Health Intake Form

<u>IMPORTANT:</u> Please complete all sections of this form. Do not leave any unanswered items. If the question does not apply, you may put "N/A"

Personal Information

Full Name

First:
Middle:
Last:

Do you have any medication allergies?

	Yes		No

Please list your allergies with a brief description of the reaction you experience.

Ex. rash, swelling, difficulty breathing, etc.

Do you have any food allergies?

	Yes		No

Please list your allergies with a brief description of the reaction you experience.

Ex. rash, swelling, difficulty breathing, etc.

Date of Birth:

Email Address:

How tall are you?

What is your current weight?

Are you allergic to IV Contrast/Dye?

	Yes		No

Please list your allergies with a brief description of the reaction you experience.

Ex. rash, swelling, difficulty breathing, etc.

Medications (May Bring List)

List your current medications, or attach your own list. Please include over-the-counter and dietary supplements including the strength and dosing instructions.

Ex. Tylenol 325mg take 1 tablet 4 times a day as needed

Family Health History

Mother

	Arthritis		Back Problems
	Diabetes mellitus		Hypertensive disorder
	Heart Disease		Substance abuse
	Malignant neoplastic disease		Blood coagulation disorder
	Other:		

Father

	Arthritis		Back Problems
	Diabetes mellitus		Hypertensive disorder
	Heart Disease		Substance abuse
	Malignant neoplastic disease		Blood coagulation disorder
	Other:		

Sister(s)

	Arthritis		Back Problems
	Diabetes mellitus		Hypertensive disorder
	Heart Disease		Substance abuse
	Malignant neoplastic disease		Blood coagulation disorder
	Other:		

Family Health History Continued

Brother(s)

	Arthritis		Back Problems
	Diabetes mellitus		Hypertensive disorder
	Heart Disease		Substance abuse
	Malignant neoplastic disease		Blood coagulation disorder
	Other:		

Maternal Grandmother

	Arthritis		Back Problems
	Diabetes mellitus		Hypertensive disorder
	Heart Disease		Substance abuse
	Malignant neoplastic disease		Blood coagulation disorder
	Other:		

Maternal Grandfather

	Arthritis		Back Problems
	Diabetes mellitus		Hypertensive disorder
	Heart Disease		Substance abuse
	Malignant neoplastic disease		Blood coagulation disorder
	Other:		

Paternal Grandmother

	Arthritis		Back Problems
	Diabetes mellitus		Hypertensive disorder
	Heart Disease		Substance abuse
	Malignant neoplastic disease		Blood coagulation disorder
	Other:		

Paternal Grandfather

	Arthritis		Back Problems
	Diabetes mellitus		Hypertensive disorder
	Heart Disease		Substance abuse
	Malignant neoplastic disease		Blood coagulation disorder
	Other:		

Other Relationship:

	Arthritis		Back Problems
	Diabetes mellitus		Hypertensive disorder
	Heart Disease		Substance abuse
	Malignant neoplastic disease		Blood coagulation disorder
	Other:		

Social History

Tobacco Status

	Current everyday smoker*
	Current some day smoker*
	Former smoker
	Never smoked
	Would like to discuss with provider
	Other:

**Smokers:* How much do you smoke?

	1 pack/week		2 packs/week
	¼ pack/day		½ pack/day
	1 pack/day		1 ½ pack/day
	2 packs/day		3+ packs/day
	Other		

How many years have you smoked?

When did you stop smoking?

How long have you used tobacco products?

Have you ever used illicit drugs?

	Yes		No
	Would like to discuss with provider		

If you answered yes to illicit drug use, please explain below.

Have you ever used smokeless tobacco products?

	Currently chews tobacco
	Current snuff user
	Current moist powdered tobacco user
	Former smokeless tobacco user
	Never used smokeless tobacco
	Would like to discuss with provider
	Other:

Have you ever used e-cigarettes/vapes?

	Current user		Former user
	Never used		
	Other:		

Do you drink alcoholic beverages?

	Occasional		Moderate
	Heavy		Never

How long have you consumed alcoholic beverages?

Have you ever had a problem with substance abuse?

