Round Rock| South Austin| Central Austin| Cedar Park| Georgetown| Waco| Killeen| Amarillo
Phone: (512) 244-4272 | Fax: (512) 244-2895 | www.austinpaindoctor.com

New Patient Intake

Patient's Name: Date of Birth:

Date of Visit: Location of Care:

Please take a few minutes to fill out this medical intake to facilitate your appointment today.

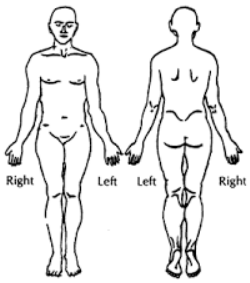
About Your Pain:

Chief Complaint (Reason for visit) :_____

_____

Where is the exact location of your pain today? _____

_____



Please shade where it hurts

When did you first have this pain?_____

Describe your pain (aching, burning, cramping, etc.):_____

Is the pain constant? ☐ Yes | ☐ No How long does the pain last?_____

Rate your pain: No Pain- 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10- Worst Pain ○

Rate your pain with meds (if applicable): 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

What makes you pain worse?_____Better?_____

What medication are you taking for pain (if applicable)?_____

What medications have you tried in the past?_____

What previous treatments for this pain?_____

Have you tried Physical Therapy? ☐ Yes | ☐ No When?_____

Have you been treated by a previous Pain Specialist? ☐ Yes | ☐ No When?_____ By who?_____

Any previous diagnoses for this pain by any doctor?_____

Past Medical History

Type of Surgery	Details	Date and Hospital

Hospitalizations other than surgery (include date and facility name):_____

_____

Condition/ Diagnosis	Details	Treating Physician

Any details:_____

_____

Type of Imaging	Body Part	Facility Name

Medication History

Name of Medication	Dose	How often do you take it?	What is it for?

Do you have any medication/ drug allergies? Please list:_____

_____

Social History

Any tobacco use? ☐ Yes | ☐ No Packs per day _____ for _____ years.

Any alcohol use? ☐ Yes | ☐ No Drinks per day _____ for _____ years.

Any recreational drug use? ☐ Yes | ☐ No Drugs used_____

Any special diet? ☐ Lactose free ☐ Caffeine Free ☐ Diabetic ☐ Vegetarian ☐ Vegan ☐ Other _____

Marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widow/ Widower Are you currently working? ☐ Yes | ☐ No

If no: Who took you off work?_____ If yes: What is your occupation?_____

When did you stop working (if applicable)? _____

Family History

Has your mother ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____

Has your father ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____

Have any of your siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____

Have any of your children ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____

Has your mother's parents ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____

Has your mother's siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____

Has your father's parents ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____

Has your father's siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____

Any other family history and relation to you:_____

Review of Systems

	Y	N		Y	N		Y	N
GENERAL			**CARDIOVASCULAR**			**MUSCUSKELETAL**		
Decreased Appetite	☐	☐	Chest Pain/Angina	☐	☐	Joint Pain/Arthritis	☐	☐
Unexpected Weight Loss	☐	☐	Coronary Artery Disease	☐	☐	Back or Neck Pain	☐	☐
Unexpected Weight Gain	☐	☐	High Blood Pressure	☐	☐	Muscle Aching/Weakness	☐	☐
Fatigue	☐	☐	Swelling in the Feet or Legs	☐	☐	Other	☐	☐
Fever or Chills	☐	☐	Abnormal Heart Rhythm	☐	☐	**GASTROINTESTINAL**		
HIV	☐	☐	Other	☐	☐	Constipation	☐	☐
STD	☐	☐	**ENDOCRINE**			Nausea	☐	☐
Other	☐	☐	Diabetes	☐	☐	Heartburn/Regurgitation	☐	☐
SKIN			Thyroid Disease	☐	☐	Vomiting	☐	☐
Rash	☐	☐	Osteoporosis/Osteopenia	☐	☐	Abdominal Pain	☐	☐
Itching	☐	☐	Other	☐	☐	Irregular Bowel Habits	☐	☐
Unusual Hair Loss	☐	☐	**RENAL/URINARY/KIDNEY**			Jaundice	☐	☐
Other	☐	☐	Renal Failure/Insufficiency	☐	☐	Gallstones	☐	☐
EYES			Kidney Stones	☐	☐	Cirrhosis	☐	☐
Blind Field of Vision	☐	☐	UTI	☐	☐	Hepatitis A, B, C, or Other	☐	☐
Cataracts	☐	☐	Difficulty Urinating	☐	☐	Fluid in Abdomen	☐	☐
Other	☐	☐	Enlarged Prostrate	☐	☐	Pancreatitis	☐	☐
EARS/NOSE/THROAT			Electrolyte Disturbances	☐	☐	Other	☐	☐
Hearing Loss/Ringing	☐	☐	Other	☐	☐	**BLOOD/LYMPH**		
Sore Throat/Hoarseness	☐	☐	**PSYCHOLOGICAL**			Anemia	☐	☐
Sinus Drainage	☐	☐	Depression	☐	☐	Bruise Easily	☐	☐
Other	☐	☐	Sleep Disturbance	☐	☐	Past Blood Transfers	☐	☐
RESPIRATORY			Anxiety	☐	☐	Swollen/Tender Lymph Nodes	☐	☐
Sleep Apnea	☐	☐	Suicide Attempt/Thoughts	☐	☐	Other	☐	☐
Complications with Sedation	☐	☐	Drug Abuse/Dependence	☐	☐	**NEUROLOGICAL**		
Chronic Bronchitis	☐	☐	Addiction	☐	☐	Headaches	☐	☐
Emphysema	☐	☐	Other	☐	☐	Stroke/CVA	☐	☐
Difficult Breathing	☐	☐	**GYNECOLOGY**			Seizures	☐	☐
Persistent Coughing	☐	☐	Pregnancy	☐	☐	Other	☐	☐
Asthma	☐	☐	Endometriosis	☐	☐			
Other	☐	☐	Heavy Periods	☐	☐			

Patient Signature Employee's Initials Provider's Initials