SPINE & PAIN
CONSULTANTS of NEW YORK

Initial Evaluation

PATIENT INFORMATION

(1) ____ (2) Sex: M / F (3) Age: _____________
Last Name First M.I.

(4) Appointment Date: ____________ (5) Referring Physician:______________________________

ABOUT YOUR PAIN

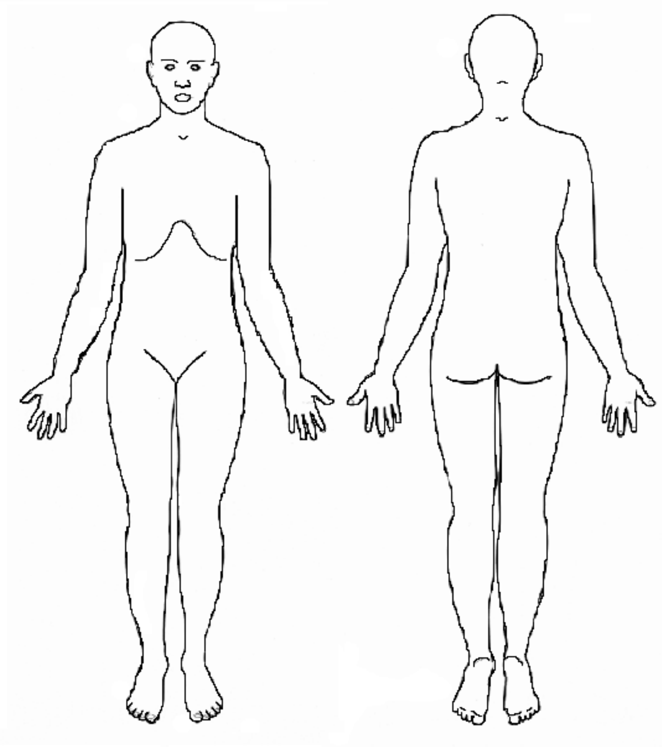
(6) What is the *main* problem for which you are seeking treatment?

____

____

____

Please mark the area(s) in which your pain is located:



For office use only: C: C/PT: _______________ C/TDD: _________________

ONSET OF PAIN AND DURATION

(7) Briefly describe when and how your current pain started?

____

____

____

____

TIMING OF PAIN

(8) How often do you have your pain (please check one)?

- ☐ Constantly (100% of the time)
- ☐ Frequently (75% of the time)
- ☐ Intermittently (50% of the time)
- ☐ Occasionally (25% of the time)

PAIN QUALITY

(9) How would you describe the pain (choose as many adjectives as are applicable)?

☐ Burning	☐ Sharp	☐ Cutting
☐ Throbbing	☐ Cramping	☐ Numbness
☐ Dull, aching	☐ Pressure	☐ Pins and needles
☐ Shooting	☐ Electric-like	☐ Other

PAIN INTENSITY

(10) Circle your current pain intensity with "0" representing no pain and "10" representing the most severe pain imaginable:

0 1 2 3 4 5 6 7 8 9 10

(11) Circle your average pain the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

(12) Circle your best pain score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

(13) Circle your worst pain score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

Patient Name________________________________

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RELIEVING AND AGGRAVATING FACTORS

How do the following affect your pain (please check one for each item)?

	(14) Decrease	(15) Increase	(16) No Change
Lying down			
Standing			
Sitting			
Walking			
Exercise (if applicable)			
Medications			
Relaxation			
Thinking about something else			
Coughing/Sneezing			
Urination			
Bowel movements			

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

Treatment	Date (approx.)	(17) Excellent Relief	(18) Moderate Relief	(19) No Relief
Hospital/bed rest				
Traction				
Surgery				
Hypnosis				
Acupuncture				
Nerve block/injections				
TENS				
Physical therapy				
Exercise				
Heat treatment				
Biofeedback				
Psychotherapy				
Chiropractic				
Other				

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FUNCTIONAL LIMITATIONS

(20) During the past month, place a check mark next to the activities that you avoided because of pain:

- ☐ Going to work
- ☐ Performing household chores
- ☐ Doing yard work or shopping
- ☐ Socializing
- ☐ Participating in recreation
- ☐ Sexual relations
- ☐ Physical exercise
- ☐ Driving
- ☐ Caring for self

(21) How many blocks can you walk before having to stop due to pain? __________

(22) How many minutes or hours can you sit before having to get up and move about?

_________ minutes _________ hours

(23) How many minutes or hours can you stand before you have to sit down?

_________ minutes _________ hours

(24) How often during the day do you lie down because of pain?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Constantly

<u>Allergies</u>

(25) Do you have symptoms such as red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following?

