PINNACLE
PAIN AND SPINE

Pinnacle Pain & Spine New Patient Intake Form

Your completed intake paperwork helps our physician and other providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (480) 407-6400 if you have any questions regarding how to complete any section on this form.

PATIENT INFORMATION

Today's date: _____Your name: _____

Date of Birth: _____ Age: _____

Referring Physician: _____

Primary Care Physician:_____

PAIN HISTORY

Chief Complaint (Reason for your visit today)?

_____

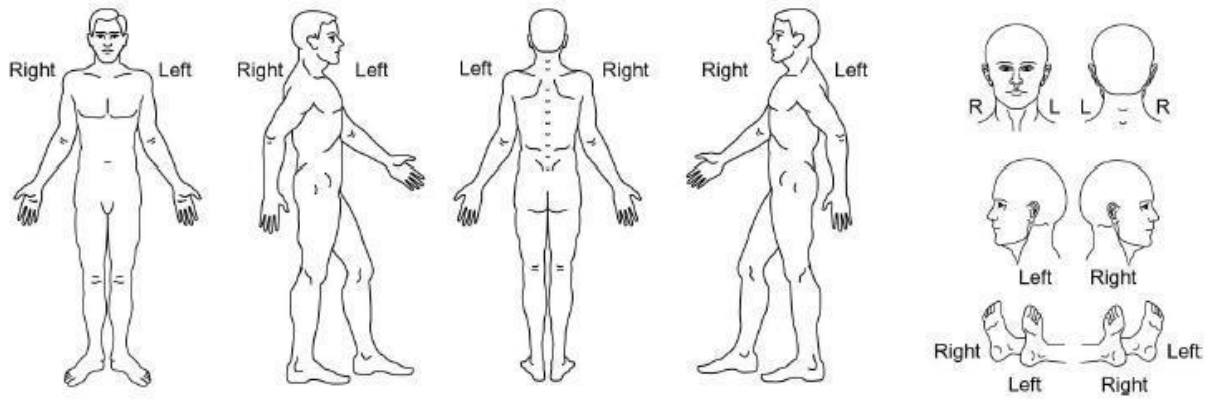
Does this pain radiate? If so where?

_____

Please list any additional areas of pain:

_____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Patient Name:_____

ONSET OF SYMPTOMS

Approximately when did this pain begin?

_____

What caused your current pain episode?

_____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

PAIN DESCRIPTION

Check all of the following that describe your pain: ☐ Dull/Aching ☐ Hot/Burning ☐ Shooting

☐ Stabbing/Sharp ☐ Cramping ☐ Numbness ☐Spasming ☐Throbbing ☐Squeezing ☐Tingling/Pins & Needles

☐ Tightness

When is your pain at its worst? ☐ Mornings ☐Daytime ☐ Evenings ☐ Middle of the night ☐ Always the same

How often does the pain occur? ☐ Constant ☐ Changes in severity but always present ☐ Intermittent

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

MARK THE EFFECT THAT EACH OF THE FOLLOWING HAVE ON YOUR PAIN

	Better	Worse	Same		Better	Worse	Same
Bending Backward	☐	☐	☐	Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐	Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐	Driving	☐	☐	☐
Lifting Objects	☐	☐	☐	Looking upward	☐	☐	☐
Looking downward	☐	☐	☐	Rising from sitting	☐	☐	☐
Sitting	☐	☐	☐	Standing	☐	☐	☐
Walking	☐	☐	☐				

What other factors worsen or affect your pain which is not mentioned above?

_____
_____
_____

Patient Name:_____

ASSOCIATED SYMPTOMS

	Yes	No	
Numbness/Tingling	☐	☐	Where? _____
Weakness in the arm/leg	☐	☐	_____
Balance Problems	☐	☐	_____
Bladder Incontinence	☐	☐	_____
Bowel Incontinence	☐	☐	_____
Joint Swelling/Stiffness	☐	☐	_____
Fevers/chills	☐	☐	_____

PLEASE MARK ALL OF THE FOLLOWING YOU HAVE USED FOR PAIN RELIEF

	Helped Pain	Worsened	No Change
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐
Spinal Cord Stimulator Trial	☐	☐	☐
Spinal Cord Stimulator Implant	☐	☐	☐

Other_____

INTERVENTIONAL PAIN TREATMENT HISTORY

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
☐ Joint Injection – Joint(s) _____
☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
☐ Nerve Blocks – Area/Nerve(s) - _____
☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar
☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____
☐ Trigger Point Injections – Where? _____
☐ Vertebroplasty/Kyphoplasty – Level(s) _____
☐ Other - _____

Which of these procedures listed above have helped with your pain?

