

The Pain Center of Central Florida, P.A.  
Intake Evaluation form

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Last

First

Middle Initial

Date of Birth: \_\_\_\_\_

**Chief Complaint(s):**

- 1) Your chief complaint(s) are: (Circle all that apply) Neck pain Mid-back pain Low-back pain  
Right arm pain Left arm pain Right leg pain Left leg pain Headache Other \_\_\_\_\_
- 2) Do you currently have a headache? \_\_\_ Yes \_\_\_ No  
a. If "Yes" are they: (Circle the one that applies) Mild Moderate Severe
- 3) Your worst pain is in the following areas: Neck Mid-back Low-back Right arm Left arm  
Right leg Left leg Other \_\_\_\_\_
- 4) Do you currently have a fracture? \_\_\_ Yes \_\_\_ No  
a. If "Yes" Please indicate what type of fracture: \_\_\_\_\_
- 5) Do you currently have tingling? \_\_\_ Yes \_\_\_ No
- 6) If "Yes" Please indicate which of the following areas: (Circle all that apply) Neck Mid-back Low-back  
Right arm Left arm Right leg Left leg Other \_\_\_\_\_
- 7) Do you currently have weakness in any of the following areas? (Circle all that apply) Neck Mid-back  
Low-back Right arm Left arm Right leg Left leg Other \_\_\_\_\_
- 8) Do you currently have stiffness of the joints in any of the following areas? (Circle all that apply) Neck  
Mid-back Low-back Right arm Left arm Right leg Left leg Other \_\_\_\_\_
- 9) Do you currently have numbness in any of the following areas? (Circle all that apply) Neck Mid-back  
Low-back Right arm Left arm Right leg Left leg Other \_\_\_\_\_

**History of Present Illness:**

- 10) Please indicate the area where you have the worst pain. Neck Mid-back Low-back Right arm  
Left arm Right leg left leg Other \_\_\_\_\_
- 11) Please indicate the actual date you started with this pain. If you cannot give exact date how long  
have you had the pain: \_\_\_\_\_
- 12) Please indicate your age when this pain started: \_\_\_\_\_
- 13) Please indicate the way your pain started: (Circle all that apply) Sudden Gradual Delayed
- 14) Please indicate the frequency of the pain: (Circle all that apply) Constant Intermittent
- 15) Please indicate how you pain has changed over the course of time: (Circle all that apply) Slowly  
improving Progressively worsening Fluctuating Decreasing in intensity Increasing in  
intensity
- 16) What led to the precipitating event? (Circle all that apply) Lifting (what) \_\_\_\_\_ Bending over  
Twisting Kneeling Pushing heavy objects Pulling a load Climbing Reaching Fall Trip  
MVA Throwing Catching Job with repetitive lifting Job with repetitive motion  
Job with tonic posture/position Other \_\_\_\_\_
- 17) Please indicate the location of the incident: Workplace Home Commercial Facility Parking  
lot While driving Company Sponsored event Traveling for work Vacation Church School  
Other \_\_\_\_\_

