NORTH FLORIDA
PAIN SPECIALISTS

North Florida Pain Specialists, LLC
4012 Kelcey Court, Suite 202, Tallahassee, FL 32308
Tel: (850) 559-2355 Fax: (800) 443-1468

Full Name **Date of birth**

Street Address **Suite/Unit/Apt**

City **State** **Zip Code**

SS#:_____ **Race/Ethnicity:**_____

Email: _____ **Employment Status:**_____

Home Phone:_____ **Emergency Contact:**_____

Cell Phone: _____ **Emergency Contact Phone #:**_____

Mobile Carrier: _____ **Referred by:**_____

Gender: _____ **Primary Care Physician:** _____

Primary Insurance: _____ **ID#:** _____ **Group:** _____

Secondary Insurance: _____ **ID#:** _____ **Group:** _____

******If you are NOT the primary policy cardholder, WE NEED the following information*******

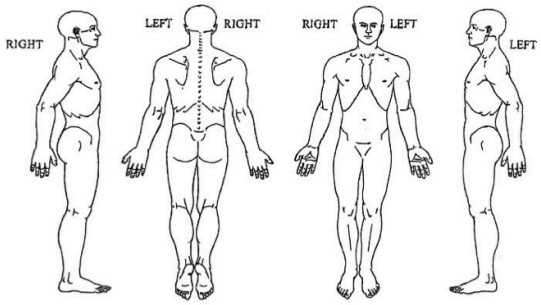
Primary Cardholder name: _____ **DOB:** _____ **SSN:** _____

New Patient Intake Form

Please complete all fields accurately. Use N/A if not applicable. All information is confidential.
Personal Information

Pain History:

Have you seen a pain physician before? Yes ☐ No ☐ **If Yes, provide details (Who, When, Where, Why):** _____
Reason for today's visit: _____
Onset of pain (Days, Weeks, Months, Years): _____
Pain is related to: Accident ☐ Fall ☐ Sports Injury ☐ Surgery ☐ Unknown ☐
Loss of bowel or bladder control? Yes ☐ No ☐



Where is your pain? (Describe or draw): _____

Describe your pain (check all that apply):
Aching ☐ Cramping ☐ Dull ☐ Sore ☐ Stiffness ☐ Swelling ☐
Tender ☐ Throbbing ☐ Burning ☐ Numbness ☐ Pins/Needles ☐
Sharp ☐ Shooting ☐ Stabbing ☐ Weakness ☐

Rate your pain (0 = no pain, 10 = worst):
Highest: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
Lowest: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
Average: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

What makes the pain worse? (Check all that apply):
Sitting ☐ Standing ☐ Leaning backward ☐ Laying down ☐ Walking ☐
Exercise ☐ Lifting ☐ Weather ☐ Other: _____

What makes the pain better? (Check all that apply):
Heat ☐ Ice ☐ Massage ☐ Brace ☐ Medication(s) ☐ Injection(s) ☐ Other:_____

Does your pain affect:
Daily Activities? Yes ☐ No ☐ Sleep? Yes ☐ No ☐ Mood/Anxiety? Yes ☐ No ☐

Medications and treatments tried (check all that apply, add details if needed):

Topical:

Bengay ☐ Diclofenac/Voltaren Gel ☐ Flector Patch ☐ Lidocaine Ointment/Gel/Patch ☐

Over the Counter:

Tylenol ☐ Ibuprofen/Motrin ☐ Celecoxib/Celebrex ☐ Diclofenac ☐
Naproxen/Aleve ☐ Meloxicam/Mobic ☐

Muscle Relaxants:

Baclofen ☐ Carisoprodol/Soma ☐ Cyclobenzaprine/Flexeril ☐ Diazepam/Valium ☐
Methocarbamol/Robaxin ☐ Tizanidine/Zanaflex ☐

Neuropathic Agents:

Amitriptyline/Elavil ☐ Desipramine/Norpramin ☐ Duloxetine/Cymbalta ☐
Gabapentin/Neurontin ☐ Gabapentin ER/Gralise ☐ Lamotrigine/Lamictal ☐
Levitiracetam/Keppra ☐ Nortriptyline/Pamelor ☐ Paroxetine/Paxil ☐
Phenytoin/Dilantin ☐ Pregabalin/Lyrica ☐ Sertraline/Zoloft ☐
Topiramate/Topamax ☐ Trazodone/Desyrel ☐ Valproic Acid/Depakote ☐
Venlafaxine/Effexor ☐

Sleep Aids:

Trazodone/Desyrel ☐ Zolpidem/Ambien ☐

Benzodiazepines:

Clonazepam/Klonopin ☐ Diazepam/Valium ☐ Lorazepam/Ativan ☐
Temazepam/Restoril ☐

Opiates:

Buprenorphine/Butrans, Belbuca, Suboxone ☐ Fentanyl Spray/Patches ☐
Hydromorphone/Dilaudid ☐ Hydromorphone ER/Exalgo ☐ Hydrocodone/Norco ☐
Morphine Sulfate ☐ Morphine ER/MS Contin ☐ Oxycodone/Percocet ☐
Oxycodone ER/Oxycontin ☐ Oxymorphone/Opana ☐ Tapentadol/Nucynta ☐
Tramadol/Ultram ☐

Other: _____

Have you had any Tests?

