Aviator Pain & Spine

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New Patient Intake Form

PATIENT INFORMATION & DEMOGRAPHICS

Name: Date of Visit:

Referring Physician: Date of Birth: Age:

Primary Care Physician: Sex: ☐ Male ☐ Female

Preferred Phone # ☐ Home ☐ Mobile ☐ Work

Emergency Contact Name: Relationship:

Emergency Contact Phone #

Employer & Occupation:

In compliance with the HITECH Act (EHR) to attain Meaningful Use, we are required to capture demographic data including your preferred language, race, and ethnicity. Please complete the information below:

Primary Language:

- ☐ Arabic
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ Korean
- ☐ Spanish
- ☐ Other:

Race:

- ☐ African-American
- ☐ Arabic
- ☐ Asian
- ☐ Caucasian
- ☐ Filipino
- ☐ Hispanic
- ☐ Other:

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic

Contact Preference:

By providing my email address or cell phone number below, I hereby consent and state my preference to have my physician and other staff at Aviator Pain & Spine , LLC communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments and billing. I understand that email and standard SMS may be insecure and could potentially be intercepted by a third-party.

Note: Messages will be related directly to your care only and will not include any marketing material or solicitation.

Email Address: **Cell Phone #:**

ADVANCE DIRECTIVES INFORMATION

Advance Directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. Although advance directives, by anesthesia standards, will NOT be honored at this facility, we will keep them on file, if you so request. In the event of an emergency, advanced cardiac life support will be instituted in every instance possible and you will be transported to higher level of care. The directives will be recognized by the receiving hospital in the case that a transfer is required from our facility due to emergency. This is for information purposes only.

Do you have any advanced directives to share with us? ☐ Yes ☐ No

If yes, please provide all relevant advance directives documentation to our front office staff to keep on record.

PRIMARY COMPLAINTS

Reasons for visit: **How long have you had pain?**

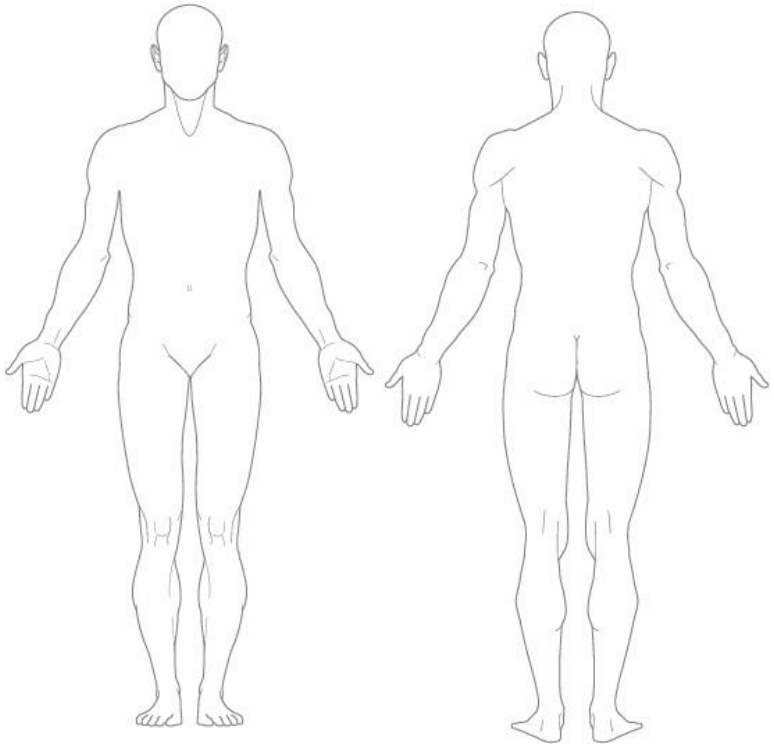
Onset of Pain *(please select the appropriate indicator listed below):*

☐ Pain Began With No Known Cause ☐ Injury Outside Of Work ☐ Injury at Work ☐ Illness

☐ Motor Vehicle Accident ☐ Other

Explain how pain started:

Mark the locations of your pain on the diagram below: (MARK X FOR PAIN AND O FOR NUMBNESS/BURNING/TINGLING)



Please circle the number that best describes the amount of pain you feel right now:

No Pain	0 1 2 3 4 5 6 7 8 9 10	*Severe Pain*

Write 'L' above number to indicate least pain
Write 'W' above number to indicate worst pain

What best describes your pain? *(select all that apply)*

- ☐ Aching / Cramping
- ☐ Hot / Burning
- ☐ Dull
- ☐ Electrical
- ☐ Numb
- ☐ Stabbing / Sharp
- ☐ Shooting
- ☐ Tingling

What makes your pain worse? *(select all that apply)*

- ☐ Bending Backwards
- ☐ Bending Forward
- ☐ Climbing Stairs
- ☐ Cold
- ☐ Coughing / Sneezing
- ☐ Driving
- ☐ Exercise
- ☐ Heat
- ☐ Lifting
- ☐ Light Touch
- ☐ Sexual Activity
- ☐ Sitting
- ☐ Standing
- ☐ Stress
- ☐ Walking
- ☐ Work