If No MVA (Motor Vehicle Accident): Please proceed to question 38

- 18) If MVA, Please indicate the date of accident: \_\_\_\_\_
- 19) If MVA, Please indicate if the vehicle was: Totaled or \$\_\_\_\_\_Amount of damage
- 20) If MVA, Please describe if the accident was: (Circle all that apply) From behind Head on  
From the left side From the right side
- 21) If MVA, Please indicate the cause of the accident: (Circle all that apply)  
Patient's vehicle lost control Other vehicle lost control Other vehicle hit patient  
Patient struck by a vehicle Other \_\_\_\_\_
- 22) If MVA, Please indicate if your vehicle was: (Circle all that apply)  
Stopped Moving at constant speed Accelerating Slowing down
- 23) If MVA, Please indicate how fast your vehicle was moving. \_\_\_\_\_ MPH
- 24) Please indicate the type of vehicle: (Circle all that apply) Compact Mid-size Motorcycle Sedan  
SUV Truck Van Other \_\_\_\_\_
- 25) Please give the make, model and year of the vehicle: \_\_\_\_\_
- 26) If MVA, Please indicate the patient's status during the accident: (Circle all that apply)  
Driving with seatbelt Driving without seatbelt Back passage with seatbelt Back passage  
without seatbelt Front passage with seatbelt Front passage without seatbelt A pedestrian
- 27) Please indicate the place of incident: (Circle all that apply) Intersection Interstate Exit ramp  
On ramp Parking Lot City street Other \_\_\_\_\_
- 28) If MVA, Please indicate if the vehicle was rolled over? \_\_\_ Yes \_\_\_ No
- 29) If MVA, Please indicate if the vehicle had airbags? \_\_\_ Yes \_\_\_ No
- 30) If MVA, Please indicate if the vehicle had headrest? \_\_\_ Yes \_\_\_ No
- 31) If MVA, Please indicate if the vehicle airbags deployed? \_\_\_ Yes \_\_\_ No
- 32) If MVA, Please indicate the following IF you suffered a head injury: (Circle all that apply)  
Brief loss of consciousness Remained conscious
- 33) Please indicate if you were able to walk: \_\_\_ Yes \_\_\_ No
- 34) Please indicate if you went to the ER? \_\_\_ Yes \_\_\_ No
- 35) If you went to the ER how did you get there? By ambulance By family member By friend  
By self Other \_\_\_\_\_
- 36) Please indicate when your pain began after MVA: Immediately \_\_\_ hours later \_\_\_ days later
- 37) Please indicate who you saw after the MVA and when: Chiropractor \_\_\_ days later Injury care  
physician \_\_\_ days later Primary care physician \_\_\_ days later
- 38) Please score your pain now: (scale 1-10 with 1 being minimum and 10 being maximum) \_\_\_\_\_
- 39) Please score your pain when at its worst:(scale 1-10 with 1 being minimum and 10 being maximum) \_\_\_\_\_
- 40) Please score your pain when at its least:(scale 1-10 with 1 being minimum and 10 being maximum) \_\_\_\_\_
- 41) Please describe your pain: (Circle all that apply) Achy Burning Dull Sharp Shooting  
Stabbing Throbbing Other \_\_\_\_\_
- 42) Please indicate the location if the pain radiates: Neck Mid-back Low-back Right arm Left  
arm Right leg Left leg Other \_\_\_\_\_
- 43) Please indicate if you have of the following symptoms associated with your pain: (Circle all that apply)  
Blurry Vision Dizziness Memory Loss Numbness Vomiting Weakness Weight Loss  
Other \_\_\_\_\_

- 44) Please indicate any aggravating factors you have due to the pain: (Circle all that apply)  
 Any Activity or Movement Bending Over Carrying Climbing Stairs Driving Exercise Lying Down Medications Overhead Movement Prolonged Sitting Walking Weight Bearing Working Other \_\_\_\_\_
- 45) Please indicate any relieving factors of the pain: (Circle all that apply) Activity Application of Cold Application of Heat Exercise Medication Movement Physical therapy Rest Sitting Standing TENS Other \_\_\_\_\_
- 46) If you are currently on medications for the pain are they: (Circle all that apply)  
 Effective Less Effective Not Effective Working Well
- 47) If you are currently on medications for the pain are you having any side effects such as: (Circle all that apply) Constipation Dizziness Drowsiness Insomnia Itching Loss of Balance Myalgia Nausea Vomiting Weakness Other \_\_\_\_\_
- 48) If you are currently on medications for the pain do you feel a tolerance for the medication?  
 \_\_\_Yes \_\_\_No
- 49) If you are currently on medications for the pain are you: (Circle all that apply) Needing more Stable Weaning down
- 50) Please indicate medications you are using now: (Circle all that apply) Actiq Advil Aleve/naproxen Butrans Carisoprodol Celebrex Dilaudid/hydromorphone Exalgo Fentanyl patch Flexeril Hydrocodone Kadian Meloxicam Methadone Morphine sulfate ER Morphine sulfate IR Nupren/ibuprofen Opana ER Oxydone ER Oxydone IR Oxycontin Robaxin Tramadol Other \_\_\_\_\_
- 51) Do you want to change medications? \_\_\_ Yes \_\_\_ No
- 52) Please indicate if you have tried these medications: (Circle all that apply)  
 NSAIDs (which ones) \_\_\_\_\_ Cymbalta Lyrica  
 Muscle relaxers (which ones) \_\_\_\_\_ Neurontin/gabapentin  
 Opiates (which ones) \_\_\_\_\_
- 53) Do the medications help with any of the following? (Circle all that apply) Daily activities Family activities Mood Sleep pattern Social activities Overall physical function
- 54) Have you tried any of the following treatments? (Circle all that apply)  
 Prescription Medication (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No  
 Biofeedback (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No
- 55) Epidural Injections (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No  
 Pain Management Program (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No  
 Physical Therapy (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No  
 Facet injection (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No  
 Spinal Cord Stimulator (what year) \_\_\_\_\_ Spine Surgery (what year) \_\_\_\_\_  
 TENS Unit (what year) \_\_\_\_\_
- Acupuncture (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No  
 Chiropractic Therapy (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No  
 Psychological Therapy (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No  
 Counseling (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No  
 Massage (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No  
 Other (what year) \_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No
- 56) If surgery to spine? By whom \_\_\_\_\_
- 57) Please indicate if any of the following apply: (Circle all that apply) Cancer Chronic Corticosteroid Use Coronary Artery Disease Diabetes Mellitus Injury Herniated Disk Obesity Osteoarthritis Osteoporosis Peripheral Vascular Disease Pulmonary Disease Rheumatoid Arthritis Spinal Stenosis Spondylolisthesis Other \_\_\_\_\_

