



New Patient Intake Form

Your completed intake paperwork helps Dr. Webb get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (678) 383-7246 if you have any question on how to complete any section on this form.

Patient Information

Today's date: _____

Your name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

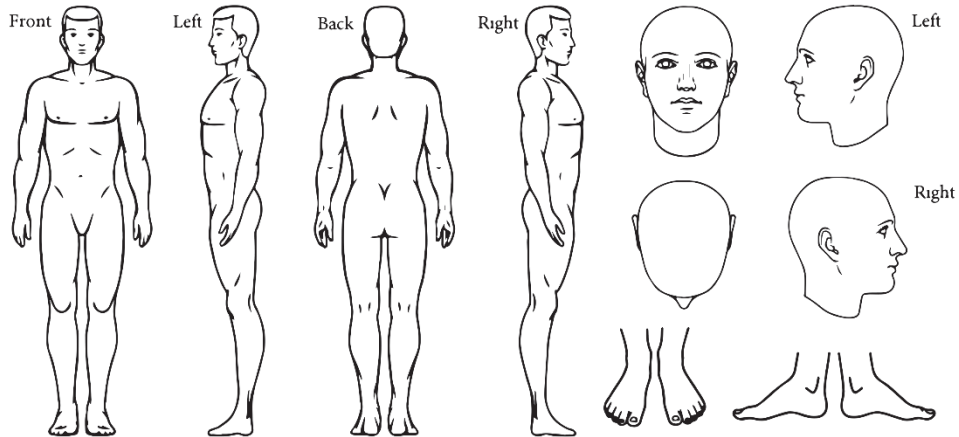
Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? Gradually Suddenly

Since your pain began how has it changed? Improved Worsened Stayed the same

Pain Description

Check all of the following that describe your pain:

- Dull/Aching Hot/Burning Shooting Stabbing/Sharp
- Cramping Numbness Spasming Throbbing
- Squeezing Tingling/Pins and Needles Tightness

When is your pain at its worst?

- Mornings Daytime Evenings Middle of the night
- Always the same

How often does the pain occur?

- Constant Changes in severity but always present
- Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now _____ The Best It Gets _____ The Worst It Gets _____

Mark the effect each of the following have on your pain level -

	<u>Increases</u>	<u>Decreases</u>	<u>No Change</u>
Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in Weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking upward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking downward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from seated position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What other factors worsen or affect your pain which is not mentioned above?

Associated Symptoms

	<u>NO</u>	<u>Yes</u>	<u>Comments</u>
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____
Weakness in the arm/leg	<input type="checkbox"/>	<input type="checkbox"/>	_____
Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fevers/chills	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please mark all of the following treatments you have used for pain relief:

	<u>No Change</u>	<u>Worsened Pain</u>	<u>Helped Pain</u>
Spine Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brace Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot/Cold Packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			

Interventional Pain Treatment History

- Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
- Joint Injection – Joint(s) _____
- Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
- MILD (Minimally Invasive Lumbar Decompression) - _____
- Nerve Blocks – Area/Nerve(s) - _____
- Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar
- Spinal Cord Stimulator – Trial Only/Permanent Implant _____
- Trigger Point Injections – Where? _____
- Vertebroplasty/Kyphoplasty – Level(s) _____
- Other - _____

Which of these procedures listed above have helped with your pain? _____

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

- MRI of the: _____ Date: _____
- X-Ray of the: _____ Date: _____
- CT Scan of the: _____ Date: _____
- EMG/NCV study of the: _____ Date: _____
- Other Diagnostic Testing: _____ Date: _____

I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

- Acupuncturist Neurosurgeon Psychiatrist/Psychologist
- Chiropractor Orthopedic Surgeon Rheumatologist
- Internist Physical Therapist Neurologist
- Other _____

Past Medical History

Please list the names of other Pain Physicians you have seen in the past? _____

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

- Cancer - Type _____
- Diabetes - Type _____

Head/Ears/Eyes/Nose/Throat

- Headaches
- Migraines
- Head Injury
- Hyperthyroidism
- Hypothyroidism
- Glaucoma