	Yes		No
	Would like to discuss with provider		

If yes, please explain:

Employment

Are you currently employed?

	Yes		No

What is your occupation?

What is your employment status?

	Working Full-time Normal Duties
	Working Full-time Light Duties
	Working Part-time Normal Duties
	Working Part-time Light Duties
	I am not currently working
	Other

Are you disabled?

	Yes		No

Are you retired?

	Yes		No

Is this a work-related injury?

	Yes		No

If yes, what was the date of injury (mm/dd/yy) and give a brief description:

Is this pain related to an active worker's compensation case/claim?

	Yes		No

Have you experienced a similar pain complaint before this injury?

	Yes		No

If yes, please explain:

Is this an auto-accident-related injury?

	Yes		No

If yes, what was the date of injury (mm/dd/yy and give a brief description:

Is this an injury related to an active legal case?

	Yes		No

Have you experienced a similar pain complaint before this accident? Please explain:

Do you have difficulty walking up and down stairs?

	Yes		No

Do you live alone or with others?

	Alone
	With others:

Marital Status

	Single		Married
	Separated		Divorced
	Domestic Partner		Widowed

How many children do you have?

Gender Identity and LGBTQ Identity

(Answering this section is optional)

Gender Identity

	Identifies as Male
	Identifies as Female
	Transgender Male/Female-to-Male (FTM)
	Transgender Female/Male-to-Female (MTF)
	Gender non-conforming (neither exclusively male nor female)
	Choose not to disclose
	Additional gender category / other, please specify:

Assigned Sex at Birth

	Male		Female
	Unknown		Choose not to disclose

Pronouns

	He/him		She/her
	They/them		
First name used:			

Sexual Orientation

	Straight/Heterosexual
	Lesbian, gay, or homosexual
	Bisexual
	Unknown

Past Surgical History

Please list any surgical procedures you've had in the past with their approximate dates and the names of the performing surgeons if known:

Ex. knee surgery on 1/14/19 by Dr. Smith

Do you have any implanted mechanical or battery-operated devices, not including any joint replacements?

	Yes		No

If yes, please specify using the space below:
(Please bring your device card at the time of your appointment to be scanned into your chart)

Past Medical History

Please check all that apply

	AIDS/HIV		Hepatitis
	Acid Reflux/ GERD		Hyperlipidemia
	Anxiety/ Depression		Hypertension
	Arthritis		Kidney Disease
	Asthma		Liver Disease
	Bleeding Disorder		Lupus
	COPD		Osteoporosis
	Coronary Artery Disease		Rheumatoid Arthritis
	Diabetes		Seizures
	Fibromyalgia		Stroke
	Gout		Thyroid Problems
	Heart Attack (MI)		Ulcers
	Heart Disease		None Known
	Cancer; type:		
	Other:		

Have you tested positive for Covid-19 in the past 10 days?

	Yes		No

Do you currently have an active infection/rash?

	Yes		No

If yes, what medications (antibiotics) are you taking for that?
Name of the prescriber:
Prescriber contact number:

Are you on blood thinners?

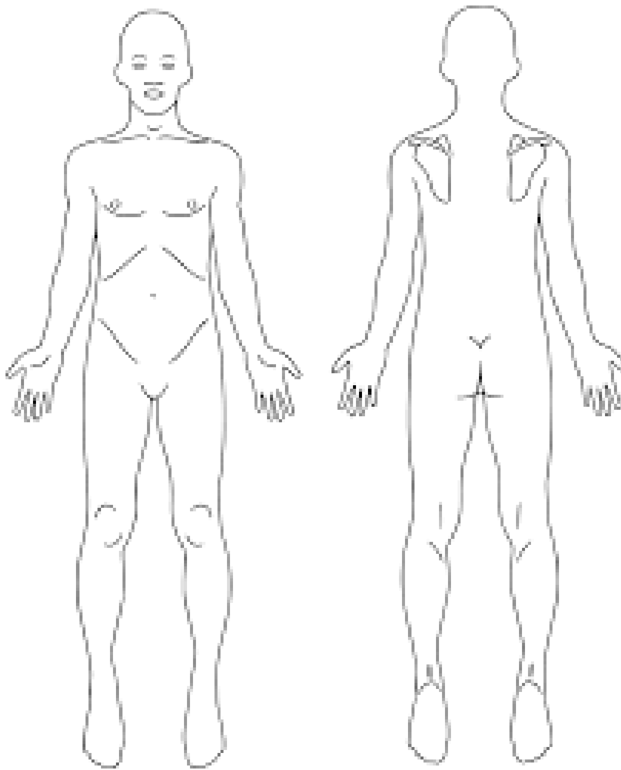
	Yes		No
If yes, which blood thinner:			
	Aspirin (if taking more than 325 mg daily)		
	BC Powder		Persantine
	Heparin		Savaysa
	Lovenox		Trental
	Aggrenox		Brillinta
	Plavix		Coumadin
	Pletal		Pradaxa
	Effient		Eliquis
	Ticlid		Xarelto
	Other:		
Name of the prescriber:			
Prescriber contact number:			

