INTEGRATIVE PAIN & SPINE INSTITUTE

AN AFFILIATE OF ECAA

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. How did your pain begin? _____
3. What medications have you tried for your pain/symptoms? _____

_____

4. Which medications were helpful? _____
5. Have you tried any of the following medications within the last year (circle all that apply)?

Gabapentin	Lyrica	Duloxetine	Ibuprofen/Advil/Meloxicam Naproxen/Diclofenac	Tizanidine/Baclofen/ Robaxin/Flexeril	Opioids

6. Have you tried any of the following within the last year (circle all that apply)?

Physical Therapy	Chiropractor	TENS Unit	Brace	Lidocaine Patch	Injections

Allergies: _____

_____

Current Medication List and Dose:

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY:

Past Medical History (check all that apply):

☐ Migraine Headaches	☐ Ulcers	☐ Arthritis OA/RA	☐ Multiple Sclerosis
☐ Kidney Disorder	☐ High Blood Pressure	☐ Bowel Disease	☐ Peripheral Nerve Disease
☐ Asthma	☐ Cancer	☐ Emphysema	☐ HIV
☐ Stroke	☐ Hepatitis	☐ Head Injury	☐ Cirrhosis
☐ Osteoporosis	☐ Coronary Artery Disease	☐ Fibromyalgia	☐ High Cholesterol
☐ Heart Arrhythmia	☐ Anxiety	☐ Sleep Apnea	☐ Depression
☐ Addiction	☐ Pancreatitis	☐ Seizures	☐ Gallbladder Disease
☐ Diabetes	☐ Reflux	☐ Spine Disorder	☐ Heart Attack

Past Surgical History: _____

_____

FAMILY HISTORY (Check all that apply and note which family member):

☐ Alcohol Addiction	☐ Anemia	☐ Anxiety
☐ Arthritis	☐ Asthma	☐ Autoimmune Disease
☐ Bipolar Disorder	☐ Bleeding Problems	☐ Cancer
☐ Crohn's Disease	☐ Chronic Pain	☐ Depression
☐ Diabetes	☐ Drug Addiction	☐ Gout
☐ Headaches	☐ Heart Attack	☐ Heart Disease
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease
☐ Liver Disease	☐ Lung Disease	☐ Mental Illness
☐ Osteoporosis	☐ Seizures	☐ Sleep Apnea
☐ Stroke		

What is your marital status?

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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

☐ Alone ☐ Spouse ☐ Children ☐ Parents

☐ Skilled Nursing Facility/Hospice House, what is the name of it: _____

SOCIAL HISTORY:

Smoking Status:

☐ Every day smoker ☐ Occasional smoker ☐ Former smoker ☐ Non-smoker

Alcohol Use:

☐ None ☐ Rarely ☐ Occasionally ☐ Regularly

Do you use street drugs? If yes, which?

☐ No ☐ Yes _____

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

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

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

Psychiatric
- ☐ Panic Attack/Anxiety
- ☐ Insomnia
- ☐ Depression

Vascular
- ☐ Poor circulation
- ☐ Current blood clot
- ☐ Swelling in legs

Skin
- ☐ Rash

Pain Descriptors
Circle ALL that apply

Burning	**Aching**	**Sharp**
Electric	**Throbbing**	**Stabbing**
Prickling	**Dull**	**Shooting**
Numbing	**Cramping**	**Stinging**