Test	Yes/No	Date	Results
X-ray			
CT scan			
MRI			
Nerve Conduction Study			
Other			

Have you tried anything for the Pain?

Therapy	Tried	Helpful	Date of last treatment
Physical Therapy			
Water/Aqua Therapy			
Acupuncture/Yoga			
Chiropractic/Massage			
TENS unit			
Brace			
Injection (Epidural)			
Surgery			
Psychological Counseling			
Other			

Past Medical History: (circle all that apply)

General	Cancer (Type:_____)	HIV/AIDS	Obesity	Anemia	Osteoporosis	Autoimmune disease (e.g., lupus, RA)	Chronic fatigue syndrome	History of frequent infections
Neurologic	Stroke	Seizure disorder/ Epilepsy	Traumatic brain injury (TBI)	Migraines	Multiple sclerosis	Parkinson's disease	Neuropathy	Dementia/ Alzheimer's disease
Psychiatric	Depression	Anxiety disorder	Bipolar disorder	Schizophrenia	Post-traumatic stress disorder (PTSD)	Substance use disorder	Opioid use disorder	Attention-deficit/ hyperactivity disorder (ADHD)
Cardiovascular	Hypertension (high blood pressure)	Coronary artery disease (CAD)	Congestive heart failure (CHF)	Atrial fibrillation	Hyperlipidemia (high cholesterol)	Peripheral artery disease (PAD)	History of heart attack (MI)	History of blood clots (e.g., DVT or PE)
Respiratory	Asthma	Chronic obstructive pulmonary disease (COPD)	Emphysema	Sleep apnea	Chronic bronchitis	Pulmonary embolism (past history)	Pneumonia (recurrent or significant past episode)	Interstitial lung disease
Renal	Chronic kidney disease (CKD)	Kidney stones	Polycystic kidney disease	Glomerulonephritis	History of urinary tract infections (recurrent)	Dialysis dependence	Acute kidney injury (if significant history)	Hydronephrosis
Endocrine	Diabetes Type 1 or Type 2	Hypothyroidism	Hyperthyroidism	Adrenal insufficiency	Cushing's syndrome	Polycystic ovary syndrome (PCOS)	Osteopenia/ Osteoporosis	Metabolic syndrome
Gastrointestinal	Gastroesophageal reflux (GERD)	Peptic ulcer disease	Irritable bowel syndrome (IBS)	Inflammatory bowel disease (Crohn's/ Ulcerative colitis)	Hepatitis (B or C)	Fatty liver disease	Gallbladder disease (e.g., cholelithiasis)	Diverticulitis
Musculoskeletal	Osteoarthritis	Rheumatoid arthritis	Chronic low back pain	Chronic neck pain	Degenerative disc disease	Fibromyalgia	Scoliosis	Osteoporosis

Other:_____

PAST SURGICAL HISTORY:

(Please list all surgeries)_____

Neck or low back surgery?_____

Joint surgery?_____

FAMILY MEDICAL HISTORY:

Mother:_____

Father:_____

SOCIAL HISTORY:

Do you smoke? Number of cigarettes per day?_____

Have you ever used any forms of tobacco products? When was last use?_____

Do you drink alcohol? YES☐ NO☐ If yes, how many drinks per day?_____

Do you use any illicit substances? Such as cocaine, Marijuana, LSD, Heroin, etc. YES☐ NO☐

What is your marital status? Single, Married, Divorced/Separated, Other_

What are your living arrangements? Living alone, With partner, With children, Other_

What is your level of education? GED, High School, Bachelors, Masters, Graduate, Other

Are you currently working? YES☐ NO☐ Occupation?_____

ALLERGIES: (Please list all and the type of reaction)_____

PAIN MEDICATIONS: Please list drug name, dosage and frequency (I.e. Tylenol 500mg, 3 times per day)

_____

OTHER MEDICATIONS: Please list all medications you take (with drug dosage and frequency)

_____

Do you take any blood thinners? (Such as: Aspirin, Plavix, Brilinta, Effient, Xarelto, Eliquis, Coumadin, Pradaxa, Lovenox) YES☐ NO ☐