Are you left or right-handed?

___ Left	___ Right	___ Both

History of Present Illness
Chief Complaint (reason for today's visit):
Where is the exact location of your pain today?

You may also help us visualize the location of your pain by shading the body part in the image provided below.



Does your pain radiate?

	Yes		No
If yes, where does the pain radiate?			
	Right Arm		Left Arm
	Right Leg		Left Leg
	Other:		
Please describe how the pain radiates.			
Approximate month and year the pain started?			
In your opinion, can you specify any events that could have caused your pain? Please describe the event briefly (with approximate date): *Ex. a fall, or an accident. (if none apply, please write n/a)*			

Do you experience any of the following?

	Numbness		Tingling
	Weakness		None of these
	Other:		
The location where you experience the above symptoms? *Ex. I have numbness and weakness in my left leg and foot.*			

Which of the following activities are you not able to perform?

	Walking		Sitting
	Standing		Bathing
	Cooking		Cleaning
	Laundry		Lawn Care
	Standing at Work		Walking at Work
	Getting Dressed		Sitting at Work
	School		Home Duties
	Childcare		Dining Outside
	Sports		
	Other:		

When is your pain worse?

	Mornings		Evenings
	Afternoons		Night
	My pain is the same all the time		
	None of the above		
	Other:		

What makes your pain better?

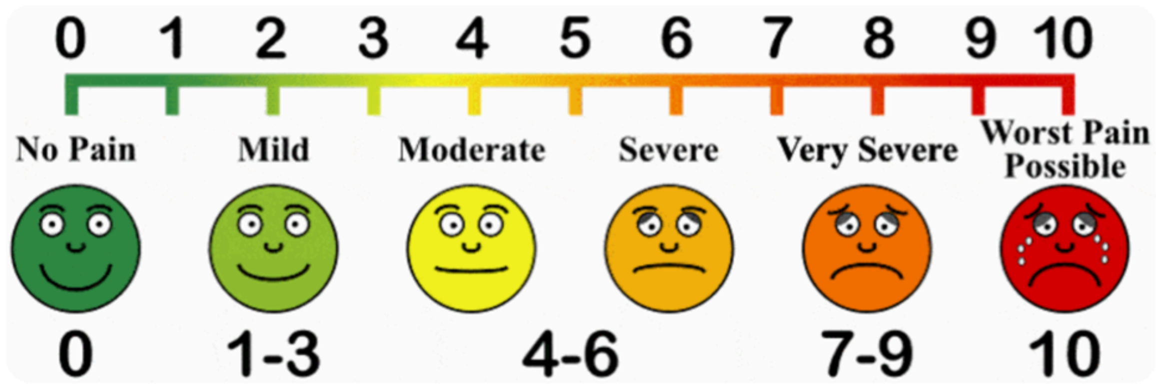
	Lying down		Sitting
	Standing		Walking
	Bending		Medications
	None of these		All of these
	Other:		

What makes your pain worse?

	Exercise (during)		Sitting
	Driving		Standing
	Walking		Bending forward
	Bending backward		Coughing
	Sneezing		Lifting
	Reaching		
	Other:		

How would you describe your pain?

