Albert Einstein Healthcare Network

Einstein

EINSTEIN PAIN INSTITUTE

Communuity Physician Pain Partnership

PATIENT INTAKE FORM

Date:_____

Last name: **First name:** **Middle:**

Date of birth: **SSN:**

Street address:

City: **State:** **Zip:**

Home phone: **Work:**

Marital status: **Religious preference:**

Referring physician:

Address: **Phone:**

Primary care physician:

Address: **Phone:**

Healthcare Insurance Carrier:

1 **ID#**

2 **ID#**

Claim adjustor (if applicable): **Phone:** **Claim number:**

Nearest relative: **Phone:**

Address:

Relationship:

Are you employed? ❑Yes ❑ No Occupation:_____

If unemployed, how long? _____ Is this due to pain? ❑Yes ❑ No

Do you plan to go on disability? ❑Yes ❑ No

Please list your medical problems, other than pain (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illness, etc..):

1._____

2._____

3._____

4._____

5._____

Please list all of your current medications with dosages:

1._____

2._____

3._____

4._____

5._____

Please list all medications and dosages taken for pain management in the past:

1._____

2._____

3._____

4._____

5._____

Please list any allergies to medications:_____

Please list any intolerance to medications:_____

Please list any prior surgeries not related to pain, and dates performed:

1._____

2._____

3._____

4._____

5._____

Please list any prior surgeries related to pain (such as laminectomy) and dates performed:

1._____

2._____

3._____

4._____

5._____

Family medical history:

1._____

2._____

3._____

4._____

5._____

With whom do you live?_____

Are there any substance abuse issues in your household? ❑Yes ❑ No If yes, please explain _____

_____

Are you able to care for yourself? ❑Yes ❑ No

If not, caregiver's name and phone number_____

Are you currently involved in a lawsuit? ❑Yes ❑ No If yes, please explain _____

_____

Where is your pain? Be specific and list **in order of most severe pain** to least severe pain:

1. _____ **Most severe**

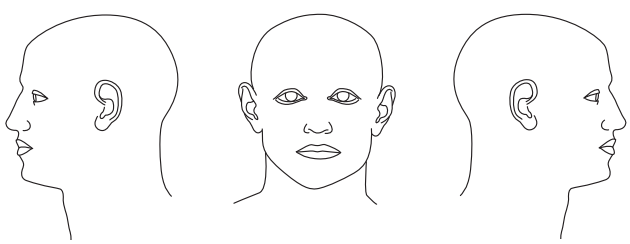
2. _____

3. _____

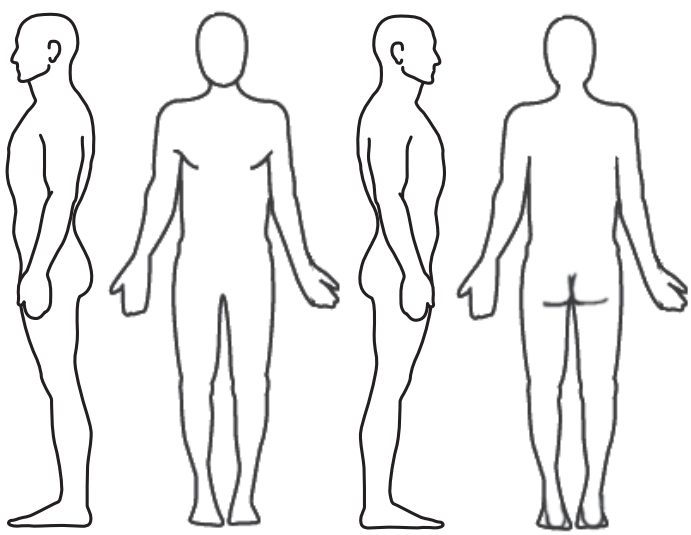
4. _____

5. _____ **Least pain**

Please mark where your pain is located.



Left R - Front - L Right



Left R - Front - L Right L - Back - R

When did your pain start? _____

Was there a particular event that caused your pain? ❑Yes ❑ No Please explain:_____

How often does your pain occur and for how long?_____

What makes your pain worse?_____

What makes your pain better?_____

Please indicate most recent diagnostic test you have had regarding your pain:

	Date	Facility	Results
_____ X-rays	_____	_____	_____
_____ CAT Scan	_____	_____	_____
_____ MRI	_____	_____	_____
_____ EMT	_____	_____	_____
_____ Myelogram	_____	_____	_____
_____ Other	_____	_____	_____

Please list any other doctors you have consulted regarding this problem:

	Name	Specialty	Date	Phone
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Please check off any treatments you have undergone for this problem, and if they have helped or not helped your problem:

	Helped Yes	Helped No		Helped Yes	Helped No
_____ Surgery	_____	_____	_____ Chiropractor	_____	_____
_____ Medications	_____	_____	_____ Ultrasound	_____	_____
_____	_____	_____	_____ Acupuncture	_____	_____
_____	_____	_____			
_____	_____	_____	_____ Biofeedback	_____	_____
_____ Nerve block, steroid or trigger pt. injections	_____	_____	_____ Hypnosis	_____	_____
_____ Bedrest	_____	_____	_____ Relation	_____	_____
_____ TENS	_____	_____	_____ Exercise	_____	_____
_____ Heat	_____	_____	_____ Traction	_____	_____
			_____ Other_____	_____	_____

Pain can be very difficult to describe. It is helpful to compare the intensity of your pain at different intervals. Please rate the intensity of your pain on a scale from 0 to 10. **0 = no pain 10 = the worst pain you can imagine**

What is your pain now? **1 2 3 4 5 6 7 8 9 10**

What is your level of pain when it is most severe? **1 2 3 4 5 6 7 8 9 10**

What is your level of pain when it is least painful? **1 2 3 4 5 6 7 8 9 10**

On subsequent visits, we will refer to the 0 to 10 pain scale and ask you to rate your pain.

Please mark an "X" on the line to represent the intensity of your pain.

0 1 2 3 4 5 6 7 8 9 10
No Pain **Worst Pain**