- 58) Please indicate your level of sleep since the pain started: (Circle all that apply) **Increased**  
**Decreased** **Stayed the same** **Other** \_\_\_\_\_
- 59) Please indicate the quality of sleep you receive since the pain started: (Circle all that apply)  
**Good** **Normal** **Poor** **Other** \_\_\_\_\_
- 60) Do you have snoring episodes?  Yes  No
- 61) Do you wake up gasping at night?  Yes  No
- 62) Do you have sleep apnea?  Yes  No
- 63) If yes to question 61 do you wear a CPAP device?  Yes  No
- 64) Please indicate if you were adopted.  Yes  NO
- 65)

**FAMILY HISTORY (Fill in health history about your family)**

Relationship	Illnesses	Habits	Date of Birth	Age at Death/ Cause of Death
Father				
Mother				
Brother				
Brother				
Sister				
Sister				

**Past Medical history**

**Have you ever had or currently have:**

- 66) A malignancy, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 67) A skin condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 68) An eyes, ears, nose and throat condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 69) A respiratory condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 70) A cardiovascular condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 71) A genitourinary condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 72) A musculoskeletal condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 73) A neurologic condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 74) A psychiatric condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 75) A hematologic/lymphatic condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 76) An endocrine condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 77) An infectious disease, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 78) An allergic/immunologic condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 79) A rheumatologic condition, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 80) Any trauma or toxin exposure, please give the diagnosis and date of diagnosis: \_\_\_\_\_
- 81) Please list any allergies you have to anesthesia: \_\_\_\_\_
- 82) Please list any allergies you have to medications: \_\_\_\_\_
- 83) Please list any other allergies you have: \_\_\_\_\_

84) Please list any surgical procedure you have had: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

85) Please indicate your marital status: (Circle all that apply)    Single    Married    Married (common law)  
Domestic partner    Separated    Divorced    Divorced and remarried    Widowed  
Widowed and remarried    Other \_\_\_\_\_

86) Are you an active smoker?    \_\_\_ Yes    \_\_\_ No

87) If "yes" to question 86, how many cigarettes/packs do you smoke a day? \_\_\_\_\_

88) If "yes" to question 86, when did you started smoking and at what age? \_\_\_\_\_

89) Are you an inactive smoker?    \_\_\_ Yes    \_\_\_ No

90) If "yes" to question 89, how many cigarettes/packs did you smoke a day? \_\_\_\_\_

91) If "yes" to question 89, when did you stop smoking and at what age? \_\_\_\_\_

92) If you drink alcohol please list the type you drink and how much daily: \_\_\_\_\_

93) If you drink alcohol please indicate at what age you started to drink and the actual date: \_\_\_\_\_

94) If you no longer drink alcohol please indicate the actual date you stopped: \_\_\_\_\_

95) If you have or currently use illicit/recreational drugs, please list the type: \_\_\_\_\_

96) If you have or currently use illicit/recreational drugs, please list the method you used: \_\_\_\_\_

97) If you have or currently use illicit/recreational drugs, please list the age and actual date you started:  
\_\_\_\_\_

98) If you have used recreational drugs, please list the age and actual date you stopped: \_\_\_\_\_

99) Please indicate the highest level of education you have received: (Circle all that apply)    High school  
College    Graduate school    Trade school    MD    JD    Masters    PhD    Other \_\_\_\_\_

100) Please indicate if you are currently:    Employed    Unemployed    Retired    Disabled    Other \_\_\_\_\_

101) If you are employed are you:    \_\_\_ Full time    \_\_\_ Part time

102) If you are employed please indicate your job title or profession: \_\_\_\_\_

103) If employed please give the name of your company: \_\_\_\_\_

104) If unemployed please indicate your last date of employment: \_\_\_\_\_

105) If retired how long have you been retired? (days, weeks, months, or years) \_\_\_\_\_

106) If disabled please list the actual age and date you became disabled: \_\_\_\_\_

107) If disabled please indicate the cause:    Accident    Congenital anomaly    Illness    Medical condition  
Inability to work because of work restrictions    Other \_\_\_\_\_

