NEW YORK PAIN MEDICINE AND PHYSICAL THERAPY

New York Pain Medicine and Physical Therapy Intake

Date:_____

Name:_____SS#:_____DOB:_____

Address:_____

City:_____State:_____Zip:_____

Home phone:_____Work:_____Cell:_____

Email:_____ Age:_____ Marital Status: S M D W P

Occupation:_____ Employer Name:_____

In Case of Emergency Contact:_____ Phone:_____

Referring Physician:_____ Phone:_____

Primary Care Physician:_____ Phone::_____

Primary Care Phyisican Address:_____

Where is your primary pain? _____

When, where and how did this problem start?_____
_____

How would you describe your pain? (Circle all that apply)
Aching Burning Dull Pins and Needles Shooting Sharp Stabbing Tingling Throbbing
Other:_____

What makes your pain **INCREASE**? (Circle all that apply)
Morning Evening Cold Heat Standing Stairs Walking Weather Sitting Exercise
Other:_____

What makes your pain **DECREASE**? (Circle all that apply)
Rest Cold Heat Exercise Walking Sitting Standing Medication Leaning Exercise
Other:_____

How long can you sit?_____stand?_____walk?_____

How many city blocks can you walk without discomfort?_____

Past Medical History (list ALL conditions that you have been diagnosed with)
_____
_____

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Past Surgical History

_____

_____

Allergies (including contrast material)

_____

Current medications

_____

_____

Have you tried any PAIN MEDICATIONS in the past (be specific with dosages)

_____

Please circle yes or no, add/circle additional information as needed

General			**GI/GU**		
Weakness/fatigue	Yes	No	Ulcers	Yes	No
Fever	Yes	No	Heartburn	Yes	No
Chills	Yes	No	Diarrhea	Yes	No
Sweats	Yes	No	Constipation	Yes	No
Sleeplessness	Yes	No	UTI	Yes	No
Poor Coordination	Yes	No	Incontinence- Bladder or Bowel?	Yes	No
Heart/Circulation			**Hematology**		
High blood pressure	Yes	No	Anemia	Yes	No
Heart attack	Yes	No	Bleeding disorder	Yes	No
Coronary artery disease	Yes	No	Easy bruising	Yes	No
Rheumatic heart disease	Yes	No	Hepatitis	Yes	No
Heart murmur	Yes	No			
Valve disease	Yes	No	**Musculoskeletal**		
Chest pain	Yes	No	Muscle weakness	Yes	No
Ankle swelling	Yes	No	Joint pain	Yes	No
Deep vein thrombosis	Yes	No	Arthritis- Osteoarthritis or Rheumatoid?	Yes	No
			Muscle cramps	Yes	No
Lungs/Breathing			Osteoporosis or Osteopenia?	Yes	No
Asthma- Exercise or Allergy induced?	Yes	No			
Pneumonia	Yes	No	**Neuromuscular**		
Bronchitis	Yes	No	Seizures	Yes	No
Cough	Yes	No	Numbness	Yes	No
Shortness of breath	Yes	No	Tingling	Yes	No
Emphysema	Yes	No	Weakness	Yes	No
Tuberculosis	Yes	No			
Abnormal chest xray	Yes	No	**Social**		
			Drug use	Yes	No
Endocrine			Smoking	Yes	No
Thyroid- Hypothyroidism or Hyperthyroidism?	Yes	No	Alchohol	Yes	No
Diabetes	Yes	No	Exercise regularly	Yes	No
Do you require insulin?	Yes	No			

Other:_____