Wellness First Chattanooga, LLC
Wellness First Pain Management, PLLC
New Patient Intake

A. Personal Information

DOB: _____

1. Name: _____ 2. Date: _____

3. Address: _____
_____

4. Phone Numbers (please circle preferred):
Home: _____ Cell: _____
Please indicate if you would prefer us to leave a brief message with our call back number or an extended message with detailed information: ___ Brief Message ___ Extended Message

5. Confidential e-mail (to send you confidential medical information and monthly newsletter):
_____

6. Confidential fax (to send you confidential medical information): _____

7. Sex: _____ Male _____ Female 8. Height: _____

9. Blood Type: _____ 10. Primary Care Physician and phone number (if you have one):

10. Referring Physician and phone number:

11. Marital Status: ____ Single ____ Married _____ Divorced _____Widowed

12. Who lives with you in your house?

13. How many children do you have?

14. What is your current job/occupation?

15. If you work, does your pain interfere with your job? _____Yes _____No
If yes, please describe:_____

16. How would you rate your current health?
____ Poor ____ Average ____ Good ____ Excellent

17. What are your health-related goals?

18. What are your expectations as a Member of Wellness First?

B. Medical History

Please check the column that applies to each question. If there are sensitive issues that you would prefer to discuss only with the Healthcare Provider, please make a note on this form so that s/he knows to ask you about it.

Please check the appropriate column below:

Condition	Does Not Apply	Myself	Siblings	Parents	Grand-parents
1. Heart Disease					
2. Cancer					
3. Diabetes					
4. High Blood Pressure					
5. Arthritis					
6. Liver Disease (hepatitis, cirrhosis, etc.)					
7. Psychiatric Illness (depression, anxiety, psychotic disorders, etc.)					
8. Autoimmune Disease (lupus, rheumatoid arthritis, etc.)					
9. Endocrine Gland Disorders (thyroid, adrenal, pituitary)					
10. Neurological Disorders (stroke, seizures, Parkinson's, Alzheimer's, multiple sclerosis, etc.)					
11. Lung Disease (asthma, emphysema, bronchitis, etc.)					
12. Kidney Disease (stones, infections, cysts, etc.)					
13. Stomach/Esophagus Disorders (reflux, stricture, ulcers, etc.)					
14. Bowel Disease (malabsorption, lactose intolerance, diverticulitis, Crohn's, colitis, etc.)					
15. Bladder disease					
16. Substance Abuse (alcohol, prescription, or recreational drugs, tobacco)					
17. Weight Control Problems					
18. Osteoporosis/Weak Bones					
19. Migraine Headaches					
20. Anemia					
21. HIV/AIDS					
22. Allergies					
23. Memory Problems					
24. Sleep Apnea/Snoring					

***** Please List all Food and Medication Allergies***: _____

_____

_____

25. Please list any surgical procedures you have had (including plastic surgery), along with the approximate date:

_____
_____
_____

26. Please list any history of injury/trauma that you have experienced and the dates (car accidents, head injuries, broken bones, etc.): _____
_____
_____

27. Please list any medical tests/diagnostic procedures you have had (example: MRI, CT scan, X-Rays, Cardiac Stress Test, EKG, Respiratory Test, Biopsy, Colonoscopy, Spine Injection, etc.)

Procedure	When?	For what reason?

28. Please list all the medications (prescription and/or over-the-counter) you are currently taking and for what condition:

Medication	For what condition?	Dose (mg):	Times per day:

29. Please describe any past or current recreational drug use:

C. Current Symptoms

For the following categories, please check the symptoms that you are experiencing today to a degree that you feel <u>are extensive or unusual</u>.

<u>1. Cardiopulmonary</u>

Symptom	Yes	No
Chest pain while walking		
Frequent and recurring upper respiratory infections or colds/flu		
Fluid retention (e.g., swollen ankles, legs, etc.)		
Can't tolerate much exercise		
Difficulty breathing		
Chronic lung congestion		
Wheezing/Difficulty breathing		
Heaviness in legs		
Muscle cramps in lower legs while walking		

Heart pounds easily		
Heart misses beats or has extra beats		
Rapid heartbeat, fluttering		
Heartburn after eating		
Irregular/erratic blood pressure		
Blood pressure issues		
Difficulty lying flat		