108) Within your work environment are you or have you been exposed to any of the following hazards:  
(Circle all that apply)    Infectious diseases    Inorganic dust    Organic dust    Radiation    Toxic chemicals  
Other \_\_\_\_\_

109) Please list any hobbies and activities you are currently involved in: \_\_\_\_\_

**Review of System:**

110) Please indicate if you have any of the following: (Circle all that apply)    Anorexia    Change in appetite  
Chills    Exercise tolerance    Fatigue    Fever    Malaise    Night sweats    Weakness    Weight changes  
Other \_\_\_\_\_

111) If you indicated change in appetite is it?    \_\_\_ Decreased    \_\_\_ Increased

112) If you indicated fatigue is it:    Mild    Moderate    Severe

113) If you indicated fever is it:    Low grade    High grade    \_\_\_ Degrees

114) If you indicate night sweats is it:    Head and shoulder    Mild    Soaking sheets    Other \_\_\_\_\_

115) If you indicate weight change is it: (Circle all that apply)    Weight gain    Weight loss    How many \_\_\_ lbs  
Over how long \_\_\_ months/years

- 116) Please indicate if you have any of the following musculoskeletal conditions: (Circle all that apply) Arthritis Atrophy Deformity Gout Limitation of motion Muscle cramps Pain, back Pain, bone Pain, joints Pain, muscle Stiffness
- 117) Do you have any of the following skin conditions: (Circle all that apply) Change in hair or nails Dry skin Excessive sweating Hives Hyperpigmentation Hypopigmentation Infection Itching Jaundice Lesions or sores Loss of hair Lumps Mole, changes Moles, new Rash
- 118) Please indicate if you have any of the following: (Circle all that apply) Bleeding gums Blurred vision Difficulty swallowing Double vision Earaches Ear discharge Ear ringing Hay fever Hearing loss Hoarseness Nose bleeds Sinus trouble Vision loss Visual flashes
- 119) Please indicate if you have any of the following neck conditions: (Circle all that apply) Enlarged thyroid Neck mass Neck pain Stiffness Swelling Swollen glands
- 120) Please indicate if you have any of the following respiratory conditions: (Circle all that apply) Chest wall pain Clubbing of fingers Cough Cyanosis Exposure to tuberculosis Hemoptysis Nocturnal gasping Shortness of breath Snoring Stridor Tuberculosis Wheezing
- 121) Please indicate when your last PPD was: \_\_\_\_\_
- 122) Please indicate if you have any of the following cardiac conditions: (Circle all that apply) Chest pain or tightness that is brought on by exertion Chest pain that is not associated with exertion Palpitations Rapid heartbeat Varicose veins
- 123) Please indicate if you have any of the following gastrointestinal conditions: (Circle all that apply) Loss of appetite Bowel habit changes Constipation Nausea Hemorrhoids Incontinence, stool Indigestion Diarrhea Heartburn Abdominal pain Rectal bleeding Vomiting
- 124) Please indicate if you have any of the following genitourinary conditions: (Circle all that apply) Blood in urine Frequent urination Incontinence, urine Painful urination Urgency

**\*\*\* FEMALES ONLY \*\*\* (go to 130 if male)**

- 125) Please indicate if you have any of the following symptoms: (Circle all that apply) Amenorrhea Decreased libido Intermenstrual bleeding Menorrhagia Metrorrhagia Painful sex Pelvic pain Postcoital bleeding Postmenopausal bleeding Sexual difficulties Vaginal dryness Vaginal itching Other \_\_\_\_\_

**\*\*\* MALES ONLY \*\*\* (go to 129 if female)**

- 126) Please indicate if you have any of the following symptoms: (Circle all that apply) Decreased libido Erectile dysfunction Hernia Impotence Reduced urinary stream Sexual difficulties Testicular mass Testicular pain Other \_\_\_\_\_
- 127) Please indicate if you have any of the following neurological conditions: (Circle all that apply) Muscle weakness Numbness/tingling Gait disturbance Mental status changes Forgetfulness Seizure Dizziness Fainting episodes
- 128) Please circle any of the following endocrinological conditions: (Circle all that apply) Brittle hair Brittle nails Hypoglycemia Hyperglycemia Heat/cold intolerance Hypercalcemia  
If diabetic, please list your average blood sugar number: \_\_\_\_\_
- 129) Please circle any of the following psychiatric conditions: (Circle all that apply) Anxiety Binge eating crying or near crying episodes Delusions Depression Irritability Mood swing Poor concentration Poor memory Suicidal thoughts and ideation Useless feelings

