SUMNER PAIN CLINIC
HIGHPOINT HEALTH PARTNERS

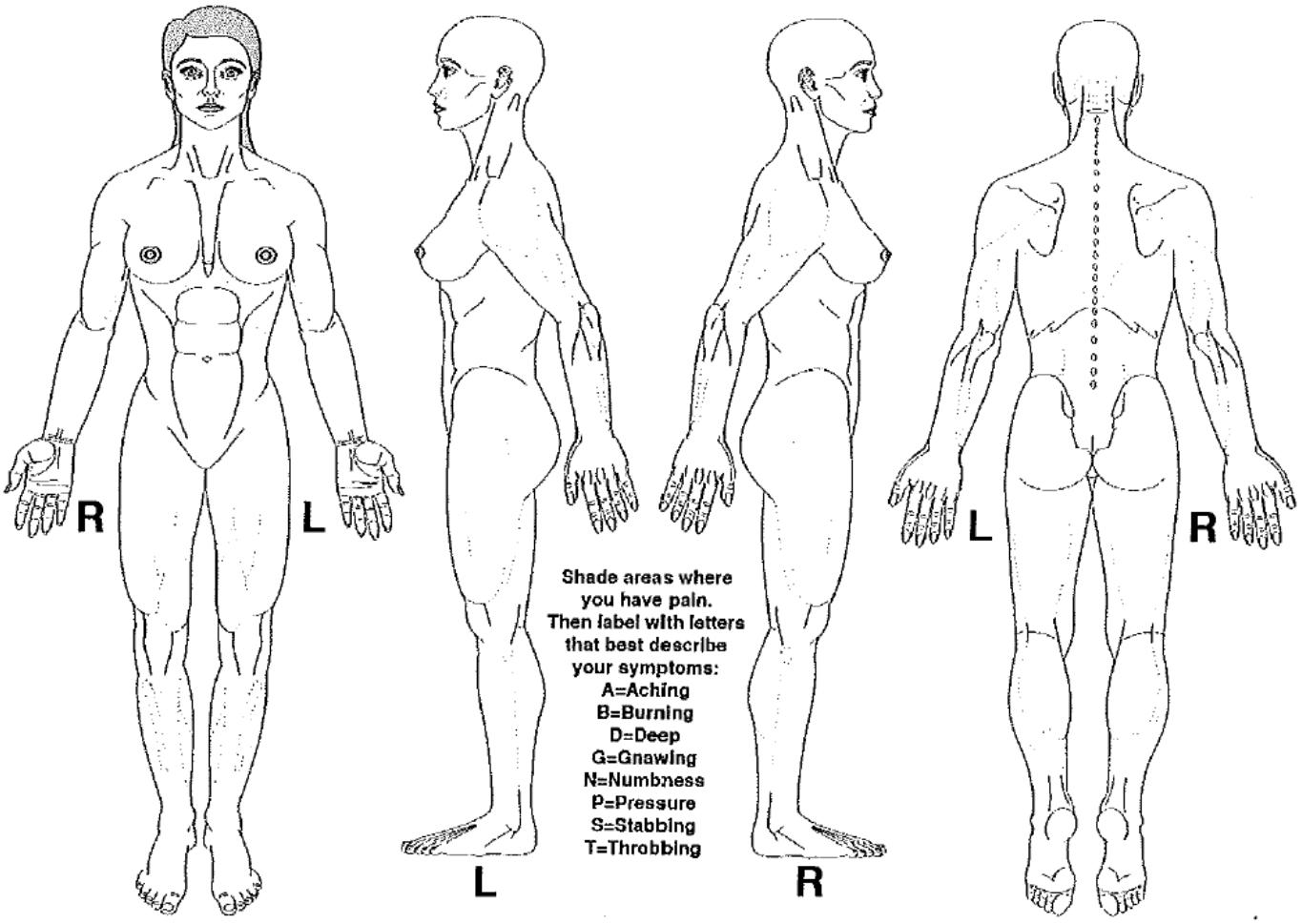
New Patient Intake – Female

Name: _____
Date of Birth: _____ Age: _____

Preferred Phone: _____

Secondary Phone: _____
Email: _____

Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____
Preferred Pharmacy: _____ Phone: _____
Pain Location:



