Triad Pain Management Clinic
Health History Intake

Date:

Patient Information

Name: Age: Height: Weight:
Date of Birth: Gender: Male Female
Occupation:
Primary Care Physician:

Emergency Contact

Name: Relationship: Phone:
List the names of individuals with whom we may discuss your records
1)
2)
3)

Current Symptoms

Briefly state the reason for seeing the doctor today

What caused your symptoms?

When did the symptoms begin?
Are they improving, worsening or staying the same?

How are your symptoms affecting your activities of daily life?

Describe your symptoms

Do your symptoms radiate anywhere? Describe.

What makes the symptoms worse?

What makes the symptoms better?

On a scale from 1 to 10 with 10 being the worst pain, please rate your pain:

Patient Name: _____

Medications
Please list all medications you are currently taking.

Do you have any drug allergies?

Previous Treatment
Have you tried any treatment prior to today? Y/N Please list below.
(Physical Therapy, Chiropractic, Injections, Medications, Surgery etc,)

Have you had any diagnostics? Y/N Please list below.
(MRI, X-Ray, CT, EMG, NCS, Ultrasound etc)

Please list other providers you have seen for this problem.

Social History
Pick One: Married Divorced Widowed Single
Children: How many? ____ Ages: _____
How many alcoholic drinks per week? _____
How many caffeinated drinks per week? _____
Recreational drug use? Y/N Describe: _____
Smoking: Y/N Packs/Day: _____ Previous Smoker: Y/N Date stopped: _____
Which hand is your dominant hand? Left Right
Have you served in the military? Y/N Describe:_____

Occupation
Describe your occupation and duties.

Do your symptoms affect your job duties? Y/N Describe.

Patient Name: _____

Past Medical History

Please circle any of the following symptoms/conditions that you have had in the past or currently experience.

Abdominal Pain
Abnormal Weight Gain/Loss
Anemia
Anorexia
Aortic Aneurysm
Arthritis
Asthma
Bladder Infection
Blood Disorder
Breast Soreness
Cancer
Chest Pain
Chronic Cough
Chrohn's/Ulcerative colitis
Constipation
Convulsions
Diabetes
Depression
Dermatitis/Eczema
Difficulty swallowing
Dizziness
Emphysema
Endometriosis
Epilepsy
Excessive Thirst
Fainting
Frequent Urination
Fatigue
Gallbladder Disease/Stones
Headaches
Heart Disease
Heart Attack
Heartburn/GERD
Hepatitis
Hypertension
Jaw Pain
Kidney Disease/Stones
Liver Disease
Loss of appetite
Bladder control problems
Neurological Disease
Osteoporosis/Osteopenia
Neck Pain
Mid-Back Pain
Low Back Pain
Shoulder Pain
Hand/Wrist/Elbow Pain
Ankle/Foot/Knee Pain
Thigh/Hip Pain
Painful urination
Prostate Disease
Rapid heartbeat/Flutters
Rheumatoid Arthritis
Scoliosis
Stoke
Tuberculosis
Thyroid Disease
Ringing in ears
Ulcer
Visual disturbances
Other:

Please list all hospitalizations and/or surgeries.

Family History

Please list any health problems associated with the following family members:
Mother:
Father:
Sibling:
Grandparents:

Patient Name: _____

Review of Systems (Please circle any of the following that you currently experience)

Constitutional
Chills
Fatigue
Fever
Night Sweats
Weight Gain
Weight Loss

ENT
Hearing loss
Ringing in ears
Earache

Cardiovascular
Murmur
Flutters/Thumping
Chest Pain
Shortness of Breath
Fainting
Aneurysm
Swelling of Legs

Eyes
Wear Glasses/Contacts
Blindness
Cataracts
Glaucoma

Respiratory
Asthma/Wheezing
Cough
Coughing blood
Shortness of breath

GI
Ulcer/Heartburn
Hiatal hernia
Poor appetite
Diarrhea/Abnormal Stool
Constipation

GU
Kidney stone
Dialysis
Pain with urination
Difficulty with urination
Incontinence
Frequent night urination
Bladder infection
Blood in urine

Endocrine
Thyroid disease
Hair loss
Goiter
Diabetes

Neuro
Headache
Seizure
Depression
Numbness
Tingling
Other _____

Psych
Anxiety
Change in appetite
Mood change
Bi-Polar
Confusion
Depression
Insomnia
Memory Loss

Musculoskeletal
Joint pain _____
Spasm
Osteoarthritis
Other _____

Other (Please List):