Genesis Pain & Spine Center
Initial Evaluation

Name:_____ Date of birth: _____

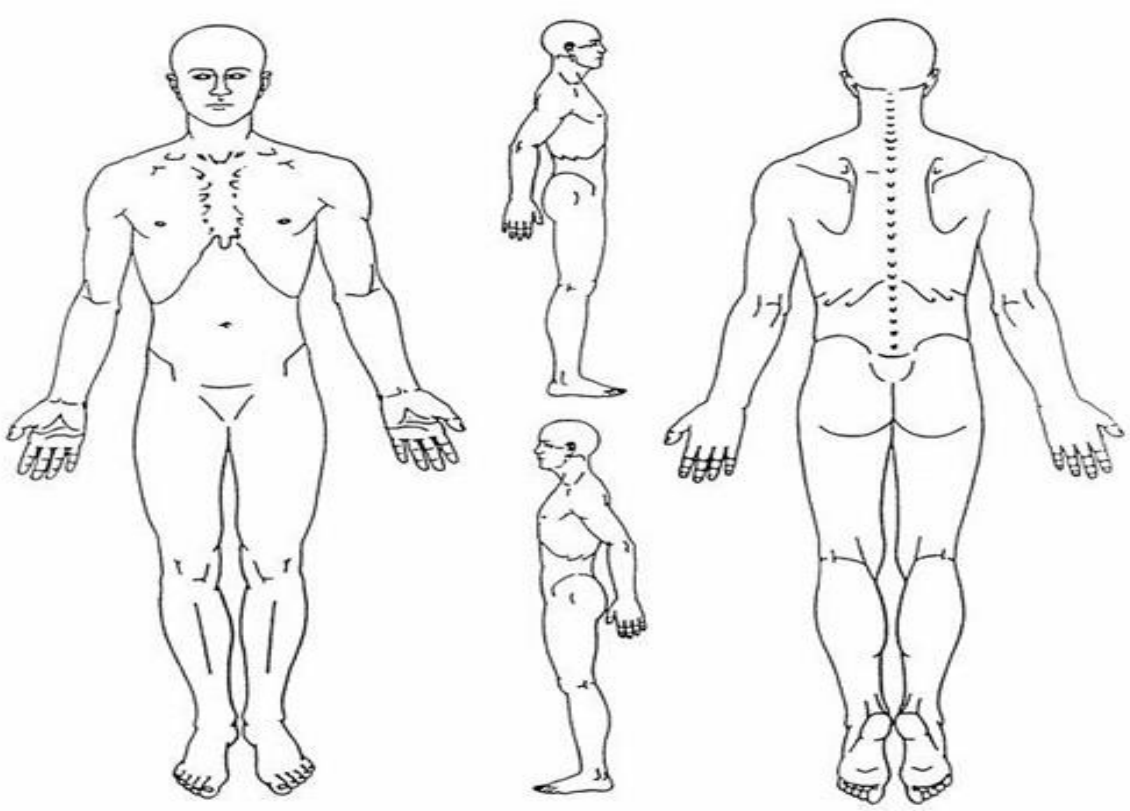
Date of visit:_____ Referring Physician_____ Family doctor_____

Circle a number below to indicate your usual level of pain:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

On the drawings below, **please shade** in the areas you feel pain:



What do you think caused the pain?_____

How long have you had your pain?_____

Is your pain constant?_____

If not, how often does it occur & how long does it last?_____

Please note the terms below that describe your pain:

___throbbing ___shooting ___stabbing ___sharp ___dull ___pins/needles ___tingling ___cramping
___aching ___pressure ___electric ___hot/burning ___heavy ___numb Other:_____

Please check items which make your pain feel <u>WORSE</u>:

___sitting ___walking ___standing ___laying down ___sexual activity ___heat/ice ___weather
___stress ___physical activity ___coughing/sneezing ___time of day-when?_____
Other: _____

Please check items which make your pain feel <u>BETTER</u>:

___sitting ___walking ___standing ___laying down ___medication ___acupuncture ___heat/ice
___alcohol/drugs ___exercise ___chiropractor ___nothing Other: _____

Please note any previous treatment for this pain

Treatment	Yes	No	When?	Did it Help? Y	N	Comments
Physical Therapy						
Home Exercise Program						
TENS unit						
Acupuncture						
Chiropractic Care						
Pain Psychology						
Injections						
Other						

Please note any previous testing for this pain:

_____MRI _____CT scan _____EMG/NCV _____ Myelogram _____Xray _____Other

Is your pain associated with: _____ auto accident _____ Workers compensation _____ Legal claims

Medications for Pain:

1. Please **check** the medications you have taken **only for your pain** in the past or present
2. Please **circle** the medications that were helpful

