PAIN WEST

NEW PATIENT INTAKE R7.23 Patient Number (Office Use):_____

How were you referred to our office? _____Today's Date_____

PATIENT INFORMATION

Patient Name (Last, First, Middle)_____

Birth date:_____Age:_____ Gender: Male / Female

Address:_____City:_____State:_____Zip:_____

Home #:_____Mobile #:_____Work #:_____

Email:_____SS #:_____ Driver's License #:_____

Best way to contact? Home # / Work # / Mobile # / Email / Text May we contact you at work? Y / N

Occupation:_____Employer:_____Address:_____

Emergency Contact:_____Phone:_____Relationship:_____

Marital Status: M / S / D / W Name of Spouse / Partner:_____# of Children:_____

Race:_____Ethnicity:_____Preferred Language:_____

PAYMENT / INSURANCE

Self Pay / Medicare / Medicaid / General Insurance / Personal Injury / Auto Accident / Work Comp

If Self Pay, I testify that I do not have insurance coverage T / F

Primary Insurance:_____Policy #:_____

Secondary Insurance:_____Policy#:_____

Other than the policies listed above, I deny having additional insurance coverage T / F

Insured's Name (Last, First, Middle):_____

Birth Date:_____ Who carries this policy? Self / Spouse / Parent

Insured's Employer:_____Address:_____

City:_____State:_____Zip:_____Employer's Ph:_____

REASON FOR SEEKING CARE

Please list all complaints:_____

_____

Are any of these related to an auto accident or work injury? Yes / No

Patient's (or Guardian) Signature_____Date_____

Doctor's Signature_____Date_____

PAIN WEST

HEALTH HISTORY

General - Weakness / Tired / Irritable / Foggy / Forgetful / Sleep Issues / Weight Gain / Loss
Other_____

Neurological - Headaches / Migraines / Seizures / Stroke / Light Headed / Dizziness / Numbness
Tingling / Head Trauma / Fainting / Pins/needles
Other_____

Musculoskeletal - Muscle Aches / Joint Pain / Low Back Pain / Neck Pain / Wrist Pain / Hand Pain
Shoulder Pain / Elbow Pain / Hip Pain / Knee Pain / Ankle Pain / Foot Pain / Osteoporosis
Previous Fractures (list)_____
Other_____

Cardiovascular - Chest Pain / Palpitations / Ankle Swelling / Cold or Hot - Feet or Hands
Leg Cramps / Calf Pain / High Blood Pressure / Low Blood Pressure / Varicose Veins
Other_____

Eyes, Ears, Nose - Change in Vision / Blurry Vision / Double Vision / Itchy or Watery Eyes
Flashes Spots in Vision / Ringing in Ears / Hearing Loss / EarAche or Infection / Stuffy Nose
Nosebleeds / Frequent Sneezing / Allergies
Other_____

Mouth, Throat - Swallowing Issues / Jaw Pain / Changes in taste / Bleeding Gums / Cold Sores
Swelling / Sore Throat / Hoarseness
Other_____

Lungs - Asthma / Difficulty or Shortness of Breath / Wheezing / Persistent Cough / Pneumonia
Cough up Phlegm or Blood / Chest Congestion
Other_____

Skin - Rash / Bruising / Hair Loss / Brittle Nails / Changes in Moles / Itching / Peeling
Other_____

Gastrointestinal - Gas / Heartburn / Indigestion / Ulcers / Vomiting / Nausea / Abdominal Pain
Diarrhea / Constipation / Blood in Stool / Hemorrhoids / Gallbladder Disease / Liver Disease
Other_____

Patient's (or Guardian) Signature_____Date_____

Doctor's Signature_____Date_____

PAIN WEST

Urinary - Difficulty Urinating / Blood in Urine / Incontinence / Increased or Decreased Urine
Urinary Infection / Kidney Stones / Prostate Issues (male)
Other_____

Psychological - Excessive Stress / Depression / Anxiety / Mood Swings
Other_____

ObGyn - (females) Are you currently pregnant? Yes / No

PREVIOUS HEALTH HISTORY

Illnesses - Diabetes / Cancer / Other_____

Surgeries / Hospitalizations - list all

Accidents / Injuries - list all

Medications / Supplements - list all

Social - Consume Alcohol / Consume Caffeine / Tobacco Use / Recreational Drugs / Other_____
Exercise Regularly? Yes / No Hours of Sleep Per Night? _____

FAMILY HISTORY - Cancer / Alcohol / Heart Disease / Diabetes / Other_____

After receiving a copy, I acknowledge that I have read and understand Pain West Consent to treat form and agree to its terms. Initial:_____

After receiving a copy, I acknowledge that I have read and understand Pain West Assignment of Benefits form and agree to its terms. Initial:_____

After receiving a copy, I acknowledge that I have read and understand Pain West Health Privacy Policy (HIPAA) and agree to its terms. Initial:_____

Patient's (or Guardian) Signature_____Date_____

Doctor's Signature_____Date_____