PREMIER CHRONIC PAIN CARE

619 Boulevard NE
Atlanta, GA 30308
Tel: (404) 523-0111; Fax: (888) 291-6290

Patient Intake Form

Name and Address	**Date of Birth**	***Appointment Date***

Home phone: ***Work phone:*** ***Cell phone:***

Who referred you or how did you hear about us?

What is the reason for your visit today? (Illness)

What other major health problems or illnesses do you have or did you have in the past?

	Past	Present		Past	Present
Arthritis			Thyroid disease:		
Asthma			Other:		
Cancer					
Diabetes					
Digestive disease					
Fibromyalgia					
Heart Disease					
Hepatitis					
Hypertension					

What operations have you had?

Tonsillectomy Year:	Appendectomy Year:	Sinus surgery Year:
Other—Please note year of procedure:		

Allergies (medication and all other):

What medications are you taking? (Include over-the-counter-drugs)

Medicine	When Started	Daily Dosage	Medicine	When Started	Daily Dosage

Review of Systems

Do you have any of the following symptoms or problems?

General	
Fatigue	☐
Difficulty sleeping	☐
Eyes	
Blurry vision	☐
Eye pain	☐
Ears / Nose / Throat / Sinuses	
Hearing loss	☐
Ringing in ears	☐
Frequent infections	☐
Pain	☐
Frequent canker sores	☐
Heart / Circulation	
Palpitations or irregular pulse	☐
Chest discomfort (tightness / pressure / pain)	☐
Leg swelling	
Lungs	
Shortness of breath	☐
Wheezing	☐
Other:	☐
Digestion / Elimination	
Heartburn	☐
Nausea / Vomiting	☐
Abdominal pain / cramps	☐
Abdominal bloating	☐
Excessive belching	☐
Excessive flatus	☐
Constipation	☐
Diarrhea	☐
Bladder / Kidneys / Urination	
Frequent infections	☐
Urgency	☐
Difficulty urinating	☐
Pain with urination	☐
Blood in urine	☐
Leakage	☐

Gynecological	
Abnormal periods	☐
Severe premenstrual symptoms	☐
Date of last menstrual period:	
Muscles / Bones / Joints	
Muscle pain	☐
Muscle cramps or spasms	☐
Tendonitis	☐
Joint pain / stiffness / swelling	☐
Low back pain	☐
Other:	☐
Nervous system	
Headaches	☐
Dizziness	☐
Balance problems	☐
Weakness / numbness / tingling sensations	☐
Memory problems	☐
Concentration problems	☐
Allergies / Immune System	
Seasonal or other allergies	☐
Hormonal / Endocrine	
Excessive thirst	☐
Excessive hunger	☐
Cold or heat intolerance	☐
Blood	
Easy bruising	☐
Abnormal bleeding	☐
Skin	
Rashes	☐
Eczema	☐
Other	☐
Psychiatric / Psychological	
Anxiety	☐
Panic attacks	☐
Depression	☐
Suicidal thoughts	☐

Diet

List any food sensitivities or intolerances:
Are you on any special diet? What foods do you avoid? Why?

Substance Use

Cigarettes	☐ Never Used	☐ Smoked from age _____ to _____, _____ packs per day.
Other Tobacco	☐ Never Used	☐ Cigars ☐ Pipes ☐ Snuff ☐ Chewing Tobacco Used from age _____ to _____, _____ times per day.
Alcohol	☐ Never Used ☐ Alcohol problem from age _____ to _____	☐ Estimate drinks per week:
Use of other recreational drugs?		