HEADACHE & PAIN CENTER, AMC

Today's Date ________________

PATIENT INTAKE FORM

NAME ____ DOB__________________________

AGE ________ SEX ________ HEIGHT ________ WEIGHT ________

This form was read and completed by whom? _________________________________ (RELATIONSHIP)

HOME PHONE (_________) ____________________ WORK PHONE (_________) ____________________

CELL PHONE (_________) __________________________ Other: ______________________________

How did you find out about Headache & Pain Center? ______________________________________

Who referred you to us?____

Who is your primary care physician (family doctor / PCP)? __________________________________

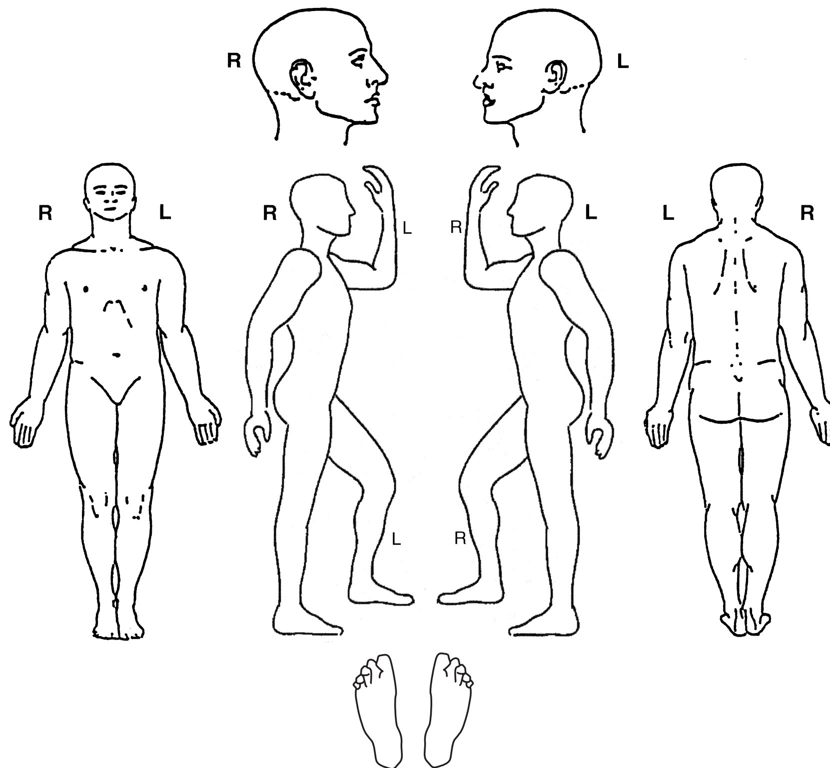
List your other current doctors: ____

To which doctors should we send our clinic notes? _______________________________________

Have you seen anyone else for this problem (doctors, therapists, chiropractors)? Who? ______________

____

PLEASE **SHADE** IN, ON THE DRAWINGS BELOW, THE AREAS WHERE YOU FEEL PAIN.



When did your pain begin? ______________________________

How did your problem start? (ACCIDENT, GRADUAL ONSET, ETC.) ______________________________

____

If it was an accident, briefly describe: ______________________________

PLEASE CIRCLE WHICH TREATMENTS YOU HAVE HAD FOR PAIN:

	DATE	HELPFUL	BY WHOM
EPIDURALS / NERVE BLOCKS / Other INJECTIONS (describe)		Y / N	
Spine or Joint Surgery		Y / N	
Therapy (Physical, Occupational, other)		Y / N	
TENS / Neuromuscular Stimulator		Y / N	
Chiropractor		Y / N	
Biofeedback / Counseling		Y / N	
Acupuncture		Y / N	
OTHER:		Y / N	

WHICH OF THE FOLLOWING TESTS HAVE YOU HAD TO EVALUATE YOUR PAIN?

TEST	**DATE DONE***	**WHAT PART OF BODY***	**WHAT FACILITY***	**RESULTS IF KNOWN***
MRI				
CAT (CT) SCAN				
X-RAY				
EMG (TEST FOR NERVE DAMAGE)				
MYELOGRAM				
BONE SCAN				
LABORATORY (BLOOD TESTS)				
BONE DENSITY				
Other:				

***Please answer completely to the best of your knowledge.**

Do you have a living will? Y N *If yes, please supply us with a copy.