	Aching		Cramping
	Numbness		Hot/Burning
	Tingling/Pins and Needles		Stabbing/Sharp
	Throbbing		Shooting
	Spasming		Dull
	Shock-like		Tiring/Exhausting
	Squeezing		
	Other:		



On a scale of 0-10, 0 being no pain and 10 being the worst pain you can imagine.

Describe your pain at its worst:					
0	1	2	3	4	5
6	7	8	9	10	

Describe your pain on average:					
0	1	2	3	4	5
6	7	8	9	10	

Medications

Have you previously tried or are you currently taking any over-the-counter medications to treat your pain? *Ex. Acetaminophen, Aleve, Advil…*

	Yes		No

Have you taken any prescription medication for your pain?

	Yes		No
Please list any over-the-counter medications, approximate date tried (mm/yy), approximate relief (ex. 50%), and still using these meds. (y/n):			

Conservative Treatment

Have you tried physical therapy for this pain?

	Yes		No
If yes, which body part did you try physical therapy for?			
If yes, are you currently attending physical therapy?			
	Yes		No
If you have tried physical therapy, please list the approximate dates tried, # of weeks tried & approximate % of relief:			

Conservative Treatment Continued

Have you tried home exercises for this pain?

	Yes		No

If yes, which body part did you try home exercises for?

If yes, are you currently in a home exercise program for this pain?

	Yes		No

If you have tried home exercises, please list the approximate dates tried, # of weeks tried & approximate % of relief:

Have you tried chiropractic treatment for this pain?

	Yes		No

If yes, are you currently having chiropractic treatment for this pain?

	Yes		No

If you have tried chiropractic treatment, please list the approximate dates tried, # of weeks tried & approximate % of relief:

Have you tried acupuncture for this pain?

	Yes		No

If yes, are you currently having acupuncture treatments for this pain?

	Yes		No

If you have tried acupuncture, please list the approximate dates tried, # of weeks tried & approximate % of relief:

Other Treatment Modalities

Have you tried TENS unit for this pain?

	Yes		No

Are you currently using a TENS unit?

	Yes		No

If you have tried a TENS unit, please list the approximate dates tried, # of weeks tried & approximate % of relief:

Have you tried heat for this pain?

	Yes		No

If you have tried heat, please list the approximate dates tried, # of weeks tried & approximate % of relief:

Have you tried ice for this pain?

	Yes		No

If you have tried ice, please list the approximate dates tried, # of weeks tried & approximate % of relief:

Other Treatment Modalities (*ex. Iontophoresis, Ultrasound, Phonophoresis, Electrical Stimulation, etc.*)

Procedures and Surgical Interventions

Have you tried spinal injection(s) for this pain?

	Yes		No
If yes, please list the type of injections, approximate date, how many, % of relief, and performing doctor.			

Have you had spine surgery for this pain?

	Yes		No
If yes, please list the approximate date of surgery, type/body location of surgery (if known), name of doctor (if known), % of relief, and duration of relief.			

Imaging

Please only list imaging studies performed in relation to this pain

Have you had an MRI Scan for this pain?

	Yes		No
Region of the body where MRI was performed:			
Approximate month, year, and the name of the facility where the MRI was performed:			

Have you had a CT scan for this pain?

	Yes		No
Region of the body where CT was performed:			
Approximate month, year, and the name of the facility where CT was performed:			

Have you had an X-ray for this pain?

	Yes		No
Region of the body where Xray was performed:			
Approximate month, year, and the name of the facility where the X-ray was performed:			

What are your expectations of your visit?

Ex: Learning about my treatment options, or receiving an injection, or other non-injection treatments.

New Patient Evaluation Agreement

By signing this form, I understand that I will have an evaluation by a provider at Richmond Spine Interventions and Pain Center. The provider will perform an evaluation, a physical examination, and review some of my medical records. This evaluation may or may not consist of possible treatments, including referrals, prescription medications, and procedures. The provider will make recommendations based on this evaluation, which may or may not include future treatment at Richmond Spine Interventions and Pain Center. I understand that there will be a charge submitted to my insurance company and I will be responsible for my copayment at the time of my visit, and my deductible as per my insurance plan policies.

Name

Signature

Date Signed