Comprehensive
PAIN & REHABILITATION

4105 Hospital Road, Suite 112-A
Pascagoula, MS 39581
228.938.0700 ● 228.938.0705 Fax

7101 Highway 90, Suite 102
Daphne, AL 36526
251.625.2228 ● 251.625.2112 Fax

www.nopaindr.com

New Patient Evaluation

What area hurts you the most? (Please choose one)

☐	Neck	☐	Back
☐	Other:		

When did this pain start? _____

How did this pain start?

☐	Work related injury	☐	Motor Vehicle Accident	☐	Fall
☐	No known cause	☐	Other		

How often do you experience this pain?

☐	Constantly	☐	Frequently	☐	Intermittently	☐	Occasionally

Describe what this pain feels like.

☐	Burning	☐	Aching	☐	Electrical	☐	Sharp
☐	Throbbing	☐	Spasms	☐	Other:		

What makes this pain worse?

☐	Bending Backward	☐	Overhead Activity	☐	Sneezing	☐	Coughing
☐	Bending Forward	☐	Looking Up	☐	Other:		

What makes this pain better?

☐	Medication	☐	Massage	☐	Heat	☐	Ice
☐	Traction	☐	Lying flat on back	☐	Other:		

If pain is worse in your neck or back, does it extend into your arms or legs?

☐	Yes, arm (s)	☐	Yes, leg (s)	☐	No

If yes, how often does this pain go into your arms or legs?

☐	Constantly	☐	Frequently	☐	Intermittently	☐	Occasionally

If yes, what does the pain in your arms or legs feel like?

☐	Burning	☐	Shooting	☐	Numbing
☐	Aching	☐	Electrical	☐	Other:

If the main pain complaint is neck pain, do you have headaches that occur as a result?

☐	Yes	☐	No

If yes, what does your headache pain feel like?

☐	Burning	☐	Shooting	☐	Throbbing	☐	Pulsing
☐	Crushing	☐	Dull & Achy	☐	Electrical	☐	Sharp
☐	Pulling	☐	Toothache like	☐	Stabbing	☐	Spasms
☐	Tingling	☐	Numbing	☐	Other:		

☐	Sinuses	☐	Behind the eyes	☐	Forehead	☐	Side of head

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Where do you experience your headache pain?

☐	Top of head	☐	Back of head	☐	Entire head	☐	Other:

What triggers your headache pain?

☐	Stress	☐	Strong smells	☐	Too little/much sleep	☐	Weather changes
☐	Caffeine	☐	Neck movement	☐	Certain foods/alcohol	☐	Other:

How frequent are your headaches?

☐	Constantly	☐	Daily	☐	1-2/week
☐	3-5/week	☐	1-2/month	☐	

Are any of the following associated with your headaches?

☐	Floaters/visual changes	☐	Sensitivity to sound	☐	Sensitivity to light
☐	Nausea	☐	Vomiting	☐	Other:

Does your pain keep you awake at night?

☐	Yes	☐	No

If yes, please explain:_____

What is your pain intensity today, with '0' representing no pain and '10' representing the most severe pain imaginable?

1	2	3	4	5	6	7	8	9	10

Do you experience any other areas of pain?

☐	Yes	☐	No

If yes, please proceed below. If no, please proceed to page 4.

In what other areas do you experience pain? When did this pain start? _____

☐	Neck	☐	Back
☐	Other:		

How did this pain start?

☐	Work related injury	☐	Motor Vehicle Accident	☐	Fall
☐	No known cause	☐	Other		

How often do you experience this pain?

☐	Constantly	☐	Frequently	☐	Intermittently	☐	Occasionally

Describe what this pain feels like.

☐	Burning	☐	Aching	☐	Electrical	☐	Sharp
☐	Throbbing	☐	Spasms	☐	Other:		

What makes this pain worse?

☐	Bending Backward	☐	Overhead Activity	☐	Sneezing	☐	Coughing
☐	Bending Forward	☐	Looking Up	☐	Other:		

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What makes this pain better?

☐	Medication	☐	Massage	☐	Heat	☐	Ice
☐	Traction	☐	Lying flat on back	☐	Other:		

If your pain is in your neck or back, does it extend into your arms or legs?

☐	Yes, arm (s)	☐	Yes, leg (s)	☐	No

If yes, how often do you experience your arm or leg pain?

☐	Constantly	☐	Frequently	☐	Intermittently	☐	Occasionally

If yes, what does your arm or leg pain feel like?

☐	Burning	☐	Shooting	☐	Numbing
☐	Aching	☐	Electrical	☐	Other:

If your pain complaint is neck pain, do you have headaches that occur as a result?

☐	Yes	☐	No

If yes, what does your headache pain feel like?

