BAYOU
INJURY TREATMENT CENTER

New Patient Intake Form

Your completed intake paperwork helps Dr. Flagg get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call if you have any question on how to complete any section on this 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: _____

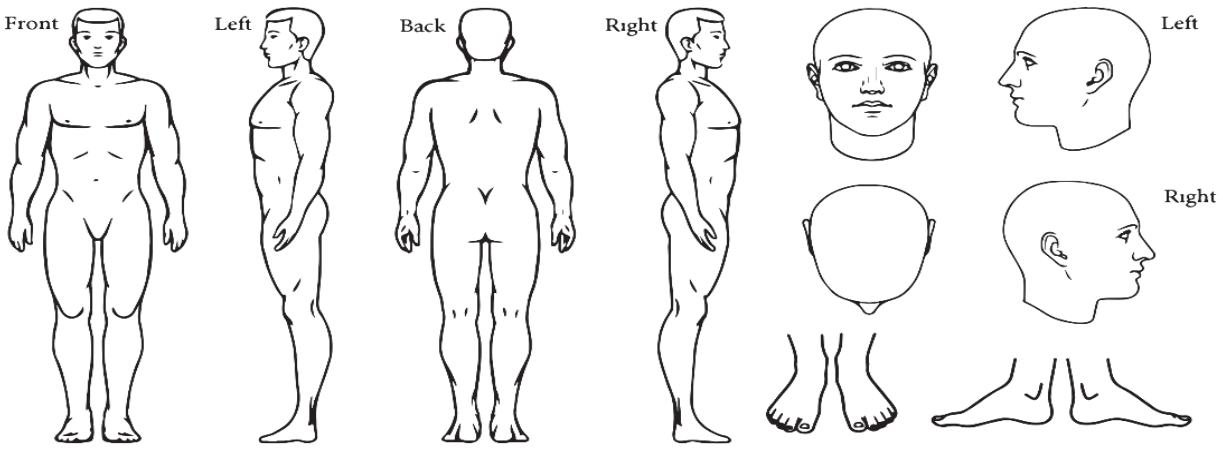
Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

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? _____

What caused your current pain? ☐ Work Accident ☐ Car Accident ☐ Fall ☐ Illness ☐ Other Injury ☐ Unknown

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

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

Pain Description

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing

☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness

When is your pain at its worst?

☐ Mornings ☐Daytime ☐ Evenings ☐ Middle of the night

☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present

☐ 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_____

Mark the effect each of the following have on your pain level - ☑

	Increases	Decreases	No Change
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

What other factors worsen or affect your pain which is not mentioned above?

_____

_____

Associated Symptoms

Numbness/Tingling	☐	☐	Where? _____
Weakness in the arm/leg	☐	☐	_____
Balance Problems	☐	☐	_____
Bladder Incontinence	☐	☐	_____
Bowel Incontinence	☐	☐	_____
Joint Swelling/Stiffness	☐	☐	_____
Fevers/chills	☐	☐	_____
	☐	☐	

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	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐

Other _____

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) _____

☐ Medial Branch Blocks/Facet Injections - (circle all that apply) Cervical/Thoracic/Lumbar

☐ MILD (Minimally Invasive Lumbar Decompression) - _____

☐ Nerve Blocks – Area/Nerve(s) - _____

☐ Radiofrequency Nerve Ablation – (circle all that apply) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____

☐ Trigger Point Injections – Where? _____

☐ Vertebroplasty/Kyphoplasty – Level(s) _____

☐ Other: _____

Which of these procedures listed above have helped with your pain? _____

_____

Diagnostic Tests and Imaging

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)			
7)			
8)			
9)			
10)			

Please list all past pain medications that you have been on at any point for your current pain complaints.

	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	Allergic Reaction
1)		
2)		
3)		
4)		
5)		

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

Past Medical History

Please list the names of other Pain Physicians you have seen in the past?_____

_____

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

General Medical
- ☐ Cancer – Type _____
- ☐ Chemotherapy
- ☐ Diabetes – Type_____

Cardiovascular/Blood Disorders
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders
- ☐ Heart Murmur
- ☐ Clotting Disorder
- ☐ Hemophillia
- ☐ Hepatitis
- ☐ HIV / AIDS

Gastrointestinal
- ☐ GERD
- ☐ Acid Reflux
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ Constipation
- ☐ Liver Disease
- ☐ Liver Failure

Neurology
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Diabetic Peripheral Neuropathy
- ☐ Post-Herpetic Neuralgia
- ☐ Seizures
- ☐ Depression
- ☐ Dementia
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ PTSD (Post-Traumatic Stress Disorder)

Head/Ears/Eyes/Nose/Throat
- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD
- ☐ Sleep Apnea

Urological
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Kidney Failure
- ☐ Dialysis

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains
- ☐ Artificial Joint

Other Diagnosed Conditions
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Family History

Mark all appropriate diagnoses as they pertain to your first-degree relatives:

☐Arthritis ☐Cancer ☐Diabetes

☐Headaches/Migraines ☐High Blood Pressure ☐Kidney Problems

☐Liver Problems ☐Osteoporosis ☐Rheumatoid arthritis

☐Seizures ☐ Stroke ☐ Depression

☐Heart Disease ☐ COPD / Emphysema ☐ Lung Disease

☐Other Medical Problems: _____

☐ I have no significant family medical history

Social History

Occupation:_____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home?_____If so how many? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ 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 ☐ History of alcoholism ☐ Current alcoholism ☐Never

☐ Daily use of alcohol

Tobacco Use: ☐ Former user ☐ Never used

☐ Current user

☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

☐ E-cigarettes/Vaping use

Illegal Drug Use:

☐ Denies any illegal drug use ☐ Currently uses illegal drugs

☐ Formerly used illegal drugs (not currently using)

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

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

☐ All other review of systems negative