INTEGRATIVE PAIN & SPINE INSTITUTE
AN AFFILIATE OF ECAA

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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

3. What is the frequency of your pain?
   - ☐ Constant
   - ☐ Fluctuating, but always present
   - ☐ Fluctuating, but usually present
   - ☐ Fluctuating, but rarely present

4. What best describes your pain? Choose one or more:
   - ☐ Aching
   - ☐ Burning
   - ☐ Cramping
   - ☐ Dull
   - ☐ Numbness
   - ☐ Sharp
   - ☐ Stabbing
   - ☐ Stinging
   - ☐ Throbbing
   - ☐ Tingling

5. What is your pain level most of the time?
   ☐ 0-No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10-Severe Pain

6. What makes your pain worse? Choose one or more:
   - ☐ Nothing
   - ☐ From sitting to standing
   - ☐ Lying on side
   - ☐ Lifting or carrying heavy loads
   - ☐ Bending or stooping
   - ☐ Sitting
   - ☐ Lying on back
   - ☐ Lifting or carrying small loads
   - ☐ Standing
   - ☐ Walking

Patient Name:______________________________ DOB: ______________________

7. What makes your pain better? Choose one or more:

- [ ] Lying on side
- [ ] Lying on back
- [ ] Sitting
- [ ] Standing
- [ ] Walking
- [ ] Stretching
- [ ] Exercise
- [ ] Nothing

8. What does your pain interfere with? Choose on or more:

- [ ] Daily Chores
- [ ] Employment
- [ ] Exercise
- [ ] Grooming
- [ ] House Chores
- [ ] Mood
- [ ] Sleep
- [ ] Relationships
- [ ] Walking
- [ ] Nothing

9. 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

10. Have you had any of the following to assist in the evaluation of your pain? Choose one or more:

- [ ] Blood work related to pain syndrome
- [ ] Bone Scan
- [ ] Vascular Studies
- [ ] Drug Screening
- [ ] Bone Density
- [ ] Functional Capacity Exam
- [ ] Depression Screening

11. 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

12. Have you received any of the following related to your pain?

- [ ] Back Brace
- [ ] Neck Brace
- [ ] Tens Unit
- [ ] None

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

- [ ] Low Back
- [ ] Mid Back
- [ ] Neck
- [ ] Hip
- [ ] Knee
- [ ] Shoulder
- [ ] None

14. Have you tried any of the following therapies?

- [ ] Physical
- [ ] Chiropractic
- [ ] Aqua
- [ ] None

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

- [ ] Spinal Cord Stimulation
- [ ] Spinal Traction
- [ ] Cane
- [ ] Walker
- [ ] Exercise
- [ ] Weight Loss
- [ ] Intrathecal Pain Pump
- [ ] None

16. Have you tried any of the Anti-Inflammatory Medications below? [ ] None Tried

Medication			Medication		
Aspirin:	[ ] Helpful	[ ] Not Helpful	Indomethacin:	[ ] Helpful	[ ] Not Helpful
Celebrex®:	[ ] Helpful	[ ] Not Helpful	Ketroprofen:	[ ] Helpful	[ ] Not Helpful
Diclofenac:	[ ] Helpful	[ ] Not Helpful	Mobic®:	[ ] Helpful	[ ] Not Helpful
Daypro®:	[ ] Helpful	[ ] Not Helpful	Naproxen:	[ ] Helpful	[ ] Not Helpful
Duexis®:	[ ] Helpful	[ ] Not Helpful	Relafen®:	[ ] Helpful	[ ] Not Helpful
Etodalac:	[ ] Helpful	[ ] Not Helpful	Toradol®:	[ ] Helpful	[ ] Not Helpful
Prednisone:	[ ] Helpful	[ ] Not Helpful	Tylenol®:	[ ] Helpful	[ ] Not Helpful

Patient Name:______________________________ DOB: ____________________

17. Have you tried any of the muscle relaxer medications below? ☐ None tried

Baclofen:	☐ Helpful	☐ Not Helpful	Norflex™:	☐ Helpful	☐ Not Helpful
Cyclobenzaprine:	☐ Helpful	☐ Not Helpful	Parafon®:	☐ Helpful	☐ Not Helpful
Carisoprodol:	☐ Helpful	☐ Not Helpful	Skelaxin®:	☐ Helpful	☐ Not Helpful
Diazepam:	☐ Helpful	☐ Not Helpful	Tizanidine:	☐ Helpful	☐ Not Helpful
Methocarbamol:	☐ Helpful	☐ Not Helpful			

18. Have you tried any of the narcotic medications below? ☐ None tried

Avinza:	☐ Helpful	☐ Not Helpful	Oxycontin®:	☐ Helpful	☐ Not Helpful
Codeine:	☐ Helpful	☐ Not Helpful	Oxycodone:	☐ Helpful	☐ Not Helpful
Duragesic®:	☐ Helpful	☐ Not Helpful	MS IR®:	☐ Helpful	☐ Not Helpful
Dilaudid®:	☐ Helpful	☐ Not Helpful	Methadone:	☐ Helpful	☐ Not Helpful
Hydrocodone:	☐ Helpful	☐ Not Helpful	Morphine ER:	☐ Helpful	☐ Not Helpful
Kadian®:	☐ Helpful	☐ Not Helpful	Tramadol:	☐ Helpful	☐ Not Helpful
Opana®:	☐ Helpful	☐ Not Helpful			

