PAINWEST
PAIN & INJURY CENTER

NEW PATIENT INTAKE R1.2026 Patient # (Office Use):_____

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

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

Occupation:_____Employer:_____Address:_____

Emergency Contact:_____Phone:_____Relationship:_____

Marital Status: ▢ M ▢ S ▢ D ▢ W Spouse / Partner name:_____# of Children:____

Race:_____Ethnicity:_____Preferred Language:_____

PAYMENT / INSURANCE

▢ Self Pay ▢ Medicare ▢ Medicaid ▢ General Insurance ▢ Auto Accident ▢ Work Comp

Primary Insurance:_____Policy #:_____

Secondary Insurance:_____Policy#:_____

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

▢ Pain Relief ▢ Improved Motion ▢ Decreased Symptoms ▢ Prevention ▢ Improved Quality of Life

▢ Other _____

Is this related to an auto accident or work Injury ? ▢ Y ▢ N If yes, when? _____

Patient's (or Guardian) Signature_____Date_____

Doctor's Signature_____Date_____

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COMPLAINT #1_____When did it start?_____

Do you know what caused it?_____

What makes it better or worse? _____

What does it feel like? ▢ Sharp ▢ Dull ▢ Aching ▢ Other_____

Severity of pain from 1-10?_____Does it shoot anywhere?_____

How often do you feel pain? ▢ Constant ▢ Intermittent ▢ Occasional _____

Have you seen anyone else for this issue? ▢ Y ▢ N _____

Have you had Xray, MRI or CT for this issue? ▢ Y ▢ N If yes, where?_____

COMPLAINT #2_____When did it start?_____

Do you know what caused it?_____

What makes it better or worse? _____

What does it feel like? ▢ Sharp ▢ Dull ▢ Aching ▢ Other_____

Severity of pain from 1-10?_____Does it shoot anywhere?_____

How often do you feel pain? ▢ Constant ▢ Intermittent ▢ Occasional _____

Have you seen anyone else for this issue? ▢ Y ▢ N _____

Have you had Xray, MRI or CT for this issue? ▢ Y ▢ N If yes, where?_____

COMPLAINT #3_____When did it start?_____

Do you know what caused it?_____

What makes it better or worse? _____

What does it feel like? ▢ Sharp ▢ Dull ▢ Aching ▢ Other_____

Severity of pain from 1-10?_____Does it shoot anywhere?_____

How often do you feel pain? ▢ Constant ▢ Intermittent ▢ Occasional _____

Have you seen anyone else for this issue? ▢ Y ▢ N _____

Have you had Xray, MRI or CT for this issue? ▢ Y ▢ N If yes, where?_____

Patient's (or Guardian) Signature_____Date_____

Doctor's Signature_____Date_____

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REVIEW OF SYMPTOMS

General - Weak / Tired / Irritable / Foggy / Sleep Issues / Weight Gain / Loss / Poor Stress Tolerance / Difficulty Recovering after Illness or Workout / 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 & Hand Pain Shoulder Pain / Elbow Pain / Hip Pain / Knee Pain / Foot & Ankle Pain / Other_____

Cardiovascular - Chest Pain / Palpitations / Ankle Swelling / Cold or Hot - Feet or Hands Leg Cramps / Calf Pain / Easily Winded / Other_____

Eyes, Ears, Nose - Vision Changes / Itchy or Watery Eyes / Ringing in Ears / Hearing Loss / EarAche / Stuffy Nose / Frequent Sneezing / Other_____

Mouth, Throat - Swallowing Issues / Jaw Pain / Swelling / Sore Throat / Other_____

Lungs - Shortness of Breath / Wheezing / Persistent Cough / Recurrent Infections / Other_____

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

GI - Heartburn / Ulcers / Vomiting / Nausea / Abdominal Pain / Diarrhea / Constipation / Hemorrhoids / Gallbladder / Liver Disease / Other_____

Urinary - Difficulty Urinating / Blood in Urine / Incontinence / Other_____

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

Additional Information - Is there anything else we should know? ▢ Y ▢ N

Explain_____

Patient's (or Guardian) Signature_____Date_____

Doctor's Signature_____Date_____

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MEDICAL & SOCIAL HISTORY

Are you currently under medical care? ▢ Y ▢ N What for?_____

Primary Care Provider? _____

Are you pregnant? *(females)* ▢ Y ▢ N Do You Exercise Regularly? ▢ Y ▢ N

Do you regularly use alcohol? ▢ Y ▢ N Do you regularly use tobacco? ▢ Y ▢ N

Do you use recreational drugs? ▢ Y ▢ N Are you currently taking NSAIDs? ▢ Y ▢ N

Previous surgeries / hospitalizations? _____

Previous accidents / injuries? _____

Current medications? _____

Family illnesses? _____

Known Allergies? _____

Patient's (or Guardian) Signature_____Date_____

Doctor's Signature_____Date_____