Valley Multi-Specialty Surgery Center
7012 Reseda Blvd., Ste. D, Reseda, CA 91335
818.996.2666 818.342-3937(fax)

Pain Management Comprehensive Intake Form

Personal Information

Name: ______ Date of Birth: ______ Age: ______ Sex: ______

Weight: ______ Height: ______ Hm Ph: ______ Cell Ph: ______ Wk Ph: ______

eMail: ______

In Case of Emergency > Notify: Name: ______ Relationship: ______

Primary Doctor: ______ Referring Doctor: ______

Date of Service: ______ **Time of Service:** ______ : ______ ❍ AM ❍ PM

CHIEF COMPLAINT (S): ______

HISTORY OF PRESENT ILLNESS (HPI)

(Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated Signs/Symptoms 1 - 3 brief 4+ extended)

MEDICAL HISTORY:

Have you ever had, or been told you have (check all that apply):

Cardiovascular:
- [ ] Chest Pain or Angina
- [ ] Heart Disease
- [ ] MI, Heart Attack, Blocked Artery
- [ ] Congestive Heart Failure
- [ ] High Blood Pressure
- [ ] Peripheral Vascular Disease
- [ ] Abnormal Heart Beat
- [ ] Pacemaker
- [ ] Angioplasty or Heart Catheter
- [ ] Rheumatic Fever
- [ ] Damaged Heart Valve

Neurological:
- [ ] Epilepsy or Seizures
- [ ] Fainting Spells or Dizziness
- [ ] Stroke Type: ______
- [ ] Headaches/Migraines

Gastrointestinal:
- [ ] Ulcers, Heartburn, Reflux
- [ ] Diverticulitis, Colitis
- [ ] Other: ______

Cancer: ❍ No ❍ Yes
Type: ______

Respiratory:
- [ ] Asthma
- [ ] Shortness of Breath
- [ ] Emphysema
- [ ] Tuberculosis
- [ ] Smoking ❍ Now ❍ Past
  ______ cigarettes per day

Metabolic:
- [ ] Diabetes Type: ______
- [ ] Thyroid Disease
- [ ] Adrenal Gland Problem
- [ ] Steroid Use Type: ______

Liver / Kidney / Blood:
- [ ] Kidney Disease
- [ ] Shunt, Graft, Fistula
- [ ] Dialysis
- [ ] Liver Disease
- [ ] Gallbladder
- [ ] Hepatitis Type: ______

Other:
- [ ] Chronic Numbness or Pain
- [ ] Depression or Anxiety
- [ ] Other Nervous Problem Type: ______
- [ ] Anticoagulants (Blood Thinners)
- [ ] Back Injury I Nerve Damage
- [ ] Skin Condition
- [ ] Arthritis Rheumatism

- [ ] Dentures
- [ ] Partial Denture Plates
- [ ] Prescription Glasses
- [ ] Hearing Aid

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SOCIAL/FAMILY HISTORY: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Domestic

MOTHER [ ] Living [ ] Deceased Cause:
FATHER [ ] Living [ ] Deceased Cause:

USUAL DIET: ____________________
SLEEP (AVERAGE HRS):
ALCOHOL: __________ drinks per day DRUG USE: Describe: ____________________

CURRENT EMPLOYMENT STATUS
[ ] Employed Full Time [ ] Employed Part Time [ ] Self Employed
[ ] Unemployed Due to Pain [ ] Unemployed for Other Reason [ ] Applied for Disability

OCCUPATION: ____________________

Are there legal / occupational issues pending in regard to your pain? ❍ yes ❍ no

With whom do you live? (check all that apply)
[ ] Self [ ] Spouse [ ] Children [ ] Parents [ ] Friends [ ] Other

ALLIERGIES: **REACTION:**

____
____

Have you or any blood relatives ever had a reaction to anesthesia? ❍ yes ❍ no

Have you had any problems with surgery? ❍ yes ❍ no

PREVIOUS SURGERIES: (include date)

PREVIOUS SURGERIES: (include date)

MEDICATIONS (Prescriptions, OTC, Vitamins, Herbals)	DOSAGE (Per Day)	MEDICATIONS (Prescriptions, OTC, Vitamins, Herbals)	DOSAGE (Per Day)
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

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FAMILY HISTORY (Document Diseases Related to the Chief Complaint(s), History of Present Illnesses, or Review of Systems, Hereditary or High Risk Diseases for the Patient's Parents, Siblings and/or Children)

____

____

____

REVIEW OF SYSTEMS I Symptoms

Please check the box if you currently experience any of the following:

[ ] Fever, Weight Loss, Stress
[ ] Cough, Sputum Production, Wheezing
[ ] Shortness of Breath
[ ] Weakness or Paralysis of Arms or Legs
[ ] Headache (s) (how often?) ________________
[ ] Dizziness, Vision Changes, Light-headedness
[ ] Pregnancy or Possibly Pregnant
[ ] Swelling or Rash
[ ] Abdominal Pain
[ ] Change in Bowel Habits, Nausea
[ ] Chest Pain, Palpitations
[ ] Easy Bruising, Bleeding, Using Blood Thinners
[ ] Change in Bladder Habits (frequency, pain)

REVIEW OF SYSTEMS I Physician

DOCUMENT Problems, Signs, Symptoms, Conditions and/or Diagnosis PRESENT ON ADMISSION

Provide comment on ALL "yes" responses

Yes	No	
❍	❍	Constitutional
❍	❍	Eyes
❍	❍	Ears, Nose, Throat
❍	❍	Cardiovascular
❍	❍	Integumentary (Skin & Breast)

Yes	No	
❍	❍	Neurological
❍	❍	Psychiatric
❍	❍	Endocrine
❍	❍	Respiratory
❍	❍	Gastrointestinal

Yes	No	
❍	❍	Genitourinary
❍	❍	Musculoskeletal
❍	❍	Hematologic/Lymphatic
❍	❍	Allergy/Immunology

Last Menstrual Period ___/___/___

❍ ALL other systems reviewed and negative

REVIEW OF SYSTEMS I COMMENTS

____

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HISTORY & PHYSICAL I Interview

Where is your pain? ______________________________

Does it go anywhere else? ❍ Yes ❍ No Where? ______________________________

When did it start? ______________________________

How long have you had this pain? ______________________________

Did it start: ❍ gradually ❍ suddenly ❍ don't know

How often do you have this pain? ❍ continuously ❍ comes and goes

How often? _____ minutes _____ hours _____ times a day _____ times a week

Is your pain: _____ getting better _____ getting worse _____ staying the same

How did your pain start?

_____ accident (date: ___/___/___)

_____ work injury (date: ___/___/___)

_____ other injury (describe: ____________________)

_____ no obvious cause

_____ after surgery (describe: ____________________)

_____ cancer (what type: ____________________)

_____ other (describe: ____________________)

What makes your pain less?

_____ sitting _____ standing _____ walking

_____ laying down _____ heat _____ cold

_____ exercise _____ stretching _____ brace

_____ immobilization _____ other ______________________________

What treatments have you tried to alleviate your pain?

_____ exercise _____ accupuncture _____ warm pack

_____ biofeedback _____ psychology _____ massage

_____ brace _____ ice pack _____ TENS unit

_____ psychiatry _____ chiropractic _____ physical therapy

_____ herbal meds _____ hypnosis _____ traction

_____ marijuana _____ surgery