Zhou Pain Management Center

1230 S Hurstbourne Pkwy Louisville KY 40222 Phone: (502)425-3225 Fax: (502)385-0880 www.zhoupaincenter.com

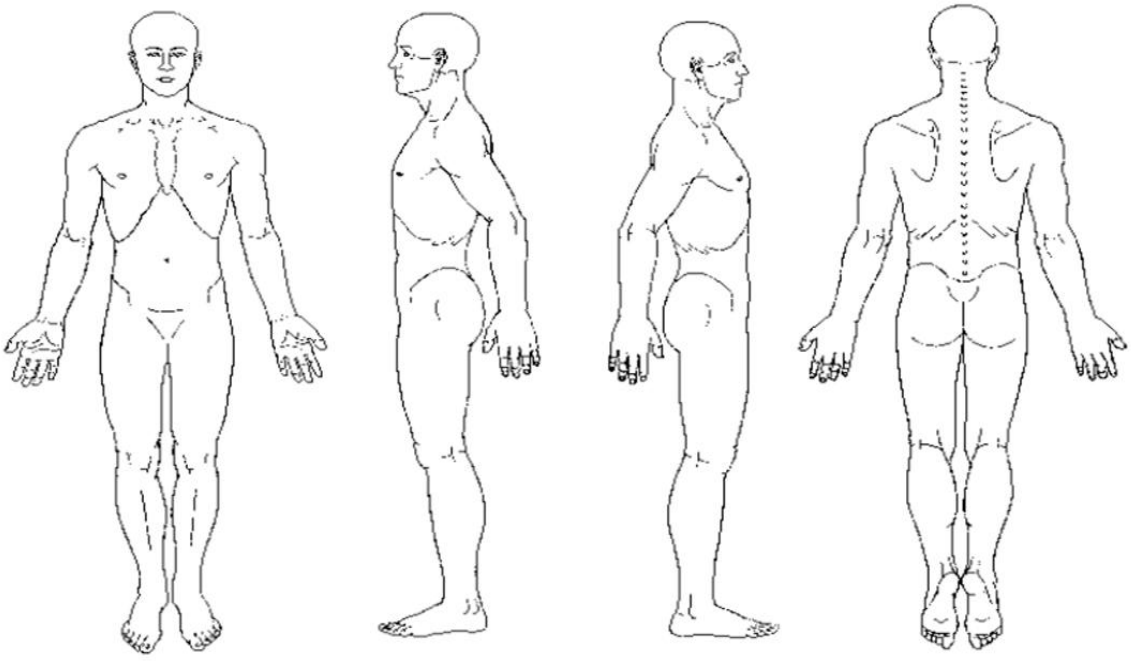
New Patient Intake Form

Patient Name:		Date:	
Date of Birth:		Age:	
SSN:		Referring Physician	
Address:		City State Zip code	
Cell Phone:		Secondary contact, relationship:	
Home Phone:		Phone:	
Marital Status		Race (optional)	
Employer:		Occupation:	
Smoking: ☐Never ☐Every day ☐Former		Alcohol: ☐Yes ☐No	
Primary Insurance:		Plan name and type:	
Insurance ID:		Group ID	
Subscriber Name:	Phone:	SSN:	
Address:			
Secondary insurance:			
Allergies:			

DESCRIBE YOUR PAIN

Main reason for visit:

INSTRUCTIONS: Please shade in or circle where your pain is located.



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On a Scale of 0-10 what is your pain (0 being no pain and 10 Being severe)

Good day 0 1 2 3 4 5 6 7 8 9 10

Bad day 0 1 2 3 4 5 6 7 8 9 10

Describe your pain(check all that apply):		**Pain is aggravated by (check all that apply)**		**Pain is alleviated by (Check all that apply)**	
☐Throbbing	☐Stabbing	☐Bending	☐Lifting	☐Bending	☐Mild Stretching
☐Aching Shooting	☐Dull	☐Exercise	☐Movement	☐Ice	☐Hot Packs
☐Spasms Weakness	☐Constant	☐Sitting	☐Standing	☐Tens unit	☐Rest
☐Hot/Burning	☐Intermittent	☐Walking	☐Lying Down	☐Sitting	☐Lying Down
☐Tiring/Exhausting	☐Sharp	☐Changing position		☐Other	
☐Numbness/Tingling	☐Cramping	☐Other			
☐Weakness	☐Pressure				

Exams	**Date:**	**Facility**
MRI		
X-Ray		
Myelogram		
CT Scan		

How & when did the pain start?

Have you ever had this pain before? ☐Yes ☐No If yes, how long ago?

Have you ever been treated for any type of addiction? ☐Yes ☐No
If yes, what kind of addiction:

PAST PAIN TREATMENT

	Yes	**No**
Pain Management/injection		
Medication		
Surgery		
Chiropractor		
Physical Therapy		
Massage Therapy		
Acupuncture		

CURRENT MEDICATIONS

List all medications you are currently taking (include prescriptions, over-the-counter):

Pharmacy Name: **Phone:**

Address:

MEDICAL HISTORY (check all that apply)

Arthritis	High Blood Pressure	Fibromyalgia	Heart Disease
Cancer	Stroke	High Cholesterol	Diabetes
Depression	Anxiety	Lung Disease	Thyroid Disease
List any other medical history			

SURGICAL HISTORY		
Lumbar Spine Surgery Date	Cervical Spine Surgery Date	Thoracic Spine Surgery Date
GI Surgery LAP band Gall Bladder Appendectomy	Cancer Surgery Date	Heart Surgery Date
GYN Surgery Date	List any other surgeries	

FAMILY HISTORY

	Father	Mother	Sibling
Arthritis			
Fibromyalgia			
High Blood Pressure			
Diabetes			
Cancer (list type)			
Heart Disease			
High Cholesterol			
Lung Disease			
Stroke			
Thyroid Disease			
Depression			