BAYOU
PAIN & SPINE
ARTEMUS FLAGG II, MD, MPH

New Patient Intake Form

Patient Information

Today's date: _____

Your name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ SSN: _____

Referring Physician: _____ Primary Care Physician: _____

Emergency Contact Name: _____ Phone Number:_____

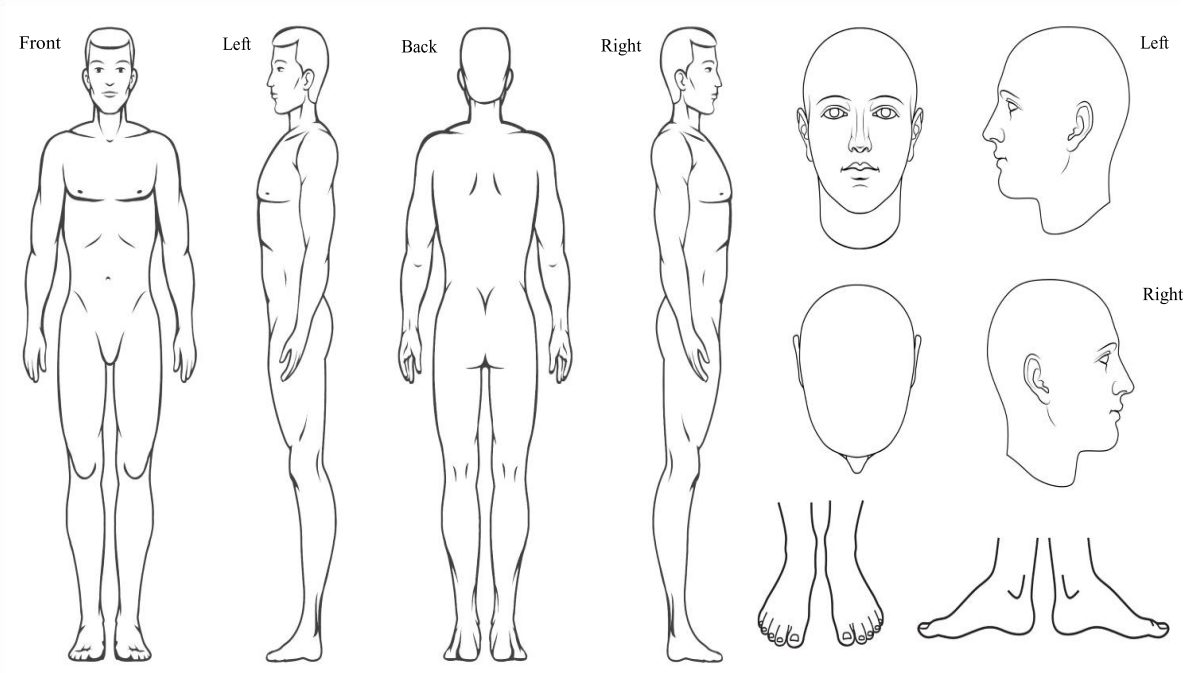
Preferred Pharmacy: _____ Phone Number: _____

Pain History

Chief Complaint (Your worst area of pain)? _____

Does this pain radiate? If so, where? _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately when did this pain begin? _____

How did your pain start? ☐ Work Accident ☐ Car Accident ☐ Fall ☐ Illness ☐ Other Injury ☐ Unknown

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description

What make your pain worse?

_____

What makes your pain better?

_____

How often does the pain occur?

☐ Constant ☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

Associated Symptoms

	NO	Yes	Comments
Numbness/Tingling	☐	☐	Where? _____
Weakness in the arm/leg	☐	☐	_____
Bladder Incontinence	☐	☐	_____
Bowel Incontinence	☐	☐	_____
Joint Swelling/Stiffness	☐	☐	_____

Please mark all of the following treatments you have used for pain relief

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐

Other _____

Interventional Pain Treatment History

☐ Epidural Steroid Injection Relief ☐ Yes ☐ No

☐ Joint Injection Relief ☐ Yes ☐ No

☐ Nerve Blocks Relief ☐ Yes ☐ No

☐ Trigger Point Injections Relief ☐ Yes ☐ No

☐ Other _____

Diagnostic Testing and Treatments

Mark all of the following tests that you have related to your current pain complaints:

☐ I have not had ANY diagnostic tests for my current pain complaint

☐ MRI of the: _____ Date: _____

☐ X-Ray of the: _____ Date: _____

☐ CT Scan of the: _____ Date: _____

☐ EMG/NCV study of the: _____ Date: _____

☐ Other Diagnostic Testing: _____ Date: _____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/Psychologist

☐ Chiropractor ☐ Orthopedic Surgeon ☐ Rheumatologist

☐ Internist ☐ Physical Therapist ☐ Neurologist

☐ Other _____

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

☐ I have **NEVER** had any surgical procedures performed.