- ❑ Dye
- ❑ Iodine
- ❑ Medications: __________________

Describe: _______________________

- ❑ Shellfish
- ❑ Foods: _____________________

____

- ❑ Latex
- ❑ Rubber (Band-aids, tape, spandex, balloons) *
- ❑ Kiwis, chestnuts, bananas, avocado*
- ❑ No Known Allergy
- ❑ After doctor/dental visits *

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MEDICATIONS

(26) Please list your current medications with dosages:

____
____
____
____
____
____
____
____
____
____
____

(27) Please list any previously taken pain medications that you stopped taking and the reason for stopping:

____
____
____
____
____
____

PAST MEDICAL HISTORY

(28) Have you had any of the following health problems? (please check all that apply)

☐ High blood pressure	☐ Diabetes	☐ Kidney disease
☐ Angina	☐ Stroke	☐ Liver disease
☐ Heart attack	☐ Cancer	☐ Arthritis
☐ Chronic cough	☐ Psychological or psychiatric problems	
☐ HIV	☐ Hepatitis	

Please explain any medical conditions checked above:

____
____
____

Other (please specify): ____

Patient Name____________________________

PAST SURGERIES

(29) Please list, with approximate date and type of operation:

____

____

____

____

Have you had any previous back surgeries (please specify)?

____

____

PSYCHOSOCIAL HISTORY

(30) Your highest educational level achieved:

- ☐ Graduate or professional training (obtained degree)
- ☐ College graduate (obtained degree)
- ☐ Partial college training
- ☐ High school graduate
- ☐ GED or trade-technical school graduate
- ☐ Partial high school (10th grade through partial 12th)

LEGAL ISSUES

(31) Have you filed any legal claims related to your pain problem?
☐ No ☐ Yes (please explain):

____

PSYCHOLOGICAL TREATMENT

(32) Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? ☐ Yes ☐ No
If yes, when? ____

(33) Have you ever considered suicide? ☐ Yes ☐ No

SUBSTANCE USE

(34) Are you suffering from or do you have a history or alcoholism? ☐ Yes ☐ No
Any illicit drug use? ☐ Yes ☐ No
Have you ever been in a detoxification program for drug abuse? ☐ Yes ☐ No
Alcoholics Anonymous? ☐ Yes ☐ No
Narcotics Anonymous? ☐ Yes ☐ No
(35) Do you or did you ever smoke cigarettes or use tobacco? ☐ Yes ☐ No
How many years have you smoked/did you smoke? ___________________________
How many packs per day do you/did you smoke? _____________________________
Have you quit using tobacco, and if so how long ago? ________________________

(36) How many drinks of each of the following do you consume in one week?
Beer ____________
Wine ____________
Liquor ____________

FAMILY LIFE

(37) “I currently am”:
☐ Living alone
☐ Living with friends
☐ Living with children
☐ Living with spouse/partner
☐ Living with spouse/partner and children

(38) Do you have members of your family who have committed suicide?
☐ Yes ☐ No
(39) Do you have members of your family who have had psychiatric illnesses?
☐ Yes ☐ No
(40) Have any of your blood relatives had substance abuse problems, including alcohol?
☐ Yes ☐ No

PREVIOUS DIAGNOSTIC STUDIES

(41) Please indicate approximate date and results, if known:
MRI ____
____
____
CT ____
X-rays ____

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EMG ____

REVIEW OF SYSTEMS

(42) Fill out and/or check all that apply to your health:

Respiratory	Heart	Elimination	
		Urinary	Bowel
❑ Shortness of Breath ❑ at rest ❑ with activity ❑ Home oxygen (Supplier:__________) ❑ Breathing medications ❑ BIPAP/CPAP ❑ Sleep Apnea/Disorder ❑ TB ❑ Lung Problem: _______ ❑ No Problem	❑ Bruising/Bleeding ❑ Heart Attack ❑ Palpitations ❑ Heart Problem: ________________ ❑ Other:__________ ❑ No Problem	❑ Catheter ❑ Burning ❑ Bleeding ❑ Ostomy ❑ Unusual Frequency ❑ Discomfort ❑ Up at night to urinate? # Times:_________ ❑ Loss of control ❑ No Problem	Last BM__________ Freq of BM_________ ❑ Ostomy ❑ Loss of control ❑ Diarrhea/Colitis ❑ Constipation ❑ Use laxatives ❑ Ulcers/Hiatal Hernia ❑ No Problem

Neurological	Skeletal/Muscle	Nutrition
❑ Memory loss/ Forgetfulness ❑ Stroke ❑ Fainting spells/ Dizziness ❑ Epilepsy, seizures, convulsions ❑ Mental illness ❑ Headaches ❑ No problem	❑ Arthritis ❑ Numbness/Tingling ❑ Back pain ❑ Muscle weakness ❑ Blood clots in legs ❑ Pain in legs with activity ❑ Skin disorder ❑ Neck pain ❑ No problem	❑ Weight Loss > 10 lbs/last 6 months _________ ❑ Nausea Appetite ❑ good ❑ fair ❑ poor ❑ Vomiting ❑ Dentures Fit properly? ❑ yes ❑ no ❑ Heartburn/ Reflux ❑ Chewing problems ❑ Swallowing problems ❑ Indigestion ❑ No problems ❑ Sores in mouth ❑ Foods you CANNOT eat. Explain: __________ ______________________________

Endocrine	
❑ Thyroid problems ❑ Other:_________ ______________ ❑ No problem	Do you have any implanted devices? ❑ Screws, pins, plates ❑ AICD ❑ Aneurysm Clip ❑ Venous Access Device ❑ None Where?____________ ❑ IUD ❑ Pacemaker ❑ Type _________

(43) Do you have a history of "passing out" with needles, medical procedures etc.? If yes, please explain.

____

____

____

Patient Name_______________________________