Pain Description

When and how did your pain start? _____

What is your understanding of what is causing your pain? _____

What makes your pain better? _____

What makes your pain worse? _____

Since your pain began, it has: ☐ Increased ☐ Decreased ☐ Remained the same

What best describes your pain? ☐ Constant ☐ Intermittent

When is your pain worst? ☐ Morning ☐ Daytime ☐ Evening ☐ Night

In the past three months, have you developed any of the following?

☐ Balance problems ☐ Difficulty walking ☐ New numbness
☐ Bladder incontinence ☐ Bowel incontinence ☐ New weakness

Pain Score

Pain score now: 0 1 2 3 4 5 6 7 8 9 10
Average pain score, last 24 hours: 0 1 2 3 4 5 6 7 8 9 10
Average pain score, last 3 months: 0 1 2 3 4 5 6 7 8 9 10

Working / Daily Activities

If employed, what type of job do you work? _____
How much does your pain interfere with your ability to do work?
☐ No Interference ☐ Moderate Interference ☐ Extreme Interference
How much does your pain interfere with your daily activities?
☐ No Interference ☐ Moderate Interference ☐ Extreme Interference
Are you on disability? ☐ Yes ☐ No
Do you have a worker's compensation claim? ☐ Yes ☐ No
Are you currently involved in a lawsuit? ☐ Yes ☐ No

Diagnostic Tests Completed:

☐ X-Rays ☐ CT Scans ☐ MRI
☐ Bone Scan ☐ Discogram ☐ EMG, nerve conduction studies
☐ Myelogram ☐ Other: _____

SUMNER PAIN CLINIC
HIGHPOINT HEALTH PARTNERS

New Patient Intake – Female

Name: _____

Medications Tried:

- ☐ Benzodiazepines
- ☐ Cymbalta *Duloxetine*
- ☐ Tylenol *Acetaminophen*
- ☐ Ultram *Tramadol*
- ☐ Neurontin *Gabapentin*
- ☐ Effexor *Venlafaxine*
- ☐ Namenda *Memantine*
- ☐ Lortab *Hydrocodone*
- ☐ Lyrica *Pregabalin*
- ☐ Savella *Milnacipran*
- ☐ Mexitil *Mexiletine*
- ☐ Percocet *Oxycodone*
- ☐ Topamax *Topiramate*
- ☐ Advil *Ibuprofen*
- ☐ Lidocaine patch
- ☐ Morphine
- ☐ Trileptal *Oxcabazepine*
- ☐ Aleve *Naproxen*
- ☐ Baclofen
- ☐ Methadone
- ☐ Tegretol *Carbamazepine*
- ☐ Mobic *Meloxicam*
- ☐ Zanaflex *Tizanidine*
- ☐ Dilaudid *Hydromorphone*
- ☐ Elavil *Amitriptyline*
- ☐ Celebrex *Celecoxib*
- ☐ Flexeril *Cyclobenzaprine*
- ☐ Fentanyl
- ☐ Norpramin *Desipramine*
- ☐ Voltaren *Diclofenac*
- ☐ Skelaxin *Metaxalone*
- ☐ Suboxone
- ☐ Pamelor *Nortriptyline*
- ☐ Aspirin
- ☐ Robaxin *Methocarbamol*
- ☐ Butrans *Buprenorphine*
- ☐ Other: _____

Procedures Tried:

- ☐ Trigger point injection
- ☐ Bursa injection
- ☐ Genicular nerve block/ablation
- ☐ Piriformis injection
- ☐ Sacroiliac joint injection
- ☐ Sympathetic nerve block
- ☐ Psoas injection
- ☐ Epidural steroid Injection
- ☐ Intrathecal pump
- ☐ Hip injection
- ☐ Facet joint injection
- ☐ Vertebroplasty/kyphoplasty
- ☐ Shoulder injection
- ☐ Medial branch block
- ☐ Interspinous Spacer
- ☐ Knee injection
- ☐ Radiofrequency ablation
- ☐ Spinal cord stimulator
- ☐ Other: _____