Cardiovascular/Hematologic

- Anemia
- Heart Attack
- Coronary Artery Disease
- High Blood Pressure
- Peripheral Vascular Disease
- Stroke/TIA
- Heart Valve Disorders

Respiratory

- Asthma
- Bronchitis/Pneumonia
- Emphysema/COPD

Gastrointestinal

- GERD (Acid Reflux)
- Gastrointestinal Bleeding
- Stomach Ulcers
- Constipation

Musculoskeletal/Rheumatologic

- Bursitis
- Carpal Tunnel Syndrome
- Fibromyalgia
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Chronic Joint Pains

Urological

- Chronic Kidney Disease
- Kidney Stones
- Urinary Incontinence
- Dialysis

Other Diagnosed Conditions

- _____
- _____
- _____
- _____
- _____
- _____

Neuropsychological

- Multiple Sclerosis
- Peripheral Neuropathy
- Seizures
- Depression
- Anxiety
- Schizophrenia
- Bipolar Disorder

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

- 1) _____ Date? _____
- 2) _____ Date? _____
- 3) _____ Date? _____
- 4) _____ Date? _____
- 5) _____ Date? _____

I have **NEVER** had any surgical procedures performed.

Current Medications

Are you currently taking any blood thinners or anti-coagulants? YES No

If **YES**, which ones? Aspirin Plavix Coumadin Lovenox Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____
10) _____	_____	_____

Please list all past pain medications that you have been on at any point for your current pain complaints?

<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

Allergies

Do you have any drug/medication allergies?

Yes

No

If so, please list all medications you are allergic to:

<u>Medication Name</u>	<u>Allergic Reaction</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Topical Allergies:

Latex

Iodine

Tape

IV Contrast

Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

Arthritis

Cancer

Diabetes

Headaches/Migraines

High Blood Pressure

Kidney Problems

Liver Problems

Osteoporosis

Rheumatoid arthritis

Seizures

Stroke

Other Medical Problems: _____

I have no significant family medical history

Social History

Occupation: _____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home? _____ If so how many? _____

Temporary Disability

Permanent Disability

Retired

Unemployed

Are you currently under worker's compensation? No

Yes

Is there an ongoing lawsuit related to your visit today? No

Yes

Alcohol Use:

Social Use

History of alcoholism

Current alcoholism

Never

Daily use of alcohol

Tobacco Use:

Current user

Former user

Never used

Packs per day? _____

How many years? _____

Quit Date: _____

Illegal Drug Use:

Denies any illegal drug use Currently uses illegal drugs

Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications?

Yes

No

R**Mark the following symptoms that you currently suffer from:**

Constitutional:	<input type="checkbox"/> Chills	<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Easy bruising
	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fevers
	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Low sex drive	<input type="checkbox"/> Tremors
	<input type="checkbox"/> Unexplained Weight Gain		<input type="checkbox"/> Weakness
	<input type="checkbox"/> Unexplained Weight Loss		

Eyes:	<input type="checkbox"/> Recent Visual changes
--------------	--

Ears/Nose/Throat/Neck:	<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Earaches	<input type="checkbox"/> Hearing Problems
	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sinus problems	

Cardiovascular:	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Blood Clots
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Swelling in feet
	<input type="checkbox"/> Shortness of breath during sleep		

Respiratory:	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of breath
---------------------	--------------------------------	-----------------------------------	--

Gastrointestinal:	<input type="checkbox"/> Constipation	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Abdominal Cramps
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Hernia

Musculoskeletal:	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Joint Pains	<input type="checkbox"/> Joint Stiffness
	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> muscle spasms	<input type="checkbox"/> Neck Pain

Genitourinary/Nephrology:	<input type="checkbox"/> Flank Pain	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Painful Urination
	<input type="checkbox"/> Decreased Urine Flow/Frequency/Volume		

Neurological:	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Tremors
	<input type="checkbox"/> Numbness/Tingling		<input type="checkbox"/> Seizures

Psychiatric:	<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Feeling Anxious	<input type="checkbox"/> Stress Problems
	<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Suicidal Planning	
	<input type="checkbox"/> Thoughts of Harming Others		

 All other review of systems negative Reviewer _____