1) _____ Date? _____

2) _____ Date? _____

3) _____ Date? _____

4) _____ Date? _____

5) _____ Date? _____

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	**Dose**	**Frequency**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____

Please list all past pain medications that you HAVE TRIED for your current pain?

	Medication Name	**Dose**	**Frequency**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

	Medication Name	
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Family History

Mark all that apply (ex. Mother and Father):

☐ I have no significant family medical history

☐ Anxiety	☐ Cancer	☐ COPD/Emphysema
☐ Depression	☐ Diabetes	☐ Fibromyalgia
☐ Headaches/Migraines	☐ Heart Disease	☐ High Blood Pressure
☐ Kidney Problems	☐ Liver Problems	☐ Osteoporosis
☐ Rheumatoid arthritis	☐ Seizures	☐ Stroke

☐ Other Medical Problems: _____

Social History

Employment Status

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Employed ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use:

☐ Social Use ☐ Daily Use ☐ Never ☐ Current Abuse ☐ History of Abuse

Tobacco Use:

☐ Current user ☐ Former user ☐ Never used ☐ E-cigarettes/Vaping Use

Illegal Drug Use:

☐ Denies illegal drug use ☐ Currently uses illegal drugs ☐ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past

☐ High Blood Pressure	☐ Asthma	☐ Hypothyroidism	☐ Hyperthyroidism	☐ Headache/Migraines
☐ Diabetes I or II	☐ Chemotherapy	☐ Shingles	☐ Multiple Sclerosis	☐ Heart Murmur
☐ Anemia	☐ COPD/Emphysema	☐ Kidney Stones	☐ Dementia	☐ Heart Attack
☐ Arthritis	☐ HIV/AIDS	☐ TMJ	☐ Alzheimer's	☐ Clotting Disorder
☐ Artificial Joint	☐ Peripheral Vascular Disease		☐ Seizure Disorder	☐ Glaucoma
☐ Hemophilia	☐ Hepatitis ____	☐ Liver Failure	☐ Kidney Disease	☐ Kidney Failure
☐ Liver Disease	☐ Anxiety	☐ Depression	☐ Fibromyalgia	☐ GERD/Acid Reflux
☐ Cancer	☐ Sleep Apnea	☐ Other psychological Disorders _____		
☐ Post-Herpetic Neuralgia		☐ Post-Trauma Stress Disorder		
☐ Diabetic Peripheral Neuropathy				

Review of Systems

Mark the following symptoms that you currently suffer from:

General Health: ☐ Fever ☐ Night Sweats ☐ Chills ☐ Fatigue ☐ Unexplained Weight Loss ☐ Unexplained Weight Gain	**Eyes:** ☐ Double Vision ☐ Blurry Vision ☐ Skin Color Changes	**Ears/Nose/Throat:** ☐ Decreased Hearing ☐ Ringing in ears ☐ Sinus Problems ☐ Sore Throat ☐ Dry Mouth ☐ Difficulty Swallowing ☐ Neck mass or growth
Lungs: ☐ Short of Breath at rest ☐ Short of Breath when Active ☐ Wheezing ☐ Snoring / stop breathing ☐ Hard to breath at night	**Heart/Cardiac:** ☐ Chest Pain ☐ Chest pressure ☐ Palpitations ☐ Shortness of breath when lying down ☐ Edema (swelling) legs ☐ Calf pain with walking	**Gastrointestinal:** ☐ Stomach pain ☐ Heartburn ☐ Acid Reflux or GERD ☐ Nausea/Vomiting ☐ Constipation ☐ Diarrhea ☐ Blood in vomit or stool ☐ Can't control bowels
Genitourinary: ☐ Blood in Urine ☐ Urinary urgency ☐ Can't control urine ☐ Erectile Dysfunction	**Endocrine/Hormones:** ☐ Excessive thirst ☐Excessive sweating ☐ Get hot to easily ☐ Excessive urination	**Musculoskeletal:** ☐ Back Pain ☐ Neck Pain ☐ Knee Pain ☐Shoulder Pain ☐ Hip Pain ☐ Joint Pains ☐ Joint Stiffness ☐ Muscle weakness
Neurology: ☐ Headaches ☐ Dizziness ☐ Seizures ☐ Problems with memory ☐ Trouble concentrating ☐ Confusion ☐ Not steady when walking	**Blood:** ☐ Easy bruising ☐ Easy bleeding ☐ Anemia **Dermatological (Skin):** ☐ Rash ☐ Itching ☐ Changes in skin color ☐ Sores that do not heal	**Psychiatric:** ☐ Anxiety ☐ Pain ☐ Hopelessness ☐ Depression ☐ Insomnia ☐ Thoughts of Suicide