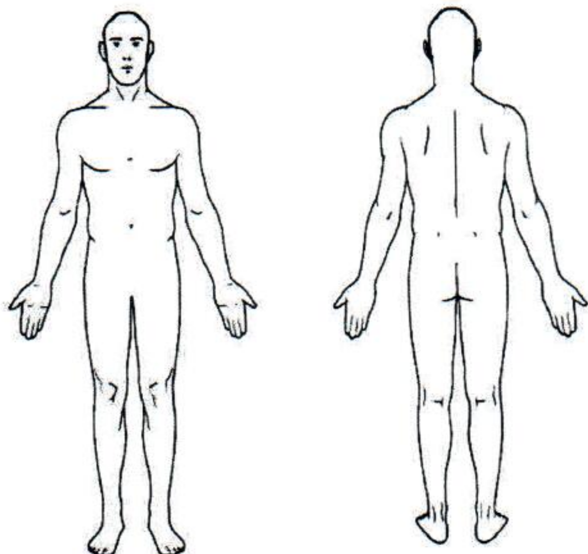
Texas Institute of Pain and Spine– NEW PATIENT INTAKE FORM

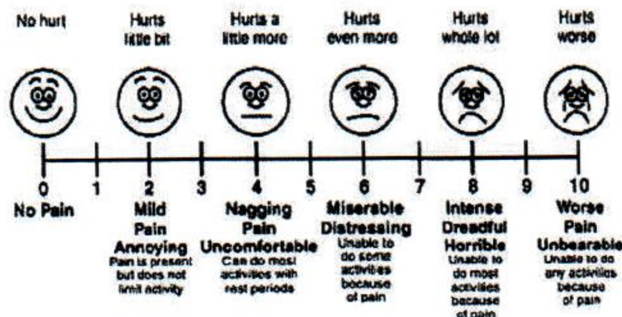
Patient's Name: ______________________ Date: ____________

PCP: ______________ Were you referred by another physician? ____________

If not, how did you hear about us? ______________________

Please use the diagram above to specify your areas of pain





What number on the scale **(0-10)...**

...best describes your pain **right now?** ______

...best describes your **worst pain?** _____

...best describes your **least pain?** ______

...best describes your **average pain over the last month?** ______

Mark on the diagram above where your pain is located.

PAIN DESCRIPTION

Where is your WORST area of pain located? ______________

Does your pain radiate? **YES / NO**: If so, where to? ______________

Do you have any additional areas of pain? **YES / NO:** If so, where? ______________

How long have these symptoms occurred?_____ **(DAYS / WEEKS/ MONTHS/ YEARS)**

Is this from a prior injury? **(YES/NO)** What is the date of injury ___/___/_____

How did the injury/symptoms occur? Motor vehicle accident / work related / sports / slip or fall

If other, please explain: ______________

How did it begin: **GRADUALLY / SUDDENLY**

Since your pain began, has it **(DECREASED / INCREASED / REMAINED THE SAME)**?

What word best describes your frequency of pain? **(CONSTANT / INTERMITTENT)**

When is your pain at its worse? **(MORNING / DAY / EVENINGS / MIDDLE OF NIGHT)**

SYMPTOMS

Circle all that apply:

Aching Cramping Hot/Burning Tiring/Exhausting Dull Shock-like Shooting Spasms Squeezing

Throbbing Numbness Stabbing/Sharp Tingling/Pins & Needles Clicking Locking Popping

Swelling Pain at Night Pain at rest Pain with Activities Soreness OTHER: ______________

Circle all of the following activities that are adversely/negatively affected by pain:

Enjoyment of Life Ability to work Normally Worsened sleep General Activity Sleep Mood

Recreational Activities Relationships with People Ability to walk normally Worsened mood Walking

In the past three months have you developed any new? Circle all that apply:

Balance Problems Bladder Incontinence Vomiting Nausea Numbness/Tingling Where? ______________

Difficulty Walking Bowel Incontinence Chills Fever Weakness Where? ______________

