

Patient Name: _____ DOB: _____



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NEW PATIENT EVALUATION

Today's Date: _____ Email: _____

Patient Name: _____
First MI Last Date of Birth

Who referred you: _____ Practice: _____

Primary Care Physician: _____

Pharmacy name and Telephone number: _____

Reason for Today's Visit: _____

1. When did your pain first begin (month and year)? _____

2. What is the main cause of your pain?

- Unknown Normal Aging Fall Sporting Accident
 Motor Vehicle Accident Work Injury Other _____

3.

- | | | | |
|-----------|----------|--------------|--------------|
| Aching | Burning | Crampi
ng | Dull |
| Numbness | Sharp | Stabbing | Stingi
ng |
| Throbbing | Tingling | | |

What best describes your pain? Choose one or more:

4. What is your pain level most of the time?

- 0-No Pain 1 2 3 4 5 6 7 8 9 10-Severe Pain

5. Have you had any of the following Imaging/Tests to assist in the evaluation of your pain:

- MRI: Yes No CT-Scan: Yes No Xray: Yes No EMG/Nerve Study: Yes No

6. Have you had any of the following injections to assist with the treatment of your pain? Choose one or more:

- Spine (neck, back) Joint Muscle None

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DOB: _____

7. Have you had any of the following surgeries? If yes, which year(s)?

- | | | | |
|-----------------------------------|-----------------------------------|-------------------------------|------------------------------|
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Neck | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Shoulder | <input type="checkbox"/> None | |

8. Have you tried any of the following therapies?

- | | | | |
|-----------------------------------|---------------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Aqua | <input type="checkbox"/> None |
|-----------------------------------|---------------------------------------|-------------------------------|-------------------------------|

9. Have you had any of the following to assist you with your pain?

- | | | | |
|--|--|--|---------------------------------|
| <input type="checkbox"/> Spinal Cord Stimulation | <input type="checkbox"/> Spinal Traction | <input type="checkbox"/> Cane | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Intrathecal Pain Pump | <input type="checkbox"/> None |

10.

-
-
-
-
-
-
-
-

- | | | | |
|--------------------|-------------------------|--------------------------|---------------------|
| Migraine headaches | High blood pressure | Emphysema | Cirrhosis |
| Kidney disorder | Cancer | Head Injury | High cholesterol |
| Asthma | Hepatitis | Fibromyalgia | Depression |
| Stroke | Coronary artery disease | Sleep Apnea | Gallbladder disease |
| Osteoporosis | Anxiety | Seizures | Heart Attack |
| Hiatal Hernia | Pancreatitis | Spine Disorder | Alcoholism |
| Addiction | Reflux | Multiple Sclerosis | Heart Arrhythmia |
| Diabetes | Arthritis OA/RA | Peripheral Nerve disease | HIV |
| Ulcers | Bowel Disease | Muscle disorder | |

Past Medical History (check all that apply):

11. Past Surgical History: _____
- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

12. Allergies: Yes No

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List Medication Allergies:

13. List all medications you are currently taking:

Patient Name: _____

DOB: _____

14. Have you tried any of the muscle relaxer medications below?

- | | | | | | |
|------------------|----------------------------------|--------------------------------------|---------------|----------------------------------|--------------------------------------|
| Baclofen: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Methocarbamol | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Cyclobenzaprine: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Tizanidine | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Carisoprodol: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Skelaxin®: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Diazepam: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Alprazolam | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |

None tried

15. Have you tried any of the narcotic medications below?

- | | | | | | |
|--------------|----------------------------------|--------------------------------------|-------------|----------------------------------|--------------------------------------|
| Codeine: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Oxycontin®: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Dilaudid: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Oxycodone: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Hydrocodone: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Morphine: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Opana | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Methadone: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |

None tried

16. Have you tried any of the following "other" medications below?

- | | | | | | |
|------------------|----------------------------------|--------------------------------------|-------------|----------------------------------|--------------------------------------|
| Cymbalta: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Lyrica: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Clonidine: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Gabapentin: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Amitriptyline: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Savella: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Keppra: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Topamax: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Klonopin: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Trileptal: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Lidoderm Patch®: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Zonegran: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Horizant: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Requip: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |

None tried

17. Have you tried any of the Anti-Inflammatory Medications below?

- | | | | | | |
|-------------|----------------------------------|--------------------------------------|---------------|----------------------------------|--------------------------------------|
| Aspirin: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Indomethacin: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Celebrex: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Ketoprofen: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Diclofenac: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Meloxicam: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Daypro: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Naproxen: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Duexis: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Relafen: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Etodalac: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Toradol: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |
| Prednisone: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | Tylenol: | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful |

None tried

18. Family Medical History (check all that apply):

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Migraine headaches

High blood pressure

Emphysema

Cirrhosis

Kidney disorder

Cancer

Head Injury

High cholesterol

Asthma	Hepatitis	Prostate disorder	Depression
Stroke	Coronary artery disease	Sleep Apnea	Gallbladder disease
Osteoporosis	Anxiety	Seizures	Heart Attack
Hiatal Hernia	Pancreatitis	Spine Disorder	Alcoholism
Addiction	Reflux	Multiple Sclerosis	Heart Arrhythmia
Diabetes	Arthritis OA/RA	Peripheral Nerve disease	Ulcers
Bowel Disease	Muscle disorder		

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19. What is your marital status?