19. Have you tried any of the following “other” medications below? ☐ None tried

Cymbalta®:	☐ Helpful	☐ Not Helpful	Lyrica®:	☐ Helpful	☐ Not Helpful
Clonidine:	☐ Helpful	☐ Not Helpful	Neurontin®:	☐ Helpful	☐ Not Helpful
Elavil®:	☐ Helpful	☐ Not Helpful	Savella®:	☐ Helpful	☐ Not Helpful
Keppra®:	☐ Helpful	☐ Not Helpful	Topamax®:	☐ Helpful	☐ Not Helpful
Klonopin®:	☐ Helpful	☐ Not Helpful	Trileptal®:	☐ Helpful	☐ Not Helpful
Lidoderm Patch®:	☐ Helpful	☐ Not Helpful	Zonegran®:	☐ Helpful	☐ Not Helpful
Horizant®:	☐ Helpful	☐ Not Helpful	Requip™:	☐ Helpful	☐ Not Helpful

20. Have you tried any Over-the-Counter Medications such as BioFreeze® or IcyHot®? ☐ Yes ☐ No

21. Have you tried any prescription creams such as EMLA Cream™ or Voltaren Gel®? ☐ Yes ☐ No

22. Have you tried a compound pain cream or scar cream? ☐ Yes ☐ No

23. Allergies: ☐ Yes ☐ No

List Medication Allergies: ______________________________

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Patient Name:______________________________________ DOB: ______________________

24. Past Medical History (check all that apply):

- [ ] 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

25. Past Surgical History: ____

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

- [ ] 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

27. What is your marital status?

- [ ] Single
- [ ] Married
- [ ] Separated
- [ ] Divorced
- [ ] Widowed

29. 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: ______________________________

30. Smoking Status:

- [ ] Every day smoker
- [ ] Occasional smoker
- [ ] Former smoker
- [ ] Non-smoker

31. Alcohol Use:

- [ ] None
- [ ] Rarely
- [ ] Occasionally
- [ ] Regularly

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

- [ ] Yes
- [ ] No

Patient Name:____ DOB: ______________________

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

- ☐ 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

34. 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
- ☐ Panic Attack/Anxiety
- ☐ Insomnia
- ☐ Depression

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

Skin
- ☐ Rash

35. List all medications you are currently taking:______________________________________

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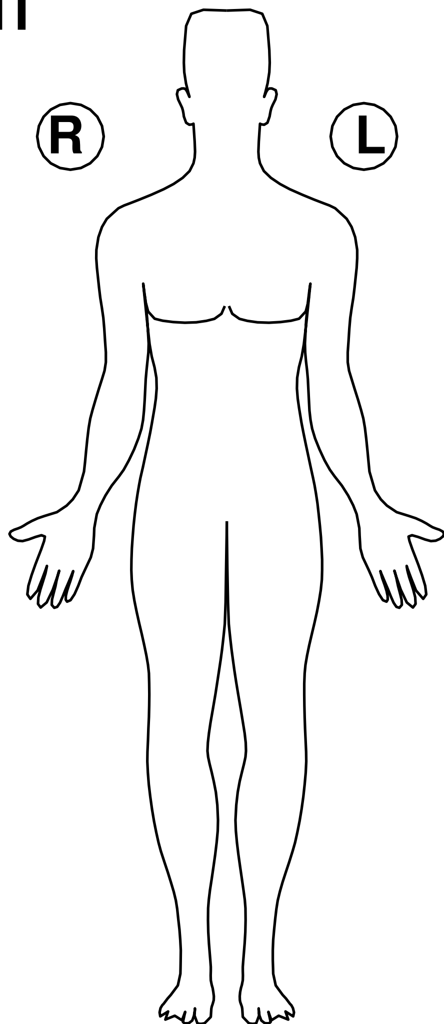
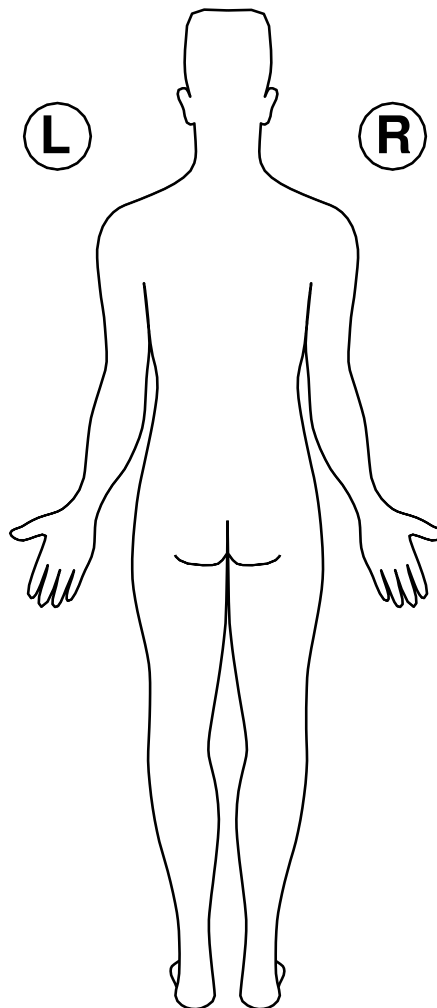
On the diagram below, shade in the areas where you feel pain. Put an 'X' on the area that hurts the most. Draw a line if the pain moves from one area to another area.

FRONT



BACK



Please let us know if you have any questions and thank you for completing this form.

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		