Symptoms worsen when... Circle all that apply:

Weight bearing Standing Driving Squatting Kneeling Sitting Bending Climbing Twisting

Lying Supine   Moving   Walking   Engaging in activities   Lifting   OTHER: ____________________

PREVIOUS STUDIES

Circle all that apply:

X-RAYS   CT SCAN   MRI   EMG/NCV   BONE SCAN   MYELOGRAM
DISCOGRAM   DEXA SCAN   ULTRASOUND   ***OTHER:*** ____________________

*Circle all previous treatments tried and * the items that have worked:*

Acupuncture   Biofeedback   Chiropractic   Massage   Physical Therapy   Psychological Therapy   TENS Unit
Joint Injections   Epidural Steroid Injections   Podiatrist Treatment
Ice   Heat   Rest   Elevation   Muscle Relaxants   Assistive Device   Immobilization   NSAIDS   Steroid Injections
Home Exercises   Hypnosis   Trigger Point Injections   Medial Branch Blocks   Nerve Blocks   Radiofrequency Ablation
Spinal Cord Stimulator   Spine Surgery   Vertebroplasty/Kyphoplasty   ***OTHER:*** ____________________

Have you seen anyone else for your condition? Circle all that apply.

Primary Care Physician   Orthopedic Surgeon   Spine Surgeon   Pain Management Physician   Chiropractic
Rheumatologist   Emergency room Physician   Podiatrist   Psychologist   Neurologist
Physical Therapist

ANESTHESIA HISTORY

Have you ever had anesthesia (sedation for a surgical procedure)? **YES / NO**
If so, have you ever had any adverse reaction to anesthesia? **YES / NO**

Which type of anesthesia did you react adversely to? Please circle all that apply.

LOCAL ANESTHESIA   EPIDURAL   GENERAL ANESTHESIA   IV SEDATION

Do you have any family history of adverse reactions to anesthesia? If so, which of the following?

LOCAL ANESTHESIA   EPIDURAL   GENERAL ANESTHESIA   IV SEDATION

PAST MEDICAL HISTORY

Please circle all that apply:

MUSCULOSKELETAL

Amputation   Rheumatoid Arthritis   Carpal Tunnel Syndrome   Bursitis
Fibromyalgia   Phantom Limb Pain   Tennis Elbow   Chronic Low Back Pain
Chronic Joint Pain   Osteoporosis   Chronic Neck Pain   Osteoarthritis
Vertebral Compression Fracture   Lupus

GENITOURINARY/NEPHROLOGY

Bladder Infection   Urinary Incontinence
Kidney Infection   Kidney Stone
Dialysis

LIVER

Hepatitis A
Hepatitis B
Hepatitis C

CARDIOVASCULAR/HEMATOLOGIC

Anemia   High Cholesterol   Stroke   Bleeding Disorder   Mitral Valve
Prolapse   Coronary Artery Disease   Murmur   Heart Attack   Phlebitis
High Blood Pressure   Pacermaker/Defibrilator
Poor Circulation

HEAD/EYES/NOSE/THROAT

Headaches   Head Injury
Thyroid Disease   Migraines
Glaucoma

GENERAL

Cancer
Diabetes
HIV/AIDS

NEUROPSYCHOLOGICAL

Alcohol Abuse   Alzheimer Disease   Epilepsy   Depression
Multiple Sclerosis   Paralysis   Prescription Drug Abuse
Peripheral Neuropathy   Schizophrenia   Seizures   Bipolar

RESPIRATORY

Bronchitis   Pneumonia
Exposure to Mold   Asthma
Emphysema/COPD   Tuberculosis

GASTROINTESTIONAL

Bowel Incontinence   Acid reflux
Constipation   Gastrointestinal Bleeding

PAST SURGICAL HISTORY

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Please circle all that apply.