2. Metabolic

Symptom	Yes	No
Certain foods cause ill feelings		
Difficulty gaining weight		
Difficulty losing weight		
Blood cholesterol Issues		
Swollen (bulging) eyes		
Cold hands and feet		
Crave salt or salty foods		
Blushing with no apparent cause		
Irritable if meal is missed		
Wake up in the middle of the night craving sweets		
Feel tired or weak if meal is missed		
Heart palpitations after eating sweets		
Need to drink caffeine to get going		
Feel tired 1 to 3 hours after eating		
Feel faint or weak		
Night sweats		
Increase thirsts		
Crave sweets (but eating sweets does not relieve symptoms)		
Sugar in urine		
Weight loss or gain of more than 10 lbs. in the last six months		

3. Kidney, Bowels, Bladder and Gastrointestinal

Symptom	Yes	No
Frequent urination or little/scant urination/dribbling		
Burning during urination		
Hemorrhoids		
Loss of bowel control		
Blood in urine		
Blood in stool		
Kidney stones		
Frequent urinary tract infections		
Diarrhea		
Constipation (hard or effortful bowel movements)		
Abdominal pain		
Nausea and/or vomiting		
Heartburn/reflux		
Flatulence (gas) or bloating		
Gallbladder problems		
Dependency on Antacids		

4. Neurological

Symptom	Yes	No
Headaches		
Faintness		
Seizures/convulsions		
Dizziness		
Tingling or numbness (list location)		
Balance problems		
Muscle weakness		
Paralysis		
Memory problems		
Loss of smell or taste		
Problems with attention and concentration		

5. Joints, muscle and bones

Symptom	Yes	No
Joint pain, swelling or stiffness		
Arthritis (osteo- or rheumatoid arthritis)		
Back pain		
Limited range of motion/movement		
Muscle tension or spasms		
Fibromyalgia		
Carpal Tunnel Syndrome		

6. Mind and Emotions

Symptom	Yes	No
Rapid mood swings		
Impatient, moody, nervous		
Lack of mental alertness		
Depression		
Anxiety/fear		
Lack of self-esteem		
Difficulty with memory, attention, or concentration		
Short attention span		
Personality changes		
Sleep disturbances		
Short temper/anger/irritability		
Excessive worrying		
Suicidal thoughts		
Confusion/poor comprehension		
Difficulty making decisions		
Excessive stress		
Restlessness, hyperactivity, or inability to relax		
Weakness, fatigue, or loss of energy		
Frequent infections		

7. Miscellaneous

Symptom	Yes	No
Frequent infections or illness		
Change in appetite		
Fatigue		

Apathy/lethargy/exhaustion		
Lumps in neck, armpits, groin or breast		
Broken bone as adult:		
Insomnia		
Hypersomnia (sleeping too much)		
Sleep Apnea		
Other symptoms (please list):		

8. For Men Only

Symptom	Yes	No
Difficulty maintaining/attaining an erection		
Ejaculation causes pain		
Sexual drive underactive or overactive		
Sexual drive overactive		
Premature ejaculation		
Pain/coldness in genital area		
Infertility		
Discharge from penis		
Past or present rash on penis		
Swollen genitals		
Genital sores		
Past or present sexually transmitted disease (specify):		
Jock itch		
Do you use Viagra?		
If yes, how often?		
If yes, has it helped you?		
Do you use any other medication for sexual function?		
If yes, please list and describe results:		
Were you a victim of physical, emotional or sexual abuse as a child? If so, please list type of abuse and ages it occurred:		
Date of last prostate exam:		
Date of last stress EKG (Treadmill Stress Test):		
Date of last chest X-ray:		

9. For Women Only

Symptom	Yes	No
Missed periods		
Pelvic or vaginal soreness or pain		
Menstrual pain		
Heavy menstrual bleeding		
Irregular periods		
Infertility		
Hot flashes/night sweats		
Underactive sex drive		
Bloating and swelling		
Tender breasts		
Low backache		
Vaginal itching, discharge or sores		
Past or present sexually transmitted disease (specify):		
Dislike of intercourse		
Pain in ovaries		

Water retention		
History of ovarian cysts/ uterine cysts/fibroids		
History of endometriosis		
Date of last menstrual period:		
Do you feel safe at home?		
Are you now or have you ever been a victim of domestic violence?		
Have you had a hysterectomy? If yes, why and when? Also please list what was taken out (e.g., uterus, ovaries, cervix):		
Form of birth control: None Pill IUD Sponge Diaphragm Foam Condoms Tubal Ligation or Hysterectomy		
Test Dates	**Results**	
Date of last pap smear/pelvic exam:		
Date of last breast exam:		
Date of last mammogram:		
Date of last colonscopy (or sigmoidoscopy):		
Date of last rectal exam:		
Date of last stress EKG (Treadmill Stress Test):		
Date of last chest X-ray:		

