**Integrative Pain & Spine Institute**

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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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What best describes your pain? Choose one or more:

|  |  |  |  |
| --- | --- | --- | --- |
| Aching | Burning | Cramping | Dull |
| Numbness | Sharp | Stabbing | Stinging |
| Throbbing | Tingling |   |  |

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

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

1. 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

1. 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
2. Have you had any of the following surgeries? If yes, which year(s)?

Low Back Mid Back Neck Hip

Knee Shoulder None

1. Have you tried any of the following therapies?

Physical Chiropractic Aqua None

1. 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

1. 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 |  |

1. Past Surgical History:
2. Allergies: Yes No

List Medication Allergies:

1. List all medications you are currently taking:
2. Have you tried any of the muscle relaxer medications below?

Baclofen: Helpful Not Helpful Methocarbamol Helpful Cyclobenzaprine: Helpful Not Helpful Tizanidine Helpful Carisoprodol: Helpful Not Helpful Skelaxin®: Helpful Diazepam: Helpful Not Helpful Alprazolam Helpful

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

Codeine: Helpful Not Helpful Oxycontin®: Helpful Dilaudid: Helpful Not Helpful Oxycodone: Helpful Hydrocodone: Helpful Not Helpful Morphine: Helpful Opana Helpful Not Helpful Methadone: Helpful

1. Have you tried any of the following “other” medications below?

CymbaIta: Helpful Not Helpful Lyrica: Helpful Clonidine: Helpful Not Helpful Gabapentin: Helpful Amitriptyline: Helpful Not Helpful Savella: Helpful Keppra: Helpful Not Helpful Topamax: Helpful Klonopin: Helpful Not Helpful Trileptal: Helpful Lidoderm Patch®: Helpful Not Helpful Zonegran: Helpful Horizant: Helpful Not Helpful Requip: Helpful

None tried Not Helpful Not Helpful Not Helpful Not Helpful

 None tried

Not Helpful Not Helpful Not Helpful Not Helpful

None tried Not Helpful Not Helpful Not Helpful Not Helpful Not Helpful Not Helpful Not Helpful

1. Have you tried any of the Anti-Inflammatory Medications below? None tried

Aspirin: Helpful Not Helpful Indomethacin: Helpful Not Helpful

 Celebrex: Helpful Not Helpful Ketroprofen: Helpful Not Helpful

 Diclofenac: Helpful Not Helpful Meloxicam: 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

1. 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 |  |  |

1. 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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **General** | **HEENT** | **Respiratory** | **Cardiology** |
| Weight loss | Headache | Chronic cough | Chest pain |
| Weight gain | Facial pain | Wheezing | Murmur |
| Fever | Sinusitis | Shortness of breath | Congestive failure |
| Night sweats | Loss of vision | Sleep Apnea | Abnormal EKG |
| FatigueMany infections | Hearing loss Teeth/Gum problems | Home oxygen use C-Pap | High Blood Pressure |
| **Gl** | **Genitourinary** | **Endocrine/Hematology** | **Musculoskeletal** |
| Appetite loss | Painful urination | Abnormal blood sugars | Joint pain |
| Chronic Anemia | Blood in urine | Easy bruising/bleeding | Muscle spasm |
| Heartburn | Bladder control loss | Dizziness | Neck pain |
| Constipation Testicular pain Diarrhea | Enlarged prostate | Thyroid Problems | Back pain Carpel Tunnel GoutSwollen Joints |
| **Neurology** | **Psychiatric** | **Vascular** | **Skin** |
| Drowsiness Dizziness Blackouts Tremors Numbness Memory Loss Balance Difficulty | Panic Attack/Anxiety lnsomnia Depression | Poor circulation Current blood clot Swelling in legs | 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

 **R L L R**

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** |  |  |