Patient Name:_____ DOB: _____

Integrative Pain & Spine Institute
Belle Grove Office Park
3315 Springbank Lane, Suite 202
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Phone: 704-317-1440
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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

Patient Name: _____ DOB: _____

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

☐ Low Back	☐ Mid Back	☐ Neck	☐ Hip
☐ Knee	☐ Shoulder	☐ None	

8. Have you tried any of the following therapies?

☐ Physical	☐ Chiropractic	☐ Aqua	☐ None

9. 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

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: _____

☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐

12. Allergies: ☐ Yes ☐ No

Patient Name: _____ DOB: _____

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

☐ None tried

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

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

☐ None tried

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

Cymbalta:	☐ Helpful	☐ Not Helpful	Lyrica:	☐ Helpful	☐ Not Helpful
Clonidine:	☐ Helpful	☐ Not Helpful	Gabapentin:	☐ Helpful	☐ Not Helpful
Amitriptyline:	☐ 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

☐ None tried

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

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

☐ None tried

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

☐ Migraine headaches	☐ High blood pressure	☐ Emphysema	☐ Cirrhosis
☐ Kidney disorder	☐ Cancer	☐ Head Injury	☐ High cholesterol

Patient Name: _____ DOB: _____

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		

Patient Name:_____ DOB: _____

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

Patient Name:_____ DOB: _____

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

- Panic Attack/ Anxiety Insomnia Depression

Vascular

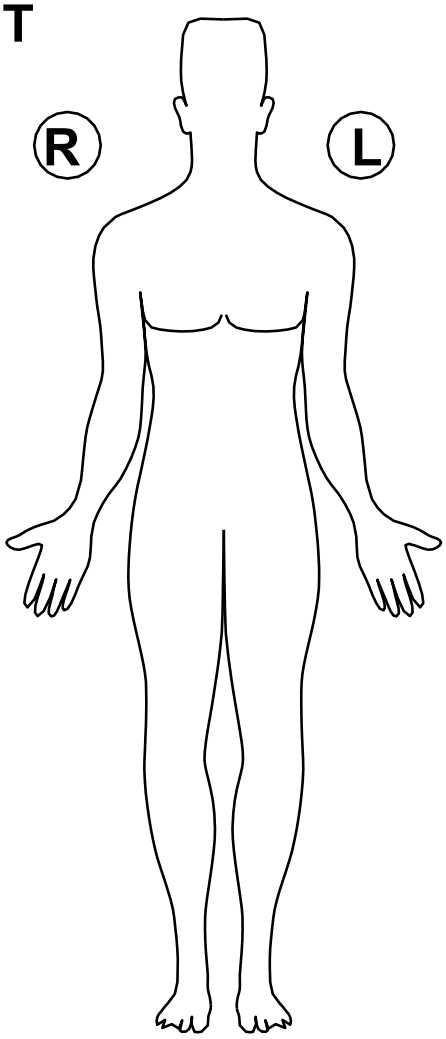
- Poor circulation
- ☐ Current blood clot Swelling in legs

Skin

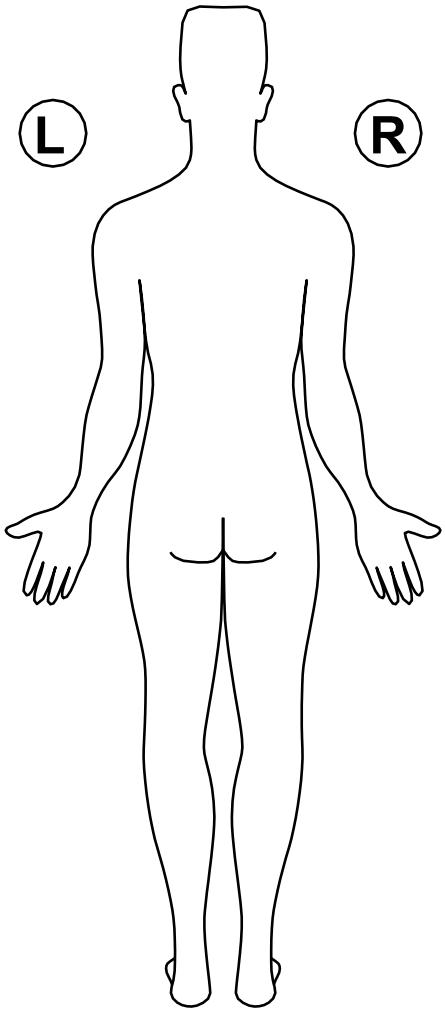
- Rash
- ☐

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		