D. Lifestyle Summary

1. What are your hobbies?
2. Have you traveled outside the country in the last 5 years? If yes, please list countries you have visited in the last 5 years:
3. Do you consider yourself to be under a great deal of stress? Please explain:
4. Do you use a seat belt: Always Most of the time Sometimes Never
5. Do you have guns in your home? Yes No If yes, are they loaded? Yes No If yes, do you keep them locked up? Yes No
6. Do you have a working smoke detector? Yes No
7. Do you have a working carbon monoxide detector? Yes No

E. Exercise Summary

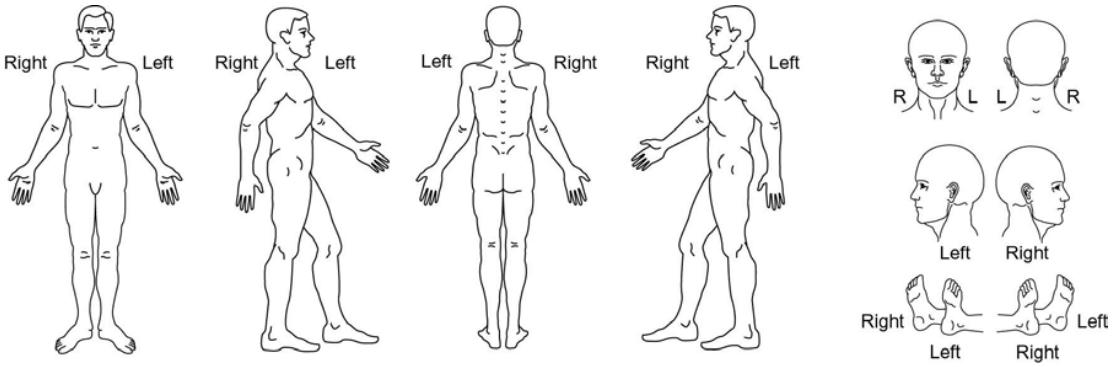
1. How often do you engage in exercise (walking, jogging, biking, swimming)?
   a. Times per week: _____
   b. Length of each exercise period: _____
2. How often do you engage in flexibility and/or stretching exercises (yoga, tai chi, stretch and toning classes, brief stretching after aerobics or weights)?
   a. Times per week: _____
   b. Length of period: _____
3. How often do you participate in resistance/strength training exercises (free weights, weight machines, body pump classes, water aerobics)?
   a. Times per week: _____
   b. Length of each exercise period: _____
   c. Please describe your routine: _____

F. Dietary Summary

1. How many cups of tea do you drink a day?	2. How many cups of coffee do you drink a day?
3. How many diet sodas or other drinks with aspartame do you drink a day?	4. How many 8 oz. glasses of water do you drink a day?
5. How many high sugar foods do you eat a day (cakes, cookies, breads, pasta, etc.)?	

G. Pain Summary

1. Where is your primary or worst pain located? (Please mark only ONE):
   □ headache □ neck pain □ mid-back pain □ low back pain
   □ facial pain □ abdominal pain □ leg pain □ arm pain
   □ groin pain □ pelvic pain □ buttock/tailbone pain □ hand pain
   □ other (please describe):
2. Where is your secondary pain located, if applicable? (Please mark only ONE):
   □ headache □ neck pain □ mid-back pain □ low back pain
   □ facial pain □ abdominal pain □ leg pain □ arm pain
   □ groin pain □ pelvic pain □ buttock/tailbone pain □ hand pain
   □ other (please describe):
3. Please mark the location of your pain below, with darker areas indicating where your pain is highest:



4. When did your pain begin? _____months _____ years

5. What is the cause of your pain? Please mark all that apply:
   □ Normal aging □ Work Injury □ A Fall □ Playing Sports
   □ A motor vehicle accident □ Unknown □ Other (please describe):

6. How often do you have pain?
   □ Constantly □ Most of the time □ Some of the time □ Only occasionally
   □ The pain is constant but the intensity fluctuates □ Depends on the location of the pain

7. How would you describe your pain? Please check all that apply:
   □ Sharp □ Dull □ Achy □ Cramping □ Throbbing □ Stabbing
   □ Burning □ Stinging □ Tingling □ Numb □ Radiating □ Pins/Needles
   □ Other (Please describe): _____

8. What is your pain level most of the time, with "0" being no pain and "10" being the worst pain imaginable?

□ 0	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10
No pain	Discomfort	Mild	Achy	Moderate	Distress	Misery	Torment	Anguish	Agony	Torture