- Single Married Separated Divorced Widowed

20. Who resides in your home and/ or assists you if needed?

- Alone Spouse Children Parents
- Skilled Nursing Facility/Hospice House, what is the name of it: _____

21. Smoking Status:

- Every day smoker Occasional smoker Former smoker Non-smoker

22. Alcohol Use:

- None Rarely Occasionally Regularly

23. Do you use street drugs? If yes, which?

- Yes No

24. Preventative Medicine: Falls Risk Screening: **IF YOU ARE 65 OR OLDER, PLEASE CHECK ALL THAT APPLY**

- No falls in the past year
 One fall with injury in the past year
 One fall without injury in the past year
 Two or more falls with injury in the past year
 Two or more falls without injury in the past year

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25. Review of systems (Mark all that apply):

General

- Weight loss
- Weight gain
- Fever
- Night sweats
- Fatigue
- Many infections

HEENT

- Headache
- Facial pain
- Sinusitis
- Loss of vision
- Hearing loss Teeth/
Gum problems

Respiratory

- Chronic cough
- Wheezing
- Shortness of breath
- Sleep Apnea
- Home oxygen
use C-Pap

Cardiology

- Chest pain
- Murmur
- Congestive failure
- Abnormal EKG
- High Blood
Pressure

GI

- Appetite loss
- Chronic Anemia
- Heartburn
- Constipation
- Testicular pain
- Diarrhea

Genitourinary

- Painful urination
- Blood in urine
- Bladder control loss
- Enlarged prostate

Endocrine/Hematology

- Abnormal blood sugars
- Easy bruising/bleeding
- Dizziness
- Thyroid Problems

Musculoskeletal

- Joint pain
- Muscle spasm
- Neck pain
- Back pain
- Carpel
- Tunnel Gout
- Swollen Joints

Neurology

- Drowsiness
- Dizziness
- Blackouts
- Tremors
- Numbness
- Memory Loss
- Balance
- Difficulty

Psychiatric

- PanicAttack/
Anxiety Insomnia
- Depression
-

Vascular

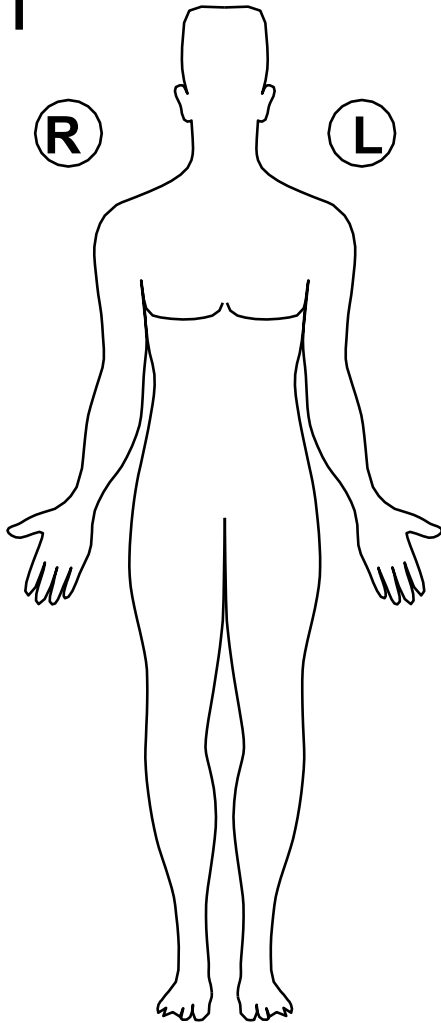
- Poor circulation
- Current blood
clot Swelling in
legs
-

Skin

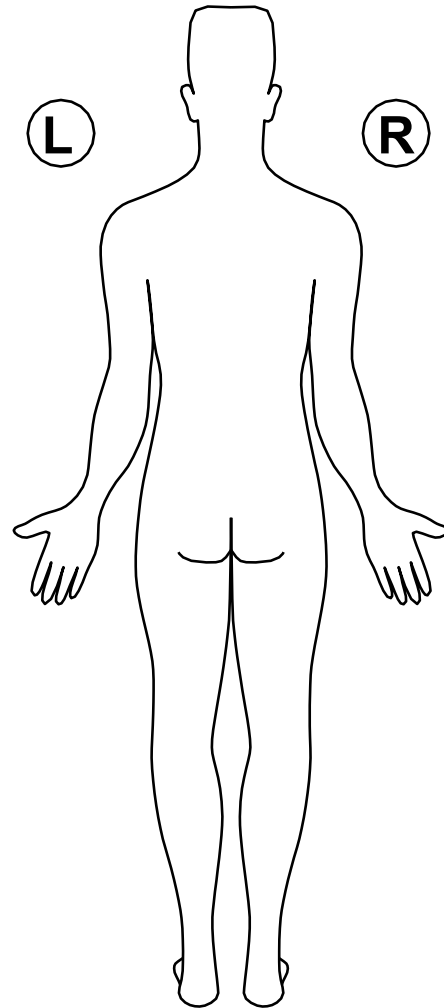
- Rash
-

On the diagram below, shade in the areas where you feel pain. Put an 'X' on the area that hurts the most. Draw a line if the pain moves from one area to another area.

FRONT



BACK



Initial Opioid Risk Tool

Circle each box that applies	Female	Male
Family History of Substance Abuse		
Alcohol	1	3
Illegal Drugs	2	3
Medication Drug Abuse	4	4
Personal History of Substance Abuse		
Alcohol	3	3
Illegal Drugs	4	4
Medication Drug Abuse	5	5
Age between 16-45 years	1	1
History of pre-adolescent sexual abuse	3	0
Psychological Disease		
ADD, OCD, Bipolar, Schizophrenia	2	2
Depression	1	1
Scoring Totals		