EXODUS PAIN CLINIC
INTERVENTIONAL SPINE & PAIN MEDICINE

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NEW PATIENT FORM PACKET

! ATTENTION PATIENTS !
PLEASE FILL THIS FORM OUT COMPLETELY.
THIS FORM MUST BE COMPLETED FOR AUTHORIZATIONS ON ANY IMAGING OR OTHER TREATMENTS.

PATIENT INTAKE FORM

PATIENT NAME:_____ DOB:_____Date: _____

Height: _____ Weight:_____

Have you had severe to moderate pain for at least 3 months? YES ___ NO ___

When was the onset of your pain? DATE: MONTH/YEAR_____

How does the pain affect your activities and daily living? (i.e. walking, sleeping, getting dressed, bathing etc.)

_____

What makes your pain better or worse?

_____

_____

_____

Have you attended physical therapy? YES ___ NO ___

How many visits did you attend? _____

When and where did you attend physical therapy?:_____

Was there any improvement? Change to pain: _____

Have you ever tried and failed NSAIDS (aspirin, ibuprofen, etc.) or muscle relaxers?
If so list the Rx & when you failed them.

_____

_____

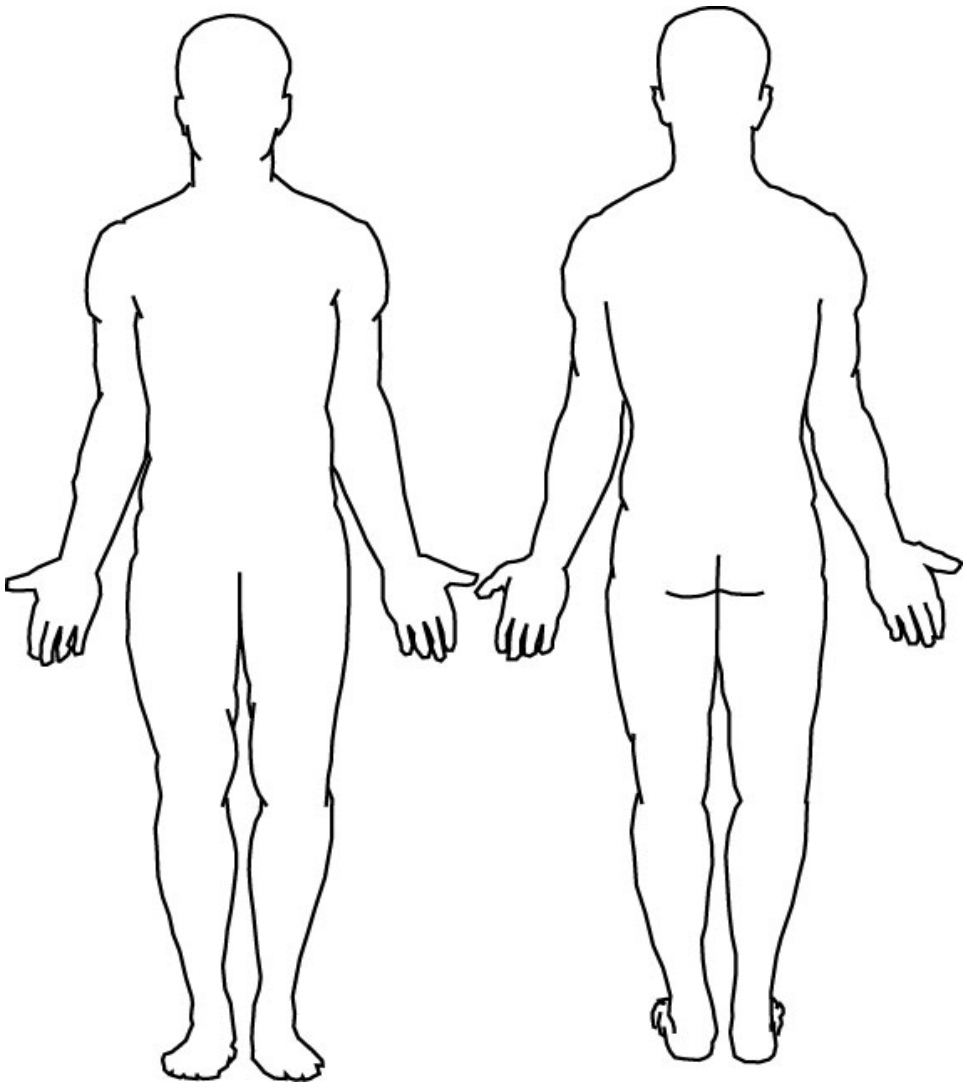
Have you seen a chiropractor? YES _____ NO _____
How many times did you see the chiropractor? _____

What was the name of the chiropractor and/or the practice name?