Do you have a cane, walker, wheelchair, scooter, special shoes or braces? Y N

If yes, explain: ______________________________

Do you have metal implants, orthodontic braces, metal piercings, or tattoos? Y N

If yes, explain: ______________________________

Are you pregnant or plan to become pregnant? Y N

MEDICATIONS

What **medications** are you taking **now**? **Include prescriptions, vitamins, herbal supplements, & over the counter medications.**

MEDICATION & Dose	How do you take it?	WHY PRESCRIBED?	**DOCTOR** WHO PRESCRIBED IT

Pharmacy name and location: ________________________ **(area code) and phone #:**________________

Are you on any of the following over the counter medications? (Circle) Aspirin, Angelica, Cloves, Danshen, Dong Quai, Feverfew, Garlic, Ginger, Ginko Biloba, Ginseng, Glucosamine, Green Tea, Horse Chestnut, Red Clover, St. John's Wort, Turmeric, Vitamin E

Are you taking any **BLOOD THINNERS?** Circle all that apply **(Aggrenox, Persantine – dipyridamole; Coumadin, Jantoven-Warfarin; Plavix – clopidogrel; Ticlid – ticlopidine, Pletal – cilostazol, Effient – prasugrel)? Why?** ____

LIST Medications tried in the past for pain or headaches that **did not** work:

____

Are you **ALLERGIC** to medications, foods, or latex?

What medicine:	What happens? (ie: rash, swollen throat, can't breathe, etc.):	What medicine:	What happens?

MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD OR PRESENTLY HAVE

- ☐ Pacemaker
- ☐ Diabetes
  - Diet Controlled? Y / N
  - Do you take insulin? Y / N
  - Oral Medications? Y / N
- ☐ Heart Failure
- ☐ Irregular Heart Beat (explain type______________)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Easy Bleeding
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Cancer Type ________________
  - Has it spread? Y / N
  - Where? ________________
- ☐ Sleep Apnea
- ☐ Ulcers / Gastric reflux
- ☐ Kidney problems (describe:________________)
- ☐ Lung problems (COPD, Emphysema, Asthma)
- ☐ Current / recent infection
- ☐ Other medical problems or diseases: ________________

HEADACHE & PAIN CENTER, AMC
HEADACHE QUESTIONS

PLEASE FILL OUT IF YOU HAVE HEADACHES.

1. ____________________ Is this the worst headache of your life?

2. ____________________ How frequently do you have headaches; has the severity or frequency increased?

3. ____________________ Was this a sudden headache that woke you from sleep?

4. ____________________ Where are your headaches located?

5. ____________________ Have you or a loved one noticed disorientation, memory problems, etc.? Explain____

6. ____________________ What time of day do your headaches start?

7. ____________________ Does it start with exertion (i.e. bowel movement, straining, exercise)?

8. ____________________ From the beginning of the headache, how long does it take to reach maximum intensity (minutes, hours, etc.)?

9. ____________________ How long do your headaches last?

10. ____________________ Do you notice any symptoms before the headache begins ("aura")? Please explain "aura". ____________________________________

11. ____________________ How would you characterize the headache pain? Is it burning, shooting, sharp, dull, pounding or other?

12. ____________________ Does anything help the headache?

13. ____________________ List of medications you are (if not yet listed) presently taking or have taken for headaches: _________________________

14. ____________________ List other therapies for your headaches: _________________________

15. ____________________ Do you have family members who experience headaches: ______________________

16. ____________________ Are the headaches a sudden onset after the age of 50?

17. ____________________ Do you experience any of the symptoms listed below during your headache?

	(Please Circle)			(Please Circle)	
Neck Stiffness	Yes	No	Tingling	Yes	No
Dizziness	Yes	No	Sensitivity to Light	Yes	No
Vomiting	Yes	No	Sensitivity to Noise	Yes	No
Numbness	Yes	No	Need to Walk or Move Around	Yes	No
Confusion	Yes	No	Disorientation	Yes	No

HEADACHE & PAIN CENTER, AMC

APPOINTMENT DATE: ____________________ TIME: ______________

PATIENT'S NAME ____

SPOUSE'S NAME ____

MAILING ADDRESS ____
STREET

____
CITY STATE ZIP

SEX_____ DATE OF BIRTH ____________ AGE _________ PHONE # (______)__________
(AREA CODE)

PATIENT EMPLOYER: ______________________________ PHONE # (______)__________
(AREA CODE)

Self Employed: Y N (Circle One)

Business address: ____________________ Occupation: ____________________

Guarantor's Name: ____________________ Guarantor's Date of Birth: ______________

Guarantor's Employer: ____

Relative or neighbor not Living with You: ________________ Phone #: ________________

NOTIFY IN CASE OF EMERGENCY - Name ______________ Relationship ______________

Phone # (______)__________ Address ________________________________
(AREA CODE)

PERSONAL PHYSICIAN: ____
FIRST & LAST NAME

WAS THIS CONDITION DUE TO AN ACCIDENT? ______________ **YES** ______________ **NO**

IF YES, PLEASE COMPLETE THE FOLLOWING:

DATE OF ACCIDENT: ____

Are you covered by WORKMAN'S COMPENSATION? ______________ **YES** ______________ **NO**

IF YES, THROUGH WHOM? ____

Is There a Current Law Suit or Liability Case? ______________ **YES** ______________ **NO**

IF YES, ADJUSTOR OR LAWYER ____