_____

Patient Name:_____

Mark all of the following tests that you have related to your current pain complaints: ☐

MRI of the: _____ Date: _____ ☐

X-Ray of the: _____ Date: _____ ☐

CT Scan of the: _____ Date: _____ ☐

EMG/NCV study of the: _____ Date: _____ ☐

Other Diagnostic Testing: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/Psychologist ☐ Chiropractor ☐ Orthopedic Surgeon

☐ Rheumatologist ☐ Internist ☐ Physical Therapist ☐ Neurologist ☐ Other:_____

List the names of any previous pain management physicians you have seen in the past:

_____

PAST MEDICAL HISTORY

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

☐ Cancer – Type _____

☐ Diabetes – Type_____

Head/Ears/Eyes/Nose/Throat

☐ Headaches ☐ Migraines ☐ Head Injury ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Glaucoma

Cardiovascular/Hematologic

☐ Anemia ☐ Heart Attack ☐ Coronary Artery Disease ☐ High Blood Pressure ☐ Peripheral Vascular Disease

☐ Stoke/TIA ☐ Heart Valve Disorders

Respiratory

☐ Asthma ☐ Bronchitis/Pneumonia ☐ Emphysema/COPD

Gastrointestinal

☐ GERD (Acid Reflux) ☐ Gastrointestinal Bleeding ☐ Stomach Ulcers ☐ Constipation

Musculoskeletal/Rheumatologic

☐ Bursitis ☐ Carpal Tunnel Syndrome ☐ Fibromyalgia ☐ Osteoarthritis ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Chronic Joint Pains

Neuropsychological

☐ Multiple Sclerosis ☐ Peripheral Neuropathy ☐ Seizures ☐ Depression ☐ Anxiety ☐ Schizophrenia

☐ Bipolar Disorder

Urological

☐ Chronic Kidney Disease ☐ Kidney Stones ☐ Urinary Incontinence ☐ Dialysis

Other Diagnosed Conditions ☐ _____

PAST SURGICAL HISTORY

Please list any surgical procedures you have had done in the past including date:
1) _____ Date? _____
2) _____ Date? _____
3) _____ Date? _____
4) _____ Date? _____
5) _____ Date? _____
☐ I have **NEVER** had any surgical procedures performed.

CURRENT MEDICATIONS

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No
If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Xarelto ☐ Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	Dose	Frequency
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Please list all past pain medications that you have been on at any point for your current pain complaints:

	Medication Name	Dose	Frequency
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

ALLERGIES

Do you have any drug/medication allergies? ☐ Yes ☐ No
If so, please list all medications you are allergic to:

	Medication Name	Allergic Reaction
1)		
2)		
3)		
4)		
5)		

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

FAMILY HISTORY

Mark all appropriate diagnoses as they pertain to your first degree relatives:
☐Arthritis ☐Cancer ☐Diabetes
☐Headaches/Migraines ☐High Blood Pressure ☐Kidney Problems
☐Liver Problems ☐Osteoporosis ☐Rheumatoid arthritis
☐Seizures ☐ Stroke
☐Other Medical Problems: _____
☐ I have no significant family medical history

SOCIAL HISTORY

Occupation: _____ When was the last time you worked? _____
Who is in your current household? _____
Are there any stairs in your current home? _____ If so how many? _____
☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed
Are you currently under worker's compensation? ☐ No ☐ Yes
Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes
Alcohol Use: ☐ Social Use ☐ History of alcoholism ☐ Current alcoholism ☐Never ☐ Daily use of alcohol
Tobacco Use: ☐ Current user ☐ Former user ☐ Never used ☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____
Illegal Drug Use: ☐ Denies any illegal drug use ☐ Currently uses illegal drugs ☐ Formerly used illegal drugs (not currently using)
Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Constitutional:
☐ Chills ☐Difficulty sleeping ☐ Easy bruising
☐ Night Sweats ☐Fatigue ☐ Fevers
☐ Insomnia ☐ Low sex drive ☐ Tremors
☐ Unexplained Weight Gain ☐ Weakness
☐ Unexplained Weight Loss

Eyes:
☐ Recent Visual changes

Ears/Nose/Throat/Neck:
☐ Dental Problems ☐ Earaches ☐ Hearing Problems
☐ Nosebleeds ☐ Sinus problems

Cardiovascular:
☐ Chest Pain ☐ Bleeding Disorder ☐ Blood Clots
☐ Fainting ☐ Palpitations ☐ Swelling in feet
☐ Shortness of breath during sleep

Respiratory:
☐ Cough ☐ Wheezing ☐ Shortness of breath

Gastrointestinal:
☐ Constipation ☐ Acid Reflux ☐Abdominal Cramps
☐ Diarrhea ☐ Nausea/Vomiting ☐ Hernia

Musculoskeletal:
☐ Back Pain ☐ Joint Pains ☐ Joint Stiffness
☐ Joint Swelling ☐ muscle spasms ☐ Neck Pain

Genitourinary/Nephrology:
☐ Flank Pain ☐ Blood in Urine ☐ Painful Urination
☐ Decreased Urine Flow/Frequency/Volume

Neurological:
☐ Dizziness ☐ Headaches ☐ Tremors ☐ Numbness/Tingling ☐ Seizures

Psychiatric:
☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems ☐ Suicidal Thoughts
☐ Suicidal Planning ☐ Thoughts of Harming Others

☐ All other review of systems negative