Gallbladder Removal   Appendectomy   Caesarean Section   Hysterectomy   Laparoscopy   Ovarian

Shoulder: Left/Right   Hip: Left/Right   Knee: Left/Right   Valve Replacement   Aneurysm Repair

Stent Placement   Discectomy   Laminectomy   Spinal Fusion   Hemorrhoid Surgery   Tonsillectomy

Hernia Repair   Vascular Surgery Thyroidectomy   Other: ______________________

(Attach an additional sheet if necessary).

ALLERGIES

Do you have any known allergies? **YES / NO**

Are you allergic to shellfish or iodine? **YES / NO**

Are you allergic to Iodine / Tape / Latex? Circle all or any that apply.

If so, please list all medications and food you are allergic to:

____

____

____

FAMILY HISTORY

Circle all appropriate diagnosis as they pertain to your biological mother & father ONLY

MOTHER	
Alcohol Problems	Headaches
Gambling Problems	Heart Disease
Diabetes	Liver Disease
Drug Problems	High Blood Pressure
Kidney Disease	Smoking
Rheumatoid Arthritis	Cancer
Stroke	

FATHER	
Alcohol Problems	Headaches
Gambling Problems	Heart Disease
Diabetes	Liver Disease
Drug Problems	High Blood Pressure
Kidney Disease	Smoking
Rheumatoid Arthritis	Cancer
Stroke	

□ Please ***check*** if you have no significant family medical history.

Were you adopted? **YES/ NO**

SOCIAL HISTORY

Are you capable of becoming pregnant? **YES / NO**

If so, are you currently pregnant? **YES / NO**

What is your occupation? ______________________

Are you currently working? **YES / NO**

Circle all that apply below.

ALCOHOL USE
Current Alcoholism
History of Alcoholism
Social Alcohol Use
Never Drinks Alcohol
Daily limited Alcohol Use

TOBACCO USE
Current tobacco user
Former tobacco user
Never used tobacco

ILLICIT DRUG USE
Denies any illicit drug use
Currently using illicit drugs

Please list all illicit drugs: ______________________

Have you formerly used illicit drugs? **YES / NO** If so, please list which. ______________________

Have you ever abused narcotic or prescription medications? **YES / NO**

Are you recovering from drugs, alcohol, or any addiction? **YES / NO**

REVIEW OF SYSTEMS

Circle the following symptoms that you currently suffer from.
Note: Diagnosed conditions/diseases should be noted under past medical history section.

CONSTITUTIONAL
Weakness Weight gain
Fatigue Weight loss
Fever Chills
Night Sweats

EYES
Recent vision changes
Eye glasses/contacts
Double Vision

EARS/NOSE/THROAT
Dental Problems Ringing in ears
Earaches Sinus Problems
Nosebleeds Recurrent sore throat

CARDIOVASCULAR
Chest Pain Irregular Heartbeat
Blood clots Murmur
Rapid Heartbeat Palpitations
Swollen Extremities Fainting

RESPIRATORY
Cough
Wheezing
Shortness of breath on exertion/effort
Shortness of breath at rest

GASTROINTESTIONAL
Acid Reflux Abdominal cramps
Constipation Diarrhea
Vomiting Coffee ground appearance in vomit
Dark & tarry stools

GENITOURINARY/NEPHROLOGY
Blood in urine Low frequency/volume
Painful urination Incontinence
Erectile dysfunction Decreased urine
Flank pain

INTEGUMENTARY/SKIN
Change in skin color
Rashes
Puritis
Dry skin

MUSCULOSKELETAL
Joint swelling Joint pain
Back pain Muscle spasms
Neck pain Pelvic pain
Joint Stiffness

PSYCHIATRIC
Depressed mood
Stress
Anxiety
Suicidal thoughts

ENDOCRINE
Heat intolerant Cold intolerant
Hair changes Excessive thirst

NEUROLOGICAL
Dizziness Seizures
Headaches Memory loss
Numbness/tingling Difficulty with speech
Incoordination

HEMATOLOGIC/LYMPHATIC
Easy bruising Easy bleeding
Slow healing wounds Lymphadenopathy

ALLERGIC/IMMUNOLOGIC
Recurrent infections
Hives
Swelling
Itching eye/nose

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Pearland, TX 77584

Patient Name: ______________________________ Date: ______________

MEDICATIONS:

Please indicate which (if any) of the following **BLOOD THINNERS** you are taking?

