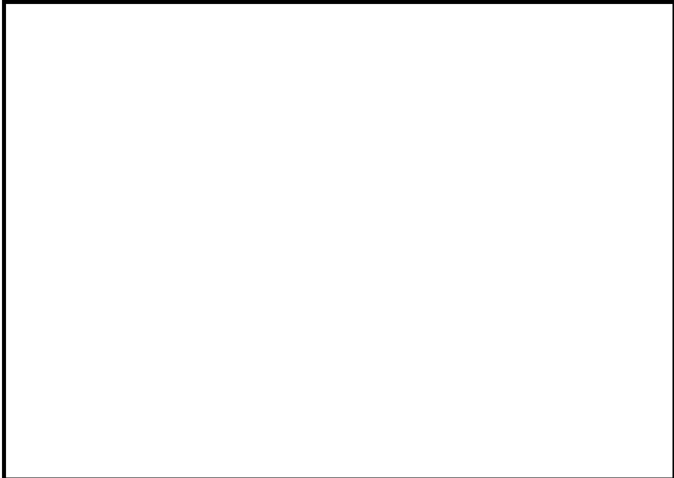
SUMNER PAIN CLINIC
HIGHPOINT HEALTH PARTNERS

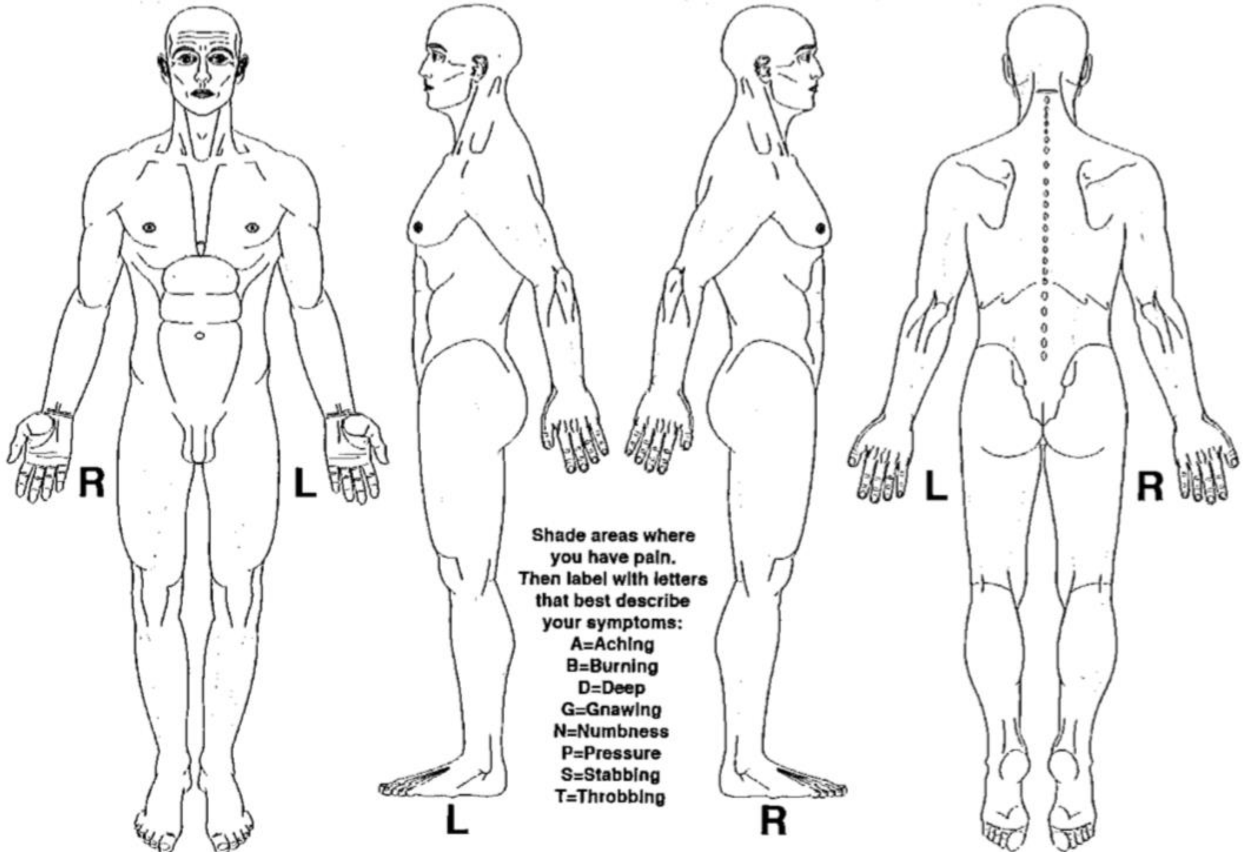


## New Patient Intake – Male

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**

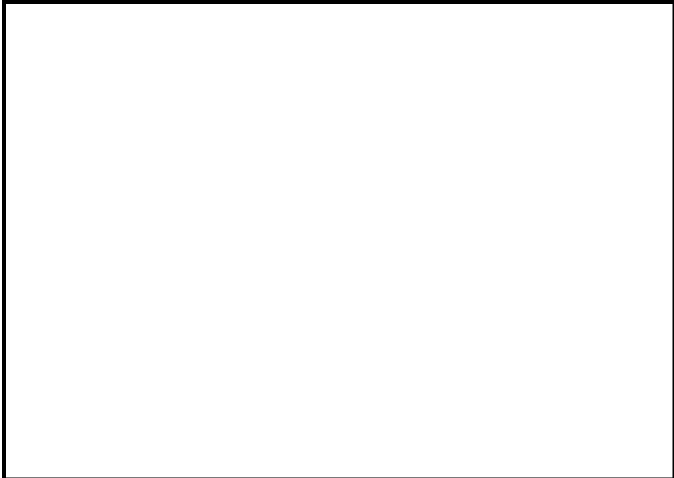
Pain score now: 0 1 2 3 4 5 6 7 8 9 10
Average pain score, last 24 hours: 0 1 2 3 4 5 6 7 8 9 10
Average pain score, last 3 months: 0 1 2 3 4 5 6 7 8 9 10

**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: ______________________________________



## New Patient Intake – Male

Name: ______________________________

### Medications Tried:

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

### Procedures Tried:

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

### Other Treatments Tried:

☐ Physical Therapy
☐ Massage
☐ TENS Unit
☐ Pilates
☐ Acupuncture
☐ Chiropractor
☐ Aquatic exercise
☐ Mindfulness
☐ Behavioral modification
☐ Biofeedback
☐ Yoga
☐ 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 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<br>☐ Weight loss<br>☐ Malaise/fatigue<br>☐ Weakness | ☐ Blurred/changes to vision<br>☐ Sensitivity to light<br>☐ Eye pain<br>☐ Eye discharge | ☐ Heartburn<br>☐ Nausea<br>☐ Vomiting<br>☐ Abdominal pain<br>☐ Diarrhea<br>☐ Constipation<br>☐ Incontinence of stool | ☐ Easy bruising<br>☐ Easy bleeding<br>☐ Blood clots |
