Southern Interventional Pain Center

New Patient Evaluation Form

Name:_____ D.O.B._____ Today's Date:_____

Chief Complaint and History of Present Illness

Please list your **DAILY SEVERE AREAS OF PAIN** only:

☐ LOW BACK PAIN: Start date: _____ Due to: _____

☐ gradual ☐ sudden ☐ constant ☐ comes/goes ☐ better ☐ worse ☐ same

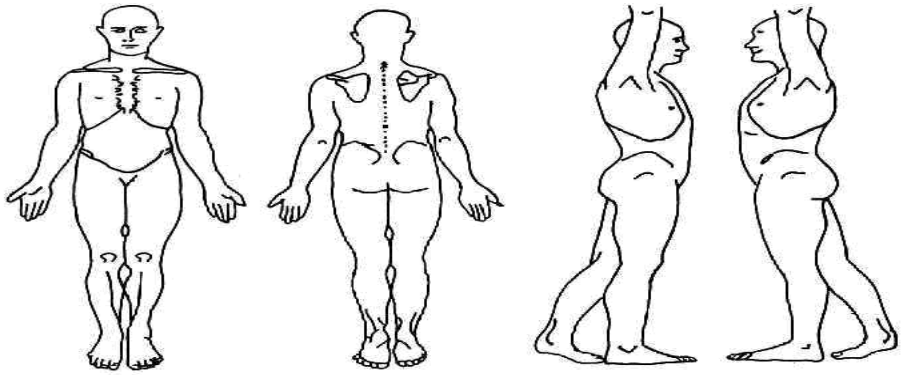
☐ NECK PAIN: Start date: _____ Due to: _____

☐ gradual ☐ sudden ☐ constant ☐ comes/goes ☐ better ☐ worse ☐ same

☐ OTHER: _____ Start date:_____ Due to: _____

☐ gradual ☐ sudden ☐ constant ☐ comes/goes ☐ better ☐ worse ☐ same

Mark your **MOST SEVERE** areas of pain? Mark and draw below (draw 'X' on most severe areas of pain and use arrows for radiating pain)



Describe your pain: ☐ ache ☐ burn ☐ cramp ☐ dull ☐ sharp ☐ stabbing ☐ tearing ☐ throb ☐ numbness ☐ pins/needles

Rate your pain level **NOW**:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
WORST pain level in past week:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
LOWEST pain level in past week:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Associated symptoms:

- ☐ numbness
- ☐ weakness
- ☐ fevers
- ☐ chills
- ☐ weight loss
- ☐ loss of bladder control
- ☐ loss of bowel control
- ☐ can't empty bladder
- ☐ imbalance
- ☐ stiffness
- ☐ swelling
- ☐ redness/warmth
- ☐ sleep problems
- ☐ Other_____

Please list recent imaging:

X-rays:	☐ neck	☐ low back	☐ other		Dates: _____
MRI:	☐ neck	☐ low back	☐ head	☐ other	Dates: _____
CT scans:	☐ neck	☐ low back	☐ head	☐ other	Dates: _____
EMG/Nerve Study:	☐ yes				Dates: _____
Other: _____					Dates: _____

Past treatments:

- □ Rest
- □ Ice
- □ Heat
- □ Exercise program
- □ Physical therapy
- □ TENS
- □ Bracing
- □ Chiropractic
- □ Joint injections
- □ Trigger point injections
- □ Facet joint injections
- □ RFA/Rhizotomy
- □ Epidurals
- □ Nerve blocks: _____
- □ Spinal cord stimulator
- □ Pain pump
- □ Other: _____

Past medications: (indicate the PAIN medications you have tried in the **PAST** and **NOT** currently taking):

Anti-inflammatories:

- □ ibuprofen (Motrin/Advil)
- □ naproxen (Aleve)
- □ meloxicam (Mobic)
- □ diclofenac (Voltaren/ Pennsaid/Flector)
- □ Indomethacin (Indocin)
- □ piroxicam
- □ Relafen
- □ Toradol
- □ Celebrex
- □ sulindac
- □ etodolac (Lodine)
- □ aspirin (BC/Goody's/Bayer/Excedrin)

Muscle Relaxers:

- □ Baclofen
- □ Flexeril
- □ Robaxin
- □ Soma
- □ Skelaxin
- □ Zanaflex
- □ Valium
- □ Norflex

Opioids:

- □ tramadol (Ultram/Ultracet)
- □ hydrocodone (Lortab/Vicodin /Lorcet/Norco)
- □ oxycodone (OxyContin/Endocet /Percocet/Tylox)
- □ Dilaudid
- □ morphine (Kadian, MS Contin)
- □ Opana
- □ Methadone
- □ fentanyl (Duragesic/Actiq)
- □ Nucynta
- □ Exalgo
- □ Butrans
- □ Suboxone (buprenorphine)
- □ Tylenol/codeine (Tylenol #3/#4)

