

INNOVATIVE PAIN RELEASE CENTER

1769 Jamestown Rd. Suite 214

Williamsburg, VA 23185

757-869-1936

Email: info@innovativepainrelease.com

INITIAL INTAKE INFORMATION

(Please complete and print this form and bring to your session)

Date:		PCP:		
GENERAL INFORMATION				
Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widowed
Street address:		Birth date:	Phone: ()	
P.O. box:	City:		State:	ZIP Code:
Email:		SSN:		

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone : ()	Work phone: ()
<p>The above information is true to the best of my knowledge. I understand that I am financially responsible for all charges incurred for my treatment and that Innovative Pain Release Center does not submit for insurance payments.</p>			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	

1. Date of injury, or when did your symptoms begin?

2. How did you injure yourself (describe briefly)?

Or was there no apparent reason?

3. Are your symptoms:

getting worse improving unchanged

4. Does your pain/symptoms interfere with your daily living and performing normal functions around the home?

Yes No

5. What is your pain rating? (0 = no pain, 10 = worst possible pain imaginable)

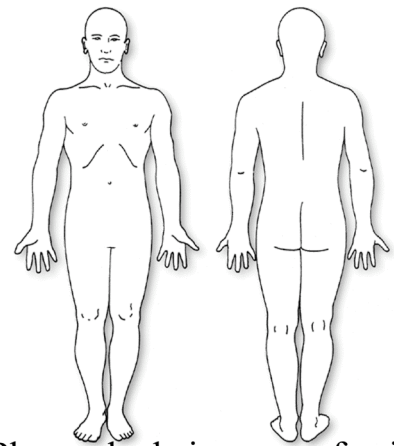
Daily average: _____ Morning: _____ Evening: _____

6. Do any of the following **intensify** your symptoms? (Check all that apply)

- | | | | |
|-------------------------------------|--|--|----------------------------------|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting | <input type="checkbox"/> Coughing/Sneezing | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Changing from sitting to standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Moving your neck | <input type="checkbox"/> Other: | |

7. Do any of the following decrease your symptoms? (Check all that apply)

- | | | | |
|-------------------------------------|--|--|----------------------------------|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting | <input type="checkbox"/> Coughing/Sneezing | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Changing from sitting to standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Moving your neck | <input type="checkbox"/> Other: | |



Please shade in areas of pain.

8. Have you noticed any loss of strength?

Yes No

9. Are you having difficulty with your bowel and/or bladder functions?

Yes No

10. Is your sleep interrupted by pain?

Yes No

11. Do you have any past history of the current problem? Briefly describe.

12. Have you had prior treatment for this condition? Yes No

Please describe the type of treatment:

13. Please list previous surgeries, with approximate date if able:

14. Have you had any of the following procedures?

Please include date and results.

X- Rays:

CAT Scan:

MRI:

EMG:

Bone scan:

Discogram:

Myelogram:

Injections:

Other test(s): _____

15. Please list any other medical conditions you have been diagnosed with:

16. Describe your overall general health?

Good Fair Poor

17. Do you smoke?

Yes, _____ packs per day No

18. Do you drink alcoholic beverages?

Often Occasionally Never

19. Are you currently employed?

Yes No

20. Current occupation?

21. Please list your current medications and any supplements. Only list the name.

22. What activities would you like to be able to perform better after therapy at Innovative Pain Release Center? (Gain more movement, less pain when doing....., etc.) Please be as specific as possible. After all, this is why you are here!!!

23 May I send you medical news updates, information about specials, and other health-related items? I will never rent, share, sell, or give away your personal data to anyone.

Yes No