SPECTRUM PAIN CLINICS
~A Division of Encore Health Group~

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	☐ Helpful	☐ Not Helpful	☐ Never Tried
Flexeril	☐ Helpful	☐ Not Helpful	☐ Never Tried
Soma	☐ Helpful	☐ Not Helpful	☐ Never Tried
Valium	☐ Helpful	☐ Not Helpful	☐ Never Tried
Robaxin	☐ Helpful	☐ Not Helpful	☐ Never Tried
Zanaflex	☐ Helpful	☐ Not Helpful	☐ Never Tried
Parafon Forte	☐ Helpful	☐ Not Helpful	☐ Never Tried

Narcotic Medication History

Codeine	☐ Helpful	☐ Not Helpful	☐ Never Tried
Duragesic	☐ Helpful	☐ Not Helpful	☐ Never Tried
Dilaudid	☐ Helpful	☐ Not Helpful	☐ Never Tried
Hydrocodone	☐ Helpful	☐ Not Helpful	☐ Never Tried
Kadian	☐ Helpful	☐ Not Helpful	☐ Never Tried
Opana	☐ Helpful	☐ Not Helpful	☐ Never Tried
Belbuca	☐ Helpful	☐ Not Helpful	☐ Never Tried
Xtampza	☐ Helpful	☐ Not Helpful	☐ Never Tried
Oxycodone	☐ Helpful	☐ Not Helpful	☐ Never Tried
Morphine IR	☐ Helpful	☐ Not Helpful	☐ Never Tried
Morphine ER	☐ Helpful	☐ Not Helpful	☐ Never Tried
Methadone	☐ Helpful	☐ Not Helpful	☐ Never Tried
Nucynta ER	☐ Helpful	☐ Not Helpful	☐ Never Tried
Nucynta	☐ Helpful	☐ Not Helpful	☐ Never Tried
Butrans	☐ Helpful	☐ Not Helpful	☐ Never Tried
Tramadol ER	☐ Helpful	☐ Not Helpful	☐ Never Tried
Oxycontin	☐ Helpful	☐ Not Helpful	☐ Never Tried

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Other Medication History

Cymbalta	☐ Helpful	☐ Not Helpful	☐ Never Tried
Clonidine	☐ Helpful	☐ Not Helpful	☐ Never Tried
Amitriptyline	☐ Helpful	☐ Not Helpful	☐ Never Tried
Keppra	☐ Helpful	☐ Not Helpful	☐ Never Tried
Klonopin	☐ Helpful	☐ Not Helpful	☐ Never Tried
Lidoderm	☐ Helpful	☐ Not Helpful	☐ Never Tried
Neurontin	☐ Helpful	☐ Not Helpful	☐ Never Tried
Topamax	☐ Helpful	☐ Not Helpful	☐ Never Tried
ZTlido	☐ Helpful	☐ Not Helpful	☐ Never Tried
Aimovig	☐ Helpful	☐ Not Helpful	☐ Never Tried
Emgality	☐ Helpful	☐ Not Helpful	☐ Never Tried

Constipation Medication History

Senna	☐ Helpful	☐ Not Helpful	☐ Never Tried
Lactulose	☐ Helpful	☐ Not Helpful	☐ Never Tried
Ducolax	☐ Helpful	☐ Not Helpful	☐ Never Tried
Biscodyl	☐ Helpful	☐ Not Helpful	☐ Never Tried
Miralax	☐ Helpful	☐ Not Helpful	☐ Never Tried
Relistor	☐ Helpful	☐ Not Helpful	☐ Never Tried
Movantik	☐ Helpful	☐ Not Helpful	☐ Never Tried
Symproic	☐ Helpful	☐ Not Helpful	☐ Never Tried
Amitiza	☐ Helpful	☐ Not Helpful	☐ 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