☐	Burning	☐	Shooting	☐	Throbbing	☐	Pulsing
☐	Crushing	☐	Dull & Achy	☐	Electrical	☐	Sharp
☐	Pulling	☐	Toothache like	☐	Stabbing	☐	Spasms
☐	Tingling	☐	Numbing	☐	Other:		

Where do you experience your headache pain?

☐	Sinuses	☐	Behind the eyes	☐	Forehead	☐	Side of head
☐	Top of head	☐	Back of head	☐	Entire head	☐	Other:

What triggers your headache pain?

☐	Stress	☐	Strong smells	☐	Too little/much sleep	☐	Weather changes
☐	Caffeine	☐	Neck movement	☐	Certain foods/alcohol	☐	Other:

How frequent are your headaches?

☐	Constantly	☐	Daily	☐	1-2/week
☐	3-5/week	☐	1-2/month	☐	

Are any of the following associated with your headaches?

☐	Floaters/visual changes	☐	Sensitivity to sound	☐	Sensitivity to light
☐	Nausea	☐	Vomiting	☐	Other:

Do you have any other areas of pain?
If yes, please list below and describe.

☐	Yes	☐	No

_____
_____
_____

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Pain Treatment History

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.

	Not Tried	Excellent Relief	Moderate Relief	No Relief	Made Worse
Surgery					
Injections					
Physical Therapy					
Chiropractic Therapy					
Psychotherapy					

If you have had injections, please specify what kind: _____
What year were they done? _____

Functional/Occupational Limitations

During the past month, place a checkmark next to the activities you avoided because of pain:

	Going to work		Performing household chores		Caring for self		Having sexual relations
	Socializing with friends		Participation in recreation		Physically exercising		Other:

Have you had to stop working or change work related activities? | | Yes | | No |
If yes, please explain: _____
Have you filed any legal claims related to your pain problems? | | Yes | | No |
If yes, please explain: _____

Family History

Please check if the family member listed has suffered from any of these medical conditions:

	Mother	Father	Brother	Sister
Stroke				
Heart Attack				
Cancer				
Diabetes				

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Past Medical History

Please place a check by the medical conditions you have been diagnosed with.

	Coronary Artery Disease		Heart Attack		High Cholesterol		Pacemaker		Defibrillator
	High Blood Pressure		Stroke		Migraines		Dementia		Osteoarthritis
	Transient Ischemic Attack (TIA)		Rheumatoid Arthritis		Asthma		Sleep Apnea		COPD
	Degenerative Joint Disease		Emphysema		Bleeding Disorder		Glaucoma		Fainting
	Gastro esophageal Reflux Disease (GERD)		GI bleeding		Kidney Stones		Hepatitis		HIV/AIDS
	End Stage Renal Disease		Diabetes		Hypothyroidism		Hyperthyroidism		Shingles
	Benign Prostatic Hypertrophy (BPH)		Psoriasis		Staph infection		Erectile dysfunction (ED)		
	Cancer (please list type):				Other:				

Past Surgical History

Please list any surgical procedures you have had done and the year they were performed.

Surgery	Year

Please list all the Physicians that are currently treating you:

Name	Specialty	Location

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Review of Systems

Please check all that apply to your health:

☐	Chest pain	☐	Shortness of breath	☐	Extremity swelling	☐	Constipation
☐	Unintentional weight gain	☐	Bowel incontinence (loss of stool control)	☐	Urinary incontinence (loss of bladder control)	☐	Gastric upset/discomfort
☐	Rash	☐	Numbness	☐	Weakness	☐	Sensory changes
☐	Nausea	☐	Unintentional weight loss	☐	Altered mental status	☐	Confusion

Social History

What is your relationship status?

☐	Single	☐	Married	☐	Separated	☐	Divorced	☐	Widowed

What city do you live in? _____

Who do you live with? _____

What is the highest level of education you have completed?

☐	High School diploma	☐	GED	☐	2 year degree
☐	4 year degree	☐	Graduate degree	☐	Other:

Please check yes or no to the following:

Yes	No	
		Do you smoke?
		If yes, how much:
		If you quit, how long ago was that:
		Do you use other nicotine products?
		Do you drink alcohol?
		If yes, how many alcoholic beverages do you drink in a week:
		Have you abused alcohol or been diagnosed with alcoholism?
		Have you used illegal drugs?
		Have you ever abused pain, sleep, anxiety, cold, psychiatric, diet or any other prescription medications?
		Has a parent or sibling abused alcohol or been diagnosed with alcoholism?
		Has a parent or sibling used illegal drugs?
		Has a parent or sibling ever abused pain, sleep, anxiety, cold, psychiatric, diet or any other prescription medications?
		Have you ever been in a detoxification program for drug abuse?
		Have you ever been treated at a Methadone clinic?
		Have you ever participated in Alcoholics Anonymous?
		Do you