Anti-inflammatories (NSAIDs)		
__Aspirin – Ecotrin	__Ibuprofen-Motrin/Advil	__Nabumetone-Relafen
__Celecoxib – Celebrex	__Indomethacin – Indocin	__Naproxen – Naprosyn
__Diclofenac – Voltaren/Arthrotec	__Ketoprofen – Orudis	__Oxaprozin – Daypro
__Diflunisal – Dolobid	__Ketorolac – Toradol	__Piroxicam – Feldene
__Etodolac – Lodine	__Meloxicam – Mobic	__Ansaid - Flurbiprofen
Others		
__Acetaminophen – Tylenol	__Other	__Orphenadrine - Norflex
Muscle Relaxants		
__Baclofen – Lioresal	__ Diazepam – Valium	__ Tizanidine – Zanaflex
__Carisoprodol – Soma	__Metaxalone – Skelaxin	__Other:
__Cyclobenzaprine – Flexeril	__Methocarbamol – Robaxin	
Antidepressants		
__Amitriptyline – Elavil	__Escitalopam – Lexapro	__Paroxetine – Paxil
__Buproprion – Wellbutrin	__Fluoxetine – Prozac	__ Sertraline – Zoloft
__Citalopram – Celexa	__Imipramine – Tofranil	__Trazadone – Desyrel
__Doxipin – Sinequan	__Milnacipran – Savella	__Venlafaxine – Effexor
__Duloxetine – Cymbalta	__Nortriptyline – Pamelor	__Other
Anti-seizure medicatons		
__Carbamazepine – Tegretol	__Levetiracetam – Keppra	__Tiagabine – Gabatril
__Gabapentin – Neurontin	__Oxcarbazepine – Trileptal	__Topiramate – Topomax
__Lamotragine – Lamictal	__Pregabalin- Lyrica, Gralise	__Zonisamide – Zonegran
Narcotics		
__Buprenorphine – Butrans patch	__Hydromorphone – Dilaudid, Exalgo, Palladone	__Oxycodone – Percocet, Roxicet, Endocet, Oxycontin
__Codeine – T#3	__Meperidine – Demerol	__Oxymorphone – Opana
__Fentanyl Patch – Duragesic	__Methadone	__Tapentadol – Nucynta
__Hydrocodone – Vicodin, Lortab, Norco, Lorcet	__Morphine – MS Contin, Avinza, Kadian	__Tramadol - Ultram

Review of Systems/Past Medical History

Constitutional

___weight change ___fevers ___fatigue ___difficulty sleeping ___appetite change ___night sweats ___chills

Cardiovascular:

___chest pain ___high blood pressure ___irregular heart beat ___murmur ___palpitations ___swelling of arms/legs ___heart attack ___high cholesterol ___pacemaker/defibrillator

Respiratory/Pulmonary:

___asthma ___short of breath ___home oxygen ___sleep apnea ___COPD ___cough ___pulmonary emboli ___cough ___wheezing ___coughing up blood

Neurologic:

___numbness ___head injury ___stroke ___MS ___Parkinson's ___paralysis ___memory loss ___dizziness/fainting ___speech problems ___hearing problems ___headaches ___seizures ___weakness ___vision problems

Gastrointestinal:

___abdominal pain ___heartburn/GERD ___constipation ___diarrhea ___ulcers ___loss of bowel control ___nausea/vomiting ___Crohn's ___Ulcerative colitis ___hepatitis ___rectal bleeding ___bloody/dark stools ___hiatal hernia ___ostomy

Integumentary:

___rash ___sores ___lesions ___itching

Musculoskeletal:

___arthritis ___stiffness ___joint pain/swelling ___muscle pain ___weakness ___cramping ___osteoporosis ___neck pain ___low back pain ___fibromyalgia

Psychiatric:

___depression ___anxiety ___suicidal thoughts ___sleep disturbance ___mood swings ___poor concentration ___bipolar

Hematologic:

___easy bruising ___easy bleeding ___gums bleed easily ___anemia ___blood clots ___Leukemia

Immunologic:

___HIV/AIDS ___Lupus ___MRSA ___Immunosuppression ___taking immunosuppressant drugs

Endocrinologic:

___adrenal problems ___diabetes ___hyperthyroidism ___hypothyroidism ___high blood sugar

Genitourinary:

___painful urination ___unusual frequency ___loss of urine control ___catheter/ostomy ___blood in urine ___renal failure/insufficiency ___enlarged prostate

Eyes/Ear/Nose/Throat:

___vision changes ___glasses ___sore throat ___hearing aids ___TMJ

Other:

___cancer (specify type)_____ ___ ___radiation ___chemotherapy ___pregnant

Past Surgical history:

Procedure Performed	Date

All Current Meds (please include over the counter, herbs & vitamins)

Medication	**Dose (strength)**	**Frequency**

**please attach separate sheet if necessary

Pharmacy:_____ Location:_____

Allergies:

___no known allergies ___Latex ___Contrast (dye) ___Iodine or shellfish ___Seasonal or Environmental

___bananas, kiwi, chestnuts, avocado ____medication (please list)_____

_____

Social/Work History:

Current or most recent occupation? _____

Are you on disability? _____No _____Yes If yes, date started_____

Reason for disability?_____

Have you ever received mental health care? ___No ___Yes If so, when & with whom _____

Are there any cultural, ethnic, or religious practices which need to be considered for your care?

___No ___Yes If yes, please explain_____

Smoking: ___No ___Yes ___Quit Packs per day_____ Number of years smoked_____

Alcohol use: ___None ___Occasional ___Daily How much per week_____

Was treatment ever recommended/received for alcohol or drug abuse? ___No ___Yes

Are you currently using any recreational drugs? ___No ___Yes What type?_____

Do you stretch daily? ___Yes ___No Do you exercise on a regular basis? ___Yes ___No

Family History:

Please list any major medical conditions (such as Cancer, Diabetes, High Blood Pressure, Thyroid disease, heart disease) in your family history:

Family Member	**Medical Condition**
Mother	
Father	
Brother	
Sister	

Are you adopted? ___yes ___no