☐Aggrenox ☐Coumadin ☐Effient ☐Eliquis ☐Lovenox ☐Plavix ☐Pletal

☐Pradaxa ☐Ticlid ☐Xarelto ☐Warfarin

Other: ____

Please list ALL medications you are currently taking. Attach an additional sheet, if required.

Medication Name, Dose, Frequency

Pharmacy Name ______________________________

Pharmacy Address ______________________________

Pharmacy Phone Number ______________________________

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Patient Name: ______________________________ Date: ________________

Modified Oswestry Low Back Pain Questionnaire

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by marking in each section **one circle** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just mark the circle that most closely describes your problem**.

Section 1 – Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

Section 2 – Personal Care

- I do not have to change my way of washing or dressing to avoid pain.
- I do not normally change my way of washing or dressing even though it causes me pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting (skip if you have not attempted lifting since the onset of your low back pain)

- I can lift heavy weights without extra low back pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me lifting heavy weights off the floor.
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift light weights at the most.

Section 4 - Walking

- I have no pain walking.
- I have some pain on walking, but I can still walk my required to normal distances.
- Pain prevents me from walking long distances.
- Pain prevents me from walking even short distances.
- Pain prevents me from walking at all.

Section 5 - Sitting

- Sitting does not cause me any pain.
- I can sit as long as I need provided I have my choice of sitting surfaces.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.

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- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 - Standing

- I can stand as long as I want without pain.
- I have some pain while standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

- I have no pain while in bed.
- I have pain in bed, but it does not prevent me from sleeping well.
- Because of pain I sleep only ¾ of normal time.
- Because of pain I sleep only ½ of normal time.
- Because of pain I sleep only ¼ of normal time.
- Pain prevents me from sleeping at all.

Section 8 – Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain prevents me from participating in more energetic activities e.g. sports, dancing.
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I hardly have any social life because of pain.

Section 9 - Traveling

- I get no pain while traveling
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling that requires me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

Section 10 – Employment / Homemaking

- My normal job/homemaking duties do not cause pain.
- My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
- I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming, etc.
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

SCORE ____________________

Patient Name:________________________ Date:________________

DOB:________________________

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in the home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

TEXAS INSTITUTE OF PAIN AND SPINE

VENOUS HEALTH HISTORY

Name:	Date of Birth:

SIGNS AND SYMPTOMS

Do you experience any of the following in your legs or ankles?

- ☐ Leg pain, aching, or cramping
- ☐ Burning or itching of the skin
- ☐ Leg or ankle swelling, especially at the end of the day
- ☐ "Heavy" feeling in legs
- ☐ Skin discoloration or texture changes, such as above the inner ankle
- ☐ Open wounds or sores, such as above the inner ankle
- ☐ Restless legs

Circle activities affected by legs: Walking, Shopping, Exercise, Cleaning, Cooking, Showering, Job Functions

RISK FACTORS

Do you have family history of varicose veins?	☐ Yes ☐ No	Who? ________
Any treatments or procedures for vein problems?	☐ Yes ☐ No	What? ________
Do you sit for long periods of time, such as at work?	☐ Yes ☐ No	
Do you stand for long periods of time?	☐ Yes ☐ No	
Do you elevate your legs for discomfort?	☐ Yes ☐ No	
Do you exercise?	☐ Yes ☐ No	How often? ________
Have you ever had varicose veins or bulging veins?	☐ Yes ☐ No	
Have symptoms worsened in recent months?	☐ Yes ☐ No	
Do you take any medications for pain in your legs?	☐ Yes ☐ No	What? _____ How Long? ____
Do you have difficulty walking?	☐ Yes ☐ No	
Do you wear/have worn compression stockings?	☐ Yes ☐ No	Rx or OTC? ________ How Long? ________

Print Name: ________________ Patient Signature: ________________