| **Skin**<br>☐ Rash<br>☐ Itching | **Cardiovascular**<br>☐ Chest pain<br>☐ Palpitations<br>☐ Ankle/leg swelling<br>☐ Difficulty breathing when lying flat | **Genitourinary**<br>☐ Painful urination<br>☐ Blood in urine<br>☐ Flank pain<br>☐ Incontinence of urine | **Neurological**<br>☐ Dizziness/ lightheadedness<br>☐ Headaches<br>☐ Tingling<br>☐ Tremor<br>☐ Sensory change<br>☐ Focal weakness<br>☐ Seizures |
| **Ears/Nose/Throat**<br>☐ Hearing loss<br>☐ Ear pain<br>☐ Nose bleeds<br>☐ Sinus pain<br>☐ Sore throat<br>☐ Dry mouth | **Respiratory**<br>☐ Cough/cold<br>☐ Sputum production<br>☐ Shortness of breath<br>☐ Wheezing | **Musculoskeletal**<br>☐ Muscle pains<br>☐ Neck pain<br>☐ Back pain<br>☐ Joint pain<br>☐ Recent falls<br>☐ Loss of height | **Psychiatric**<br>☐ Depression<br>☐ Suicidal thoughts<br>☐ Hallucinations<br>☐ Anxiety<br>☐ Difficulty sleeping<br>☐ Memory loss |

Other: ____________________________________________

Signature: ______________________________ Date: ____________ Time: _______