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. 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

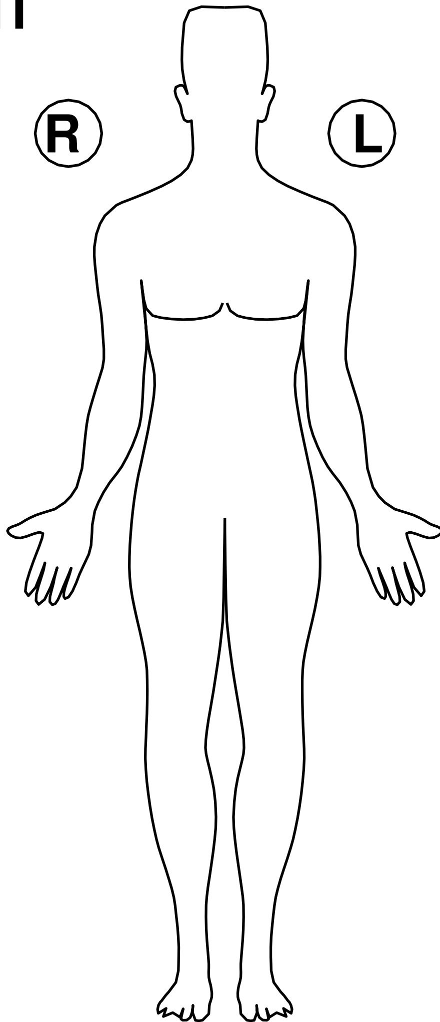
Vascular
- [ ] Poor circulation
- [ ] Current blood clot
- [ ] Swelling in legs

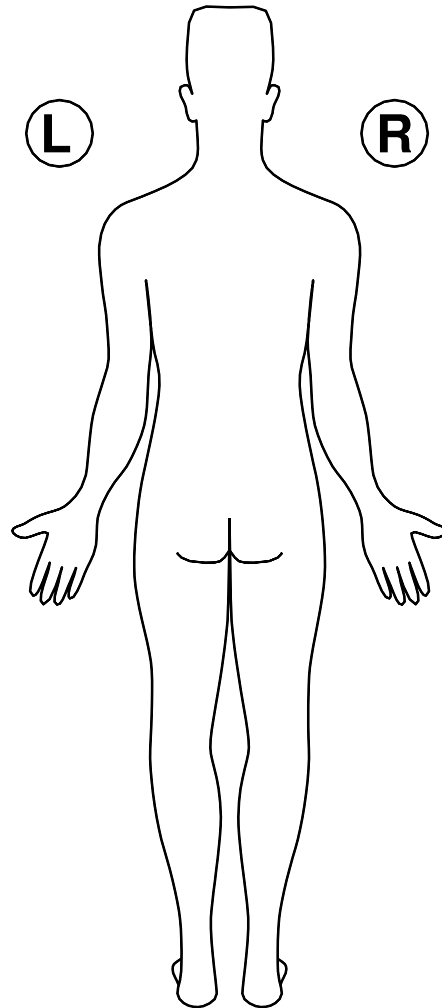
Skin
- [ ] Rash

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.





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)		