_____

Mark the areas of your body where you typically feel your pain. If you are having multiple types of pain please use the provided key:

Aching - ---------- Tingling – 00000000 Burning – XXXXXX Sharp/Stabbing - //////////



MEDICAL HISTORY

Current Physician Name/Number:_____(_____)_____-_____

Current Pharmacy Name/Number:_____(_____)_____-_____

Current/Past Medications

Name	Dose	Frequency	Start	End	Dr	Purpose

Surgical Procedures

Date	Procedure	Surgeon	Notes

Current Medical Problems

Illness	Start Date	Treating Physician	Treatment Notes

List all your allergies and your reactions:

_____

_____

_____

Family History

M = Mother F = Father S = Sister B = Brother

Illness	M	F	S	B	Illness	M	F	S	B
Alzheimers					Migraine Headaches				
High Blood Pressure					Cancer				
Stroke					Epilepsy				
High Cholesterol					Diabetes				
Blood Clots					Heart Disease				
Muscular Weakness					Arthritis				
Other Dementia					Allergic Diseases				
Depression					Drug Addiction				
Alcoholism									

Social History

Are You?: (circle one) Single Married Widowed Divorced Separated Significant Other

Do You?:

1. Smoke: NO ____ YES ____ How many per day?_____
2. Drink: NO ___ YES ___ How many per day?_____ (Circle one) Socially Rarely Moderately
3. Use Marijuana: NO ___ YES ___ How often?
   _____
4. Use Kratom: NO ___ YES ___ How much/how often? _____
5. Use Illegal Substances: NO ___ YES ___ Which ones?_____
   In the Past?: _____
   Presently?:_____

Have you ever been treated for, or do you feel you have problems w/ alcoholism, or any type of substance abuse? NO ___ YES ___

Explain:

_____

_____

_____

Have you ever been hospitalized for psychiatric condition? NO ___ YES. ___

When? _____

Where?:_____

Do you have a history of prescription or street drug abuse? NO ___ YES ___

explain:_____

Does anyone in your family have a substance abuse history? NO ___ YES ____

Is there any substance abuse in your household? NO ___ YES ___ Type?_____

Work: (Circle One) Full Time Part Time Retired Disabled Unemployed

What kind of work do you do?

_____

_____

What kind of hobbies and/or recreational activities do you do and/or partake?

_____

_____

_____

_____

REVIEW OF SYSTEMS
Please check all boxed that apply

General:	❑ Weakness ❑ Fatigue ❑ Headaches	❑ Body Aches ❑ Weight Gain/Loss	❑ Fever/ Chills ❑ Excessive Appetite	❑ Poor Appetite
Skin:	❑ Hives ❑ Eczema	❑ Dryness ❑ Itching	❑ Rash ❑ Color Changes	❑ Change in Nails
Head/ Neurologic:	❑ Headaches ❑ Migraines ❑ Numbness	❑ Dizziness ❑ Passing Out ❑ Tremor	❑ Fainting ❑ Head Injury ❑ Seizures	❑ Tingling **Other:**
Ears:	❑ Ringing ❑ Hearing Loss	❑ Drainage ❑ Vertigo	❑ Ear Ache	
Eyes:	❑ Pain	❑ Blurred Vision	❑ Changes in Vision	❑ Double Vision
Nose:	❑ Congestion ❑ Hay Fever	❑ Itching ❑ Sinus Pain	❑ Nosebleeds ❑ Runny Nose	❑ Snoring
Throat/Mouth:	❑ Difficult Swallowing	❑ Dry Mouth	❑ Sores in Mouth	❑ Hoarseness
Respiratory:	❑ Asthma ❑ Shortness of Breath	❑ Wheezing ❑ Sleep Apnea	❑ Cough ❑ Pneumonia	❑ Painful Breathing
Gastrointestinal:	❑ Abdominal Pain ❑ Heartburn ❑ Ulcers	❑ IBS ❑ Diarrhea ❑ Blood In Stool ❑ Colitis	❑ Jaundice ❑ Hernia ❑ Bloating ❑ Change in Appetite	❑ Nausea / Vomiting ❑ Constipation ❑ Excessive Gas
Cardiovascular:	❑ Pacemaker ❑ High Blood Pressure	❑ Blood Clots ❑ Heart Attack ❑ Chest Pain	❑ High Cholesterol ❑ Leg Edema	❑ Rheumatic Fever ❑ Murmur
Psychiatric/ Mood:	❑ Depression ❑ Anxiousness ❑ Poor Energy	❑ Short Temper ❑ Trouble Sleeping	❑ Compulsive Behavior ❑ Mood Changes	❑ Poor Concentration ❑ Stress

Muscles/Bones/ Joints:	**❑ Arthritis ❑ Muscle/Joint Pain ❑ Cramps**	**❑ Joint Swelling ❑ Fractures ❑ Gout**	**❑ Osteo-porosis ❑ Fi-bromyalgia ❑ Polio**	**Other:**
Back and Neck	**❑ Back Pain ❑ Back Stiff-ness ❑ Sciatica**	**❑ Neck Pain ❑ Neck Stiff-ness**	**❑ Restricted Movement ❑ Disc Prob-lems**	**Fractures Other:**
Other conditions not listed:				