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:

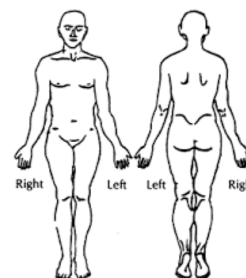
Chief Complaint (Reason for visit) :____

____

Where is the exact location of your pain today? ____________________________________

____

When did you first have this pain?____



Please shade where it hurts

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 your 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?	Who prescribes it?

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			**GASTROINTESTINAL**			**HEENT**		
Decreased Appetite			Nausea / Vomiting			Blind Field of Vision		
Unexpected Weight Loss			Abdominal Pain			Cataracts		
Unexpected Weight Gain			Irregular Bowel Habits			Hearing Loss / Ringing		
Fatigue			Loss of Control of Bowels			Sore Throat / Hoarseness		
Fever or Chills			Jaundice			Other		
Other			Gallstones			**MUSCOLOSKELETAL**		
NEURO			Hepatitis			Joint Pain / Arthritis		
Headache			Cirrhosis			Back Pain		
Strokes / CVA			Fluid In Abdomen			Neck Pain		
Seizures			Pancreatitis			Muscle Aching		
Other			Other			Other		
RENAL/URINARY			**CARDIOVASCULAR**			**PSYCH**		
Renal Failure/Insufficiency			Chest Pain			Drug Abuse / Addiction		
Electrolyte Disturbances			Coronary Artery Disease			Depression		
Kidney Stones			High Blood Pressure			Anxiety		
Difficulty Urinating			Swelling In Feet			Suicide Attempt		
UTI			Abnormal Headaches			Other		
Prostate Cancer			Other					
Other			**BLOOD/LYMPH**					
RESPIRATORY			Anemia					
Sleep Apnea			HIV					
Complications with Sedation			Bruise Easily					
Chronic Bronchitis			Past Blood Transfusion					
Difficult Breathing			Swollen / Tender Lymph Nodes					
Persistent Coughing			Cancer					
Asthma			Other					
Other			**ENDOCRINE**					
SKIN			Diabetes					
Rash			Thyroid Problems					
Itching			Osteoporosis					
Unusual Hair			Other					

Patient Signature | Employee's Initials | Provider's Initials