐ N Cerabral Aneurysm
☐ Y ☐ N Stroke
☐ Y ☐ N Brain Tumor
☐ Y ☐ N Seizure Disorder
☐ Y ☐ N Neuropathy

GASTROINTESTINAL
☐ Y ☐ N Hiatal Hernia
☐ Y ☐ N Ulcer
Other:_____

CARDIOVASCULAR
☐ Y ☐ N Hypertension
☐ Y ☐ N Valve Disease
☐ Y ☐ N Heart Attack
Date_____
☐ Y ☐ N Irregular Heartbeat
☐ Y ☐ N Pacemaker

GENITOURINARY
☐ Y ☐ N Kidney Disease
☐ Y ☐ N **Are you now pregnant?**

RESPIRATORY
☐ Y ☐ N Asthma
☐ Y ☐ N Emphysema
☐ Y ☐ N Bronchitis

PSYCHIATRIC
☐ Y ☐ N Depression
☐ Y ☐ N Anxiety

BONE/MUSCLE
☐ Y ☐ N Arthritis
☐ Y ☐ N Fibromyalgia
Other:_____

METABOLIC
☐ Y ☐ N Liver Disease
☐ Y ☐ N Diabetes/Type_____
☐ Y ☐ N Thyroid
☐ Y ☐ N Bleeding Disorder
Type:_____
☐ Y ☐ N Overweight

INFECTIOUS
☐ Y ☐ N Hepatitis-Type_____
☐ Y ☐ N AIDS
☐ Y ☐ N Cancer
Type:_____
Treatment:_____

17. REVIEW OF SYMPTOMS

CONSTITUTIONAL:
☐ Y ☐ N Fever ☐ Y ☐ N Weight Loss ☐ Y ☐ N Insomnia

MUSCULOSKELETAL:
☐ Y ☐ N Joint Pain ☐ Y ☐ N Joint Swelling

ENT:
☐ Y ☐ N Sinus Headaches

OPTHALMOLOGY:
☐ Y ☐ N Loss of Vision ☐ Y ☐ N Blurring of Vision

RESPIRATORY:
☐ Y ☐ N Shortness of Breath ☐ Y ☐ N Cough

CARDIOLOGY:
☐ Y ☐ N Chest Pain ☐ Y ☐ N Congestive Heart Failure ☐ Y ☐ N Leg Swelling

GASTROGENTEROLOGY:
☐ Y ☐ N Heartburn ☐ Y ☐ N Vomiting

NEUROLOGY:
☐ Y ☐ N Headache ☐ Y ☐ N Dizziness ☐ Y ☐ N Seizures

UROLOGY:
☐ Y ☐ N Frequent Urination ☐ Y ☐ N Recurrent UTI

ENDOCRINOLOGY:
☐ Y ☐ N Diabetes ☐ Y ☐ N Osteoporosis

PSYCHOLOGY:

□ Y □ N Depression □ Y □ N Sleep disturbances □ Y □ N High Stress Level

18. SURGICAL HISTORY:

SURGERIES: LIST PROCEDURE & DATE OF PROCEDURE

_____

_____

_____

19. FAMILY HISTORY

HAVE ANY OF YOUR FAMILY HAD THE FOLLOWING:

□ Y □ N Cancer. If Yes, who _____ □ Y □ N Alcoholism. If Yes, who_____

□ Y □ N Diabetes. If Yes, who _____ □ Y □ N Drug Abuse. If Yes, who_____

□ Y □ N Heart Disease. If Yes, who_____ □ Y □ N Suicide. If Yes, who_____

□ Y □ N Psychiatric Disorders. If Yes, who_____ What type?_____

20. SOCIAL HISTORY

MARITAL STATUS: □MARRIED □SINGLE □WIDOWED □DIVORCED

CHILDREN: □ NO □ YES How Many? _____

EDUCATION: (Circle highest level attended)

GRADE SCHOOL JUNIOR HIGH SCHOOL 7 8 9 HIGH SCHOOL 10 11 12

COLLEGE 1 2 3 4 GRADUATE SCHOOL

HABITS:

SMOKING: □ NONE PACKS PER DAY:_____ HOW MANY YEARS? _____

ALCOHOL: □ NEVER □ SOCIAL □ LIGHT □ MODERATE □ HEAVY

DRUGS: □ NEVER □ OCCASIONALLY □ FREQUENTLY WHAT KIND?_____

INTRAVEINOUS DRUG USE? □ Y □ N

21. EMPLOYMENT: (IF INJURY IS WORK RELATED, COMPLETE WORK ACCIDENT SECTION)

OCCUPATION AT TIME OF INJURY (ONSET): _____ _____ □ UNEMPLOYED □ RETIRED

CURRENT OCCUPATION: _____ □ UNEMPLOYED □ RETIRED

TYPE OF WORK: □ OFFICE/CLERICAL □ LIGHT LABOR □ MODERATE LABOR □ HEAVY LABOR

IF UNEMPLOYED, ARE YOU RECEIVING ANY OF THE FOLLOWING:

□ DISABILITY INCOME □WORKMAN'S COMP □RETIREMENT

WHEN DID YOU LAST WORK? _____

WHAT TYPE OF WORK DO/DID YOU DO?_____

NUMBER OF HOURS WORKED PER WEEK?_____

IF ON DISABILITY, WHO PUT YOU ON IT?_____

HAVE YOU EVER BEEN PUT ON WORK RESTRICTIONS? □ Y □ N

IF YES, WHAT ARE THEY?_____

22. DOCTOR'S NOTES:_____

_____

_____

_____

_____

ALL OF THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:_____ DATE:_____