9. When the pain is at its worst, what limitations do you have at home and at work?
   Home:_____
   Work: _____

10. What, if anything, *decreases* your pain? _____

10b. What, if anything, *increases* your pain? _____

11. My pain has been evaluated by the following (mark all that apply):

□ X-rays □ MRI □ CT scan □ Bone Scan □ Bone Density Test □ Lab/Blood work
□ EMG/nerve conduction □ Depression evaluation □ Vascular studies □ None
□ Other (please describe): _____

12a. Please check any of the following you have received for your pain:

□ No Treatments □ Neck brace □ Back brace □TENS unit □ Cane or Walker
□ Weight loss □ Exercise Program □ Water therapy □ Physical Therapy □ Muscle injections
□ Spinal injections □ Surgery □ Spinal Cord Stimulator
□ Chiropractic care □ Acupuncture □ Massage □ Supplements □ Yoga
□ Hypnosis □ Therapeutic Touch □ Psychological Treatment (e.g., pain management skills)
□ Other (please describe): _____

12b. Please check which of the treatments you marked above that were helpful in managing your pain:

□ None of the above □ Neck brace □ Back brace □TENS unit □ Cane or Walker
□ Weight loss □ Exercise Program □ Water therapy □ Physical Therapy □ Muscle injections
□ Spinal injections □ Surgery □ Spinal Cord Stimulator
□ Chiropractic care □ Acupuncture □ Massage □ Supplements □ Yoga
□ Hypnosis □ Therapeutic Touch □ Psychological Treatment (e.g., pain management skills)
□ Other (please describe): _____

13a. Which of the following anti-inflammatory/analgesic medications have been used to ***treat*** your pain?

□ None □ Aspirin, ASA, Bayer, BC or Goody Powders, Bufferin, Excedrin, Norgesic
□ Ibuprofen (Advil, Motrin) □ Acetaminophen (Tylenol) □ Naproxen (Naprosyn, Aleve, Anaprox)
□Arthrotec □ Celebrex □ Daypro □ Ketoprofen □ Etodolac (Lodine)
□ Mobic □ Relafen □ Toradol □ Tramadol (Ultracet) □ Indomethacin (Indocin)
□ Other (Please list): _____

13b. Which of the above anti-inflammatory/analgesic medications have been ***helpful*** in managing your pain?

□ None of the above □ Aspirin, ASA, Bayer, BC or Goody Powders, Bufferin, Excedrin, Norgesic
□ Ibuprofen (Advil, Motrin) □ Acetaminophen (Tylenol) □ Naproxen (Naprosyn, Aleve, Anaprox)
□Arthrotec □ Celebrex □ Daypro □ Ketoprofen □ Etodolac (Lodine)
□ Mobic □ Relafen □ Toradol □ Tramadol (Ultracet) □ Indomethacin (Indocin)
□ Other (Please list): _____

14a. Which of the following muscle relaxer medications have been used to ***treat*** your pain?

□ None □ Baclofen (Lioresal) □ Carisoprodol (Soma) □ Diazepam (Valium)
□ Norflex □ Methocarbalmol (Robaxin) □ Parafon Forte □ Skelaxin
□ Tizanidine (Zanaflex) □ Cyclobenzaprine (Flexeril)
□ Other (Please list): _____

14b. Which of the above muscle relaxer medications have been ***helpful*** in managing your pain?

□ None of the above □ Baclofen (Lioresal) □ Carisoprodol (Soma) □ Diazepam (Valium)
□ Norflex □ Methocarbalmol (Robaxin) □ Parafon Forte □ Skelaxin
□ Tizanidine (Zanaflex) □ Cyclobenzaprine (Flexeril)
□ Other (Please list): _____

15a. Which of the following narcotic medication have been used to ***treat*** your pain?

□ None □ Codeine (Tylenol #3 or #4) □ Darvocet (Darvon, propoxyphene) □ Methadone
□ Lorcet (Lortab, Norco, Vicoden, hydrocodone) □ Percocet (Oxy-IR, Percodan, Roxicodone, Tylox, oxycodone)
□ Dilaudid (hydromorphone) □ MSContin (Oramorph SR, morphine) □ Actiq
□ Avinza □ OxyContin □ Kadian
□ Other (Please list): _____

15b. Which of the above narcotic medications have been ***helpful*** in managing your pain?

