Rainbow Medical Corporation — *Intake Form*

Name: ______________________________ **DOB:** ____________ **Today's Date:** ____________

1. What is your **chief complaint** today?____

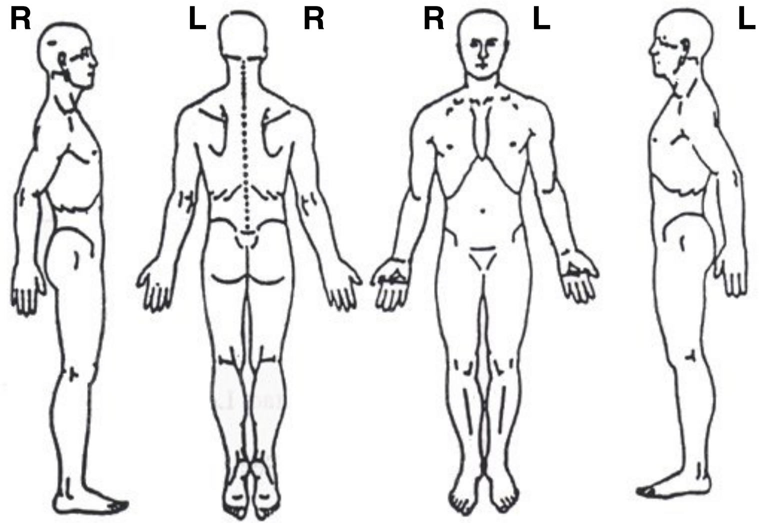
2. On the **diagram** below, mark where your pain is now and where it has been since your last visit:

3. Pain Control:
a) How has your pain been since last visit?
Improved   Worse   Same   Different

b) On a 0-10 scale with 10 = worst imaginable, what is your pain now? __________________

c) What is the lowest pain level (______) and the highest pain level (_______) you have felt in the last month?

d) What time of day is your pain at its highest?
____



e) What factors relieve your pain? ____

f) What factors worsen your pain? ____

g) How much pain relief do your medications provide?   25%   50%   75%   100%

h) How many hours of relief do your medications provide?   3 hours   4+ hours   6 hours   Other _______

i) When did you take your last dose of pain medication? ______________________________________

4. Regarding your currently prescribed medications:
a) Do you have side effects?   Yes No Sometimes
**If yes, please explain ____

b) Do you feel the medications you are taking impair your driving ability? Yes No Sometimes   Don't Drive

5. Have you experienced any new medical problems since your last visit? __________________________
____

6. Have you started any new medication from other doctors since your last visit? ____________________
____

7. Allergies (food or medications): ____

8. Sleep:
a) How many hours per night do you sleep? ____________   **b)** How many awakenings? ____________
c) Do you have trouble falling asleep?   Yes No Sometimes
d) Do you wake up in pain?   Yes No Sometimes

9. Activities:

a) Do you exercise? Yes No Sometimes Type(s): ____

b) Do you measure your steps per day? If so, how many: ____

c) Please describe your activities on a typical day: ____

____

d) Do you participate in any social activities on a regular basis? ________________________________

____

e) Have you been doing any of the non-medicinal methods that you've agreed to do? ________________

____

f) Are you interested in any of the following classes (circle all that apply): cooking/nutrition, yoga, meditation, aquatic therapy, wellness programs, other: ____

10. What is your current "mood"?: ____

11. What was the highlight of your week / or one thing you are grateful for: ________________________

12. I attest that I understand the risks of opioid therapy and the increased risks when used with alcohol and/or benzodiazepines (Ativan, Diazepam, Xanax, etc.) ________ *(initial)*

a) Do you smoke cigarettes? Yes No Sometimes

- **i.** How many packs per week __________

b) Do you drink alcohol? Yes No Sometimes

- **i.** How many drinks per week __________

13. Dr. Perry explained that the standard of care regarding opioid prescribing has changed such that many of his patients using opioids with an Morphine Equivalent Dose (MED) greater than 90 mg (CDC requirement) will have to <u>be tapered</u>. I understand, and I agree to this. ________ *(initial)*

14. Do you have any other <u>concerns</u> or <u>questions</u> you would like to address today?

____

____

____

____

Patient's Signature: ______________________ **Dr. Franklin Perry's Signature:** ______________________

*Space below is used for Dr. Perry's notes:

____

____

____

____

____

Patient's current MED: __________________

Date Revision (1/30/19)