What makes your pain better? *(select all that apply)*

- ☐ Bath/Shower
- ☐ Exercise
- ☐ Heat
- ☐ Ice
- ☐ Lying Down
- ☐ Medications
- ☐ Meditation
- ☐ Physical Therapy
- ☐ Bending Forward
- ☐ Bending Backwards
- ☐ Sitting
- ☐ Standing
- ☐ Walking

☐ Other: _____

Pain interferes with *(select all that apply):*

- ☐ Appetite
- ☐ Cooking
- ☐ Driving
- ☐ Exercise
- ☐ Hobbies
- ☐ House Chores
- ☐ Job Performance
- ☐ Self-Care
- ☐ Sex
- ☐ Shopping
- ☐ Sleep
- ☐ Social Life
- ☐ Traveling

Does your pain limit your ability to walk? ☐ Y ☐ N

How long can you sit? ☐ Minimal ☐ 30 Mins ☐ >1 Hour

How long can you stand? ☐ Minimal ☐ 30 Mins ☐ >1 Hour

To assist with walking, I use a: ☐ Cane ☐ Walker ☐ Wheelchair ☐ No Assistance Device

PRIOR WORKUP & TREATMENT

Please list the studies you have had for your pain complaints in the last 3 years

☐ X-Ray of the	Date:	Facility:
☐ CT scan of the	Date:	Facility:
☐ MRI of the	Date:	Facility:
☐ EMG of the	Date:	Facility:
☐ Other:		

☐ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

PRIOR PAIN MEDICATIONS *(check all medications you have used in the past for treatment of pain)*

NSAIDS / Tylenol	☐ Aspirin	☐ Indocin	☐ Relafen
	☐ Celebrex	☐ Lodine (etodolac)	☐ Goodies Powder
	☐ Sulindac	☐ Mobic (meloxicam)	☐ Toradol
	☐ Feldene	☐ Motrin	☐ Tylenol
	☐ Ibuprofen	☐ Naproxen (Aleve)	
Opioids	☐ Codeine	☐ Hydrocodone/Norco	☐ Nucynta
	☐ Demerol	☐ Levorphanol	☐ Buprenorphine/Belbuca
	☐ Dilaudid	☐ Methadone	☐ Oxycodone/Percocet
	☐ Fentanyl	☐ Morphine / MSContin	☐ Oxycontin
	☐ Xtampza	☐ Exalgo	☐ Tramadol
Anti-Depressants	☐ Bupropion (Wellbutrin)	☐ Duloxetine (Cymbalta)	☐ Paroxetine (Paxil)
	☐ Citalopram (Celexa)	☐ Escitalopram (Lexapro)	☐ Sertraline (Zoloft)
	☐ Desvenlafaxine (Pristiq)	☐ Fluoxetine (Prozac)	☐ Venlafaxine (Effexor)
		☐ Imipramine (Tofranil)	
Anti-Anxiety	☐ Ativan	☐ Valium	
	☐ Clonazepam	☐ Xanax	

Muscle Relaxants	☐ Baclofen	☐ Robaxin	☐ Valium (Diazepam)
	☐ Flexeril	☐ Skelaxin	☐ Zanaflex/Tizanidine
	☐ Parafon Forte	☐ Soma	
Nerve Pain	☐ Amitriptyline	☐ Neurontin/gabapentin	☐ Tegretol
	☐ Cymbalta	☐ Nortriptyline	☐ Topamax
	☐ Lyrica/pregabalin	☐ Savella	

Have you been treated at another pain management center or program? ☐ YES *(answer below)* ☐ NO

Where? When?

PREVIOUS PAIN TREATMENTS *(select all that apply)*:

☐ Acupuncture/Biofeedback
☐ Epidural steroid injections Site/date _____
☐ Joint Injections (Knees, hips, shoulders)
☐ Bracing – Type: _____
☐ Chiropractic Manipulation
☐ Radiofrequency ablation—Site/date _____
☐ Home Exercise Program - Date Completed: _____
☐ Nerve blocks
☐ Physical Therapy - Date Completed/Place: _____
☐ Spinal cord stimulator trial
☐ Spinal cord stimulator implant
☐ Other: _____

☐ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

MEDICATION THERAPY

Please list all of the medications you are taking now. Include all over-the-counter, herbal, and other supplemental medications and vitamins.

☐ **I HAVE PROVIDED MY PHYSICIAN WITH A PRINTED MEDICATION LIST**

Medication	Dose (mg)	How Often? (# times/day)	What is this medication for?	Date Started?	Prescribing Doctor

Do you take any blood thinning medications? ☐ YES ☐ NO ; If Yes, which one? _____

PAST MEDICAL HISTORY

Please check all that apply.