Nerve Medicines:

- □ gabapentin/Neurontin
- □ Lyrica
- □ Cymbalta
- □ amitriptyline (Elavil)
- □ nortriptyline (Pamelor)
- □ Savella
- □ Topamax
- □ Tegretol
- □ Trazodone

Other:

- □ Lidoderm
- □ capsaicin
- □ menthol

Past evaluations:

Have you seen a **PAIN MANAGEMENT SPCECIALIST** in the past? □ Yes □ No, if yes then who? _____

List the pain medications they were recently prescribing you **IF you are not currently taking them:**

Medication	Dose	Number of pills/day

Were you discharged from the practice? □ Yes □ No. If yes, why? _____

List **ANY OTHER** specialists you have seen about your pain: _____

Medications

Please list all medications that you are currently taking, **INCLUDE OVER THE COUNTER**

Medication Name	Dosage	Frequency	Who Prescribed Medication

Allergies

List Allergies	Reaction you had

Past Medical History

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Abuse-sexual or domestic
- ☐ Acid reflux
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Arrhythmia
- ☐ Atrial fibrillation
- ☐ Bipolar disorder
- ☐ Blood clots
- ☐ Brain injury
- ☐ Cancer (type: _____, remission?: ☐ yes ☐ no)
- ☐ COPD (home oxygen?: ☐yes ☐ no)
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Fractures: _____
- ☐ Gastrointestinal disease
- ☐ Gout
- ☐ Heart disease
- ☐ Hypertension
- ☐ Kidney stones
- ☐ Lupus
- ☐ Migraines
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Sleep apnea (CPAP?: ☐ yes ☐ no)
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Ulcers
- ☐ Other: _____

Past Surgical History

Provide a complete list of **ALL** surgeries. (Use back of page if necessary)

☐ Spine surgery (cervical/thoracic or lumbar?, number of times, levels involved and dates):_____

_____

☐ ALL OTHER:_____

_____

_____

Family History

Please list any major illness in your family:

- ☐ Autoimmune disease
- ☐ Back/spine problems
- ☐ Bleeding disorder
- ☐ Stroke
- ☐ Chronic pain
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hypertension
- ☐ Cancer, type?: _____
- ☐ Mental disorder
- ☐ Neuropathy
- ☐ Substance abuse
- ☐ Lupus
- ☐ Tobacco dependence
- ☐ Other: _____

Social History

Tobacco Use: ☐ Never ☐ Quit ☐ Current: ☐ daily ☐ some days of week for _____ # of years

Marital Status (circle one): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic partner

Occupation: ☐ employed, type of work:_____ ☐ unemployed ☐ retired ☐ student ☐ disabled

Education: ☐ high school grad, if no highest grade:____ ☐ trade school ☐ college ☐ graduate/professional school

Alcohol Use: ☐ Never ☐ # of Beer(s)/week_____ ☐ # of Liquor drinks/week_____ ☐ # of Wines/week_____

☐ Recovering Alcoholic: # of years sober_____

Illicit Drug Usage: ☐ Never ☐ Past History ☐ Current. Please list drugs used _____

Drug/Alcohol Abuse Treatment in Past: ☐ Yes ☐ No. If yes, ☐ In-Patient ☐ Out-Patient ☐ Both

Exercise (circle one): ☐ Not Exercising ☐ Occasional ☐ Moderate ☐ Heavy

Difficulty Walking/Climbing: ☐ Yes ☐ No

Able to Care for Self: ☐ Yes ☐ No, Caregiver: ☐ Yes ☐ No

Review of Systems

Symptoms you are CURRENTLY having only:

Constitutional	**ENT**	**CV**	**Resp**	**GI**
☐ Lethargy/sedation ☐ Fevers ☐ Weight loss	☐ Hearing loss ☐ Snoring	☐ Fainting ☐ Palpitations	☐ Short of breath ☐ Sleep apnea	☐ Nausea/vomiting ☐ Constipation
GU	**Neuro**	**Psych**	**Heme/Lymph**	**Skin/Allergy**
☐ loss of urine control ☐ Urinary retention	☐ Seizures ☐ Dizziness	☐ Depression ☐ Anxiety ☐ Insomnia	☐ Swollen glands ☐ Easy bruising	☐ rashes ☐ itching ☐ allergic reaction

By signing below I certify that the above information is true to the best of my knowledge and I consent for the provider to evaluate, and treat me for the condition or conditions present above.

_____ _____

Signature of Patient, Guardian or Patient Representative Date

Southern Interventional Pain Center ***Max Shokat, DO***
Fax 229.226.2237

CONSENT TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and consent that _____ to release healthcare information of the patient named above to:

Southern Interventional Pain Center

Address: 615 South Hansell Street

City: Thomasville State: GA Zip Code: 31792

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I consent the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I consent the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS CONSENT EXPIRES 180 DAYS AFTER IT IS SIGNED.