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:			❑ Mr. ❑ Mrs.	❑ Miss ❑ 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: ( )

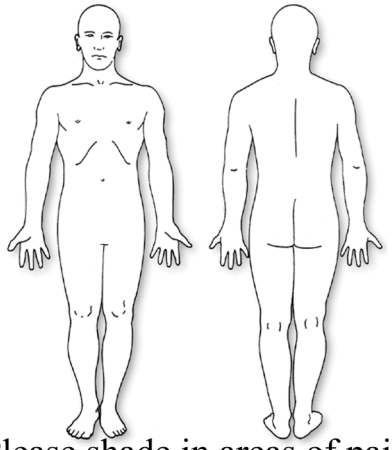
The above information is true to the best of my knowledge. I understand that I am financially responsible for all charges incurred for my treatment and that Innovative Pain Release Center does not submit for insurance payments.

Patient/Guardian signature *Date*

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

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

   Or was there no apparent reason? ❑



Please shade in areas of pain.

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)

❑ Bending	❑ Lifting	❑ Coughing/Sneezing	❑ Sitting
❑ Standing	❑ Changing from sitting to standing	❑ Walking	❑ Driving
❑ Lying down	❑ Moving your neck	❑ Other:	

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

❑ Bending	❑ Lifting	❑ Coughing/Sneezing	❑ Sitting
❑ Standing	❑ Changing from sitting to standing	❑ Walking	❑ Driving
❑ Lying down	❑ Moving your neck	❑ Other:	

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