Cardiovascular

- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Rhythm Disturbances
- ☐ Diabetes
- ☐ Insulin
- ☐ High Blood Pressure
- ☐ Colitis
- ☐ Irritable Bowel Syndrome
- ☐ High Cholesterol

Respiratory

- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Chronic Bronchitis
- ☐ Anticoagulation
- ☐ Venous Insufficiency
- ☐ Low Blood Pressure
- ☐ Hiatal Hernia

Gastrointestinal

- ☐ Acid Reflux/GERD
- ☐ Ulcers
- ☐ Polyps
- ☐ Easy Bruising
- ☐ Arterial Insufficiency
- ☐ Bowel Problems
- ☐ Blood Thinners
- ☐ Embolism
- ☐ Liver Disease

Endocrine

- ☐ Obesity
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Frequent Pneumonia
- ☐ Positive TB Test
- ☐ Frequent Colds/Sore Throat
- ☐ Blood Clots
- ☐ Gallbladder Problems
- ☐ Special Diet

Hematologic

- ☐ Bleeding Disorders
- ☐ Anemia
- ☐ Hepatitis A, B, C
- ☐ Pancreatitis
- ☐ Abnormal Chest X-Ray
- ☐ Crohn's Disease
- ☐ Other

Neurological

- ☐ Memory Problems
- ☐ Seizures
- ☐ Stroke
- ☐ Movement Disorder
- ☐ Muscular Dystrophy
- ☐ Neuropathy
- ☐ Migraine
- ☐ Epilepsy
- ☐ Headaches

Psychological

- ☐ Nervous Breakdown
- ☐ Depression
- ☐ Anxiety
- ☐ Panic Disorder
- ☐ Psychosis
- ☐ Alcohol or Drug Abuse
- ☐ Other

Genitourinary

- ☐ Sexual Dysfunction
- ☐ Sexually Transmitted Disease
- ☐ Prostate Disease
- ☐ Kidney Problems
- ☐ Chronic Infection
- ☐ Bladder Problems

Musculoskeletal

- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Back Problems
- ☐ Neck Problems

Miscellaneous

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Visual Problems
- ☐ Hearing Loss
- ☐ Chronic Skin Disorder
- ☐ Pregnancy

General

- ☐ Medical Equipment
- ☐ Cane
- ☐ Walker
- ☐ Wheel Chair
- ☐ Hospital Bed
- ☐ Oxygen

Allergic/ Immunological

- ☐ Autoimmune Disorder
- ☐ Lupus, Sjogren's
- ☐ Raynaud's Syndrome
- ☐ Immune Deficiency
- ☐ HIV

Cancer

- ☐ Site
- ☐ Diagnosis Date:
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Other

ALLERGIES

Please list any known drug, food, or environmental allergies and indicate the adverse effect/reaction:

Medications Allergic To	Reaction To Medication

☐ Contrast/IV Dye
☐ Iodine
☐ Latex
☐ Shellfish
☐ Other (specify): _____
☐ **I HAVE NO KNOWN ALLERGIES**

PAST SURGICAL HISTORY

Type of Surgery	Date

☐ **I HAVE NOT HAD ANY SURGICAL PROCEDURES DONE**

SOCIAL HISTORY

Are you a smoker?

☐ CURRENT, How Many/Day? _____
☐ FORMER ☐ NEVER

Do you use illicit street drugs?

☐ YES, Which Ones? _____
☐ NO

Who do you live with?

☐ Alone ☐ Spouse ☐ Children ☐ Parents

Do you drink alcohol?

☐ YES, How Much/Day? _____
☐ NO

What is your marital status?

☐ Single ☐ Married ☐ Cohabitating ☐ Separated
☐ Divorced ☐ Widowed

Are you pregnant, or planning a pregnancy?

☐ YES ☐ NO

PAST PSYCHOLOGICAL HISTORY

Have you ever had psychiatric or psychological evaluation or treatment for any problem, including pain?

☐ YES, Treated For: ☐ ADD ☐ OCD ☐ Bipolar ☐ Schizophrenia ☐ Other: _____

☐ NO

Have you ever been treated for symptoms of depression?

☐ YES, When? _____

☐ NO

Have you ever considered/planned/attempted suicide?

☐ YES, When? _____

☐ NO

CERTIFICATION

I certify that the above information is accurate, complete, and true. I understand that this will become part of my medical record.

Printed Name:
_____/Signature:_____

If patient is minor, Guardian's Printed
Name:_____/Signature:_____

Date:

SCREEN AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN - REVISED {SOAPP® - R)

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible by checking the box. There are no right or wrong answers.

	0 Never	1 Seldom 2 Sometimes	3 Often 4 Very Often		
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

Opioid Risk Tool (ORT)		
CIRCLE EACH BOX THAT APPLIE		
Personal History of Substance Abuse		
Alcohol	YES	NO
Illegal Drugs	YES	NO
Rx Drugs	YES	NO
Family History of Substance Abuse		
Alcohol	YES	NO
Illegal Drugs	YES	NO
Rx Drugs	YES	NO
Age between 16-45	YES	NO
History of Pre-Adolescent Sexual Abuse	YES	NO
ADD, 0CD, Bipolar, Schizophrenia	YES	NO
Depression	YES	NO