balcones
PAIN CONSULTANTS

Patient Intake Form

Please complete the following:

Name:

_____Date_____

What is your average pain level?

0(no pain)>10(worst pain imaginable)

Without Meds: _____

With Meds: _____

Comfort level: Poor Fair Good

Functional Status: Poor Fair Good

Since your last visit, pain is: Same Better Worse

Date of last injection:_____

Did it help? Yes No

For how long? _____

Additional Problems/Notes:

_____

_____

Comments/Questions for this visit:

_____

_____

_____

_____ _____

Signature Date

Review of Systems:

PLEASE CHECK ONLY THOSE THAT APPLY TO TODAY

GENERAL:
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Dry Mouth
- ☐ Fatigue
- ☐ Fever

SKIN
- ☐ Itching
- ☐ New Lesions
- ☐ Rash

HEENT
- ☐ Blurred Vision
- ☐ Headache
- ☐ Nasal Congestion
- ☐ Sinus Pain
- ☐ Sore Throat

NECK
- ☐ Neck Pain
- ☐ Neck Stiffness

RESPIRATORY:
- ☐ Cough
- ☐ Snoring
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Bloody Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY
- ☐ Flank Pain
- ☐ Frequency
- ☐ Incontinence
- ☐ Painful Urination
- ☐ Urgency

MALE (ONLY)
- ☐ Impotence
- ☐ Testicular pain

MUSCULOSKELATAL:
- ☐ Leg Cramps
- ☐ Back Pain
- ☐ Calf Pain
- ☐ Decreased ROM
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness

MUSCULOSKELATAL:
- ☐ Joint Swelling
- ☐ Muscle Atrophy
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Swelling of Extremities

NEURO:
- ☐ Dizziness
- ☐ Paresthesias
- ☐ Unusual Sensation
- ☐ Weakness

PSYCH:
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Changes
- ☐ Insomnia
- ☐ Suicidal Ideation
- ☐ Suicidal Planning
- ☐ Previous Suicide Attempts

ENDOCRINE:
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Libido Change
- ☐ Thyroid Problems

Shade in the area where you have pain: