

NEW PATIENT EVALUATION FORM QUESTIONNAIRE

(PLEASE FILL OUT THIS QUESTIONNAIRE AND BRING IT WITH YOU TO YOUR FIRST APPOINTMENT)

Date: _____ Patient Name: _____ DOB: _____

Have you had the FLU Vaccine in the last year? Yes No If so, when? _____

Have you had the Pneumonia Vaccine in the last year? Yes No If so, when? _____

Where is the primary location of your pain? 1. _____

2. _____ 3. _____

What year did your pain begin? _____

What precipitated/caused your pain? Unknown Normal Aging Fall Work Injury Sporting Accident Auto Accident

Are you currently on pain medications: Yes No

**Please be aware that ALL pain medications and any medications prescribed by SPC must be present at every visit.*

Do you have a Pain Pump? Yes No

Do you have a Spinal Cord Stimulator? Yes No

Have you previously tried any of the following therapies to assist in your treatment? (If so list year) Back Brace _____

Knee Brace _____ Neck Brace _____ TENS Unit _____

Physical Therapy _____ Chiropractic Therapy _____ Aquatic Therapy _____

None Tried

Anti-Inflammatory Medication History

Aspirin Helpful Not Helpful Never Tried

Celebrex Helpful Not Helpful Never Tried

Diclofenac Helpful Not Helpful Never Tried

Ibuprofen Helpful Not Helpful Never Tried

Mobic Helpful Not Helpful Never Tried

Naproxen Helpful Not Helpful Never Tried

Toradol Helpful Not Helpful Never Tried

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Muscle Relaxer Medication History

| | | | |
|---------------|----------------------------------|--------------------------------------|--------------------------------------|
| Baclofen | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Flexeril | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Soma | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Valium | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Robaxin | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Zanaflex | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Parafon Forte | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |

Narcotic Medication History

| | | | |
|-------------|----------------------------------|--------------------------------------|--------------------------------------|
| Codeine | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Duragesic | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Dilaudid | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Hydrocodone | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Kadian | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Opana | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Belbuca | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Xtampza | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Oxycodone | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Morphine IR | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Morphine ER | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Methadone | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Nucynta ER | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Nucynta | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Butrans | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Tramadol ER | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Oxycontin | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |

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Other Medication History

- | | | | |
|---------------|----------------------------------|--------------------------------------|--------------------------------------|
| Cymbalta | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Clonidine | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Amitriptyline | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Keppra | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Klonopin | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Lidoderm | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Neurontin | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Topamax | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| ZTlido | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Aimovig | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Emgality | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |

Constipation Medication History

- | | | | |
|-----------|----------------------------------|--------------------------------------|--------------------------------------|
| Senna | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Lactulose | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Ducolax | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Biscodyl | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Miralax | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Relistor | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Movantik | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Symproic | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |
| Amitiza | <input type="checkbox"/> Helpful | <input type="checkbox"/> Not Helpful | <input type="checkbox"/> Never Tried |

Past Medical History (Please check all diseases or disorders YOU have had)

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

Please List your Allergies: No Known Allergies Noted Yes If yes, please list? _____

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Please List your previous surgeries: (Please include the year) No Yes If yes, please list? _____

Family History: (Please check the family members who have had the following disease/disorders)

| Family History of Mental Disorder | Father | Mother | Grandparent |
|-----------------------------------|--------|--------|-------------|
| Family History of Drug abuse | | | |
| Family History of Alcohol Abuse | | | |
| Family History of Diabetes | | | |
| Family History of Hypertension | | | |

Any other notable Family History: _____

Review of Systems: Please mark each of the following symptoms/problems that you CURRENTLY have.

General: Weight Loss Weight Gain Fever Night Sweats Fatigue
HEENT: Headaches Sinusitis Hearing Loss
Respiratory: Shortness of breath Sleep Apnea C-Pap
Cardiology: Chest Pain Irregular Heartbeat High Blood Pressure
Gastroenterology: Appetite Loss Chronic Nausea Heartburn Constipation
Genitourinary: Painful Urination Blood in Urine Enlarged Prostate
Endocrine: Abnormal Blood Sugars Easy Bruising/Bleeding
Vascular: Swelling in Legs
Musculoskeletal: Joint Pain Muscle Spasms Neck Pain Back Pain
Neurology: Drowsiness Dizziness Seizures Weakness/Numbness
Psychiatric: Depression Anxiety

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Review of Systems: Please mark each of the following symptoms/problems that you CURRENTLY have.

Do you use Marijuana Yes No

What is your Marital Status? Single Married Widowed Divorced

Who resides in your home to help you? Alone Spouse Children Parents Friend Other

What is your Employment Status? Retired Unemployed Self Employed Works from Home Works Part Time
 Works Full Time

What is your Disability Status? Short Term Disability Long Term Disability Disability Determination in process

Fall Risk Assessment: Are you 65 or Older?

Yes No If yes, have you had any of the following occur? 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