□ None of the above □ Codeine (Tylenol #3 or #4) □ Darvocet (Darvon, propoxyphene) □ Methadone
□ Lorcet (Lortab, Norco, Vicoden, hydrocodone) □ Percocet (Oxy-IR, Percodan, Roxicodone, Tylox, oxycodone)
□ Dilaudid (hydromorphone) □ MSContin (Oramorph SR, morphine) □ Actiq
□ Avinza □ OxyContin □ Kadian
□ Other (Please list): _____

16a. Which of the following other medications have been used to *treat* your pain?

□ None □ EMLA cream (lidocaine ointment) □ Lidoderm patch □ Neurontin (gabapentin)
□ Zonegram □ Topamax □ Trileptal □ Keppra □ Cymbalta
□ Lyrica □ Clonidine □ Klonopin (clonazepam) □ Duragesic Patch □ Elavil (amitriptyline)
□ Other (Please list): _____

16b. Which of the above other medication have been ***helpful*** in managing your pain?

□ None □ EMLA cream (lidocaine ointment) □ Lidoderm patch □ Neurontin (gabapentin)
□ Zonegram □ Topamax □ Trileptal □ Keppra □ Cymbalta
□ Lyrica □ Clonidine □ Klonopin (clonazepam) □ Duragesic Patch □ Elavil (amitriptyline)
□ Other (Please list): _____

17. Please rate all of the following based on how you feel <u>today</u>:

Activity	**Difficulty Level**			
	No Difficulty	**Some Difficulty**	**Much Difficulty**	**Unable to Do**
Dress yourself completely				
Comb, brush or style your hair				
Get in/out of bed or chairs				
Lift a full cup / glass to mouth				
Walk outdoors on flat ground				
Wash & Dry entire body				
Reach Overhead/bend/pick up clothes				
Open a jar or prescription bottle				
Get in & out of car or bus				
Ride in a car for more than 30 minutes				
Walk one mile with or without stops				
Climb one flight of stairs				
Play in sports/games as you would like to				
Sit at kitchen table for 30 minutes or more				
Sleep at least 6-8 hours a night				

18. In the morning, how long do you experience "morning stiffness": Hours ___ Minutes ____

19. How does your pain affect you? Please circle all that apply:

nausea shaky impaired appetite impaired sleep irritability

moodiness decreased physical activity crying affects relationships with others

decreased attention, concentration or memory suicidal thoughts hopelessness anxiety

helplessness impatient decreased desire for sex unable to work angry

other (please describe): _____

WELLNESS FIRST
TREATMENT GOALS CHECKLIST

As you embark or continue on your journey to improve your health and quality of life, you likely have a number of different goals in mind. It would help us to know what you would like to focus on, and we will help you track your progress in each area. Please **circle** the number of those goals that you would like to focus on. Please feel free to leave a comment next to any item.

1	Controlling my eating or weight
2	Starting or increasing an exercise program
3	Better managing my health
4	Learning how to relax/decreasing my stress
5	Improving my relationship with my partner or spouse
6	Improving my sexual relationship
7	Improving my nutrition
8	Better managing my pain
9	Feeling less depressed or anxious
10	Obtaining quality hormone modulation (e.g., improved libido, decreased hot flashes, stabilized mood, etc.)
11	Controlling my alcohol or drug use
12	Improving my sleep

Your signature and that of your health care provider indicates that this form was reviewed and that any information contained within it is as complete and accurate as possible :

Signature of patient_____ Date_____

Signature of Wellness First Health Care Provider _____

Survey of Internet/E-mail Capability and Interest

Do you have access to the Internet at your home or place of residence?
❍Yes ❍No ❍Not sure

Do you have an e-mail account?
❍Yes ❍No ❍Not sure

If we could provide medical information to you via e-mail or the Internet, would you be interested?
❍Yes ❍No ❍Not sure

If we could send a reminder of your appointment time and date to you via e-mail or the Internet, would you be interested?
❍Yes ❍No ❍Not sure

If you are interested in receiving information by email, please indicate the services that interest you (check all that apply):

❍Receiving laboratory and X-ray results by e-mail

❍Scheduling appointments online

❍Receiving appointment reminders by e-mail

❍Accessing copies of your personal medical record online

❍Accessing information about our office via a practice Web site

❍Receiving a health newsletter or health tips by e-mail

If you would like to receive appointment reminders, the Wellness First monthly newsletter (with health and wellness information), or other information from Wellness First please print your name below and sign your name and complete the date:

By signing below I am giving my consent to Wellness First to send me information and newsletters to the email listed below. I understand that I can request to stop receiving information and newsletters at any time by calling and requesting that my email be taken off the mailing list.

_____ _____
Printed Name Email Address (Please print clearly!)

_____ _____
Patient Signature Date