Functional Status
Circle ALL that apply

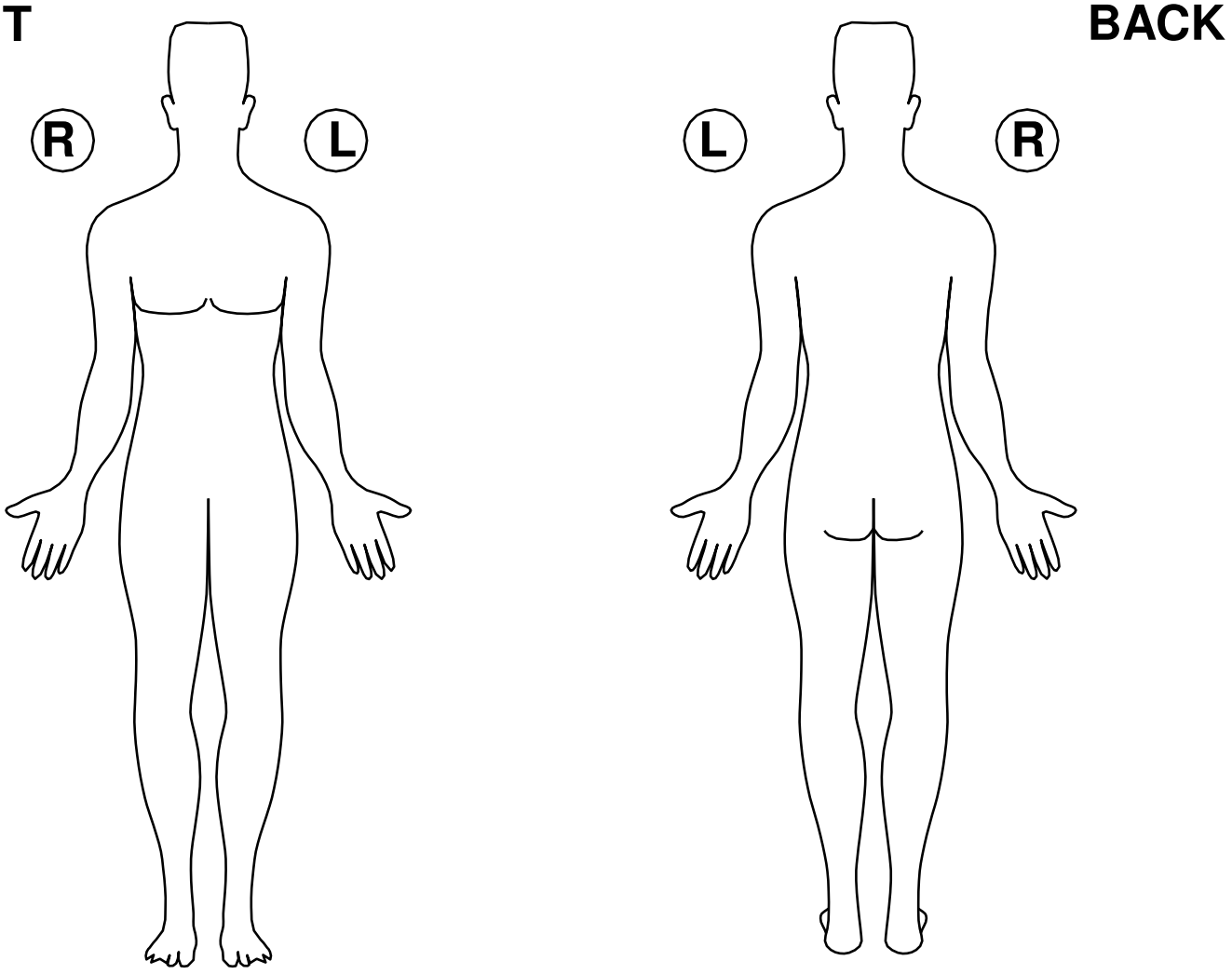
Sleep	**Mood**	**Household Chores**
Exercise	**Work**	**Walking**
Sexual activities	**Social activities**	**Shopping**
Other _____		

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**



What number best describes your pain on average in the past week?

0	1	2	3	4	5	6	7	8	9	10
None										**Severe**

Circle the frequency of your pain:

Rare	Intermittent	Frequent	Constant

What factors worsen your pain? _____

What factors relieve your pain? _____

Initial Opioid Risk Tool

	If you are **FEMALE**, answer this column only	If you are **MALE**, answer this column only
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
Family History of Substance Abuse (count if male and/or female relative)		
Alcohol	1	3
Illegal Drugs	2	3
Medication Drug Abuse	4	4
Scoring Totals (add column total)		