Other Treatments Tried:

- ☐ Physical Therapy
- ☐ Acupuncture
- ☐ Behavioral modification
- ☐ Massage
- ☐ Chiropractor
- ☐ Biofeedback
- ☐ TENS Unit
- ☐ Aquatic exercise
- ☐ Yoga
- ☐ Pilates
- ☐ Mindfulness/meditation
- ☐ Other: _____

Medical History:

Do you take blood thinners or anticoagulants? ☐ Yes ☐ No

☐ Aspirin ☐ Plavix *Clopidogrel* ☐ Coumadin *Warfarin* ☐ Lovenox *Enoxaparin* ☐ Aggrenox

☐ Other: _____

Do you have diabetes? ☐ Yes ☐ No

Do you have an implantable device or pacemaker? ☐ Yes ☐ No

If yes, what device? _____

Have you had any recent infections? ☐ Yes ☐ No

If yes, what type? _____

Are you taking antibiotics? ☐ Yes ☐ No

Family History:

Do you have a family history of alcohol abuse? ☐ Yes ☐ No
Do you have a family history of illegal drug use? ☐ Yes ☐ No
Do you have a family history of prescription drug abuse? ☐ Yes ☐ No

Social and Psychological History:

Do you have a personal history of alcohol abuse? ☐ Yes ☐ No
Do you have a personal history of illegal drug use? ☐ Yes ☐ No
Do you have a personal history of prescription drug abuse? ☐ Yes ☐ No
Do you have a personal history of sexual, physical, or verbal abuse? ☐ Yes ☐ No
Do you have a history of ADD/ADHD, OCD, bipolar, or schizophrenia? ☐ Yes ☐ No
Do you have a history of depression? ☐ Yes ☐ No
Do you receive outpatient psychiatric treatment or have you ever been hospitalized for a psychiatric reason? ☐ Yes ☐ No
Have you ever used prescription medications inappropriately? ☐ Yes ☐ No
Do you use street drugs? ☐ Yes ☐ No
Do you ever have nightmares or flashbacks about traumatic experiences? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____
Are you currently taking any opioid/narcotic medications? ☐ Yes ☐ No
If yes, which medication(s)? _____

Please indicate if you suffer from any of the following symptoms:

Constitution	**Eyes**	**Gastrointestinal**	**Hematology**
☐ Fever/chills ☐ Weight loss ☐ Malaise/fatigue ☐ Weakness	☐ Blurred/changes to vision ☐ Sensitivity to light ☐ Eye pain ☐ Eye discharge	☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea ☐ Constipation ☐ Incontinence of stool	☐ Easy bruising ☐ Easy bleeding ☐ Blood clots
Skin	**Cardiovascular**	**Genitourinary**	**Neurological**
☐ Rash ☐ Itching	☐ Chest pain ☐ Palpitations ☐ Ankle/leg swelling ☐ Difficulty breathing when lying flat	☐ Painful urination ☐ Blood in urine ☐ Flank pain ☐ Incontinence of urine	☐ Dizziness/ lightheadedness ☐ Headaches ☐ Tingling ☐ Tremor ☐ Sensory change ☐ Focal weakness ☐ Seizures
Ears/Nose/Throat	**Respiratory**	**Musculoskeletal**	**Psychiatric**
☐ Hearing loss ☐ Ear pain ☐ Nose bleeds ☐ Sinus pain ☐ Sore throat ☐ Dry mouth	☐ Cough/cold ☐ Sputum production ☐ Shortness of breath ☐ Wheezing	☐ Muscle pains ☐ Neck pain ☐ Back pain ☐ Joint pain ☐ Recent falls ☐ Loss of height	☐ Depression ☐ Suicidal thoughts ☐ Hallucinations ☐ Anxiety ☐ Difficulty sleeping ☐ Memory loss

Other: _____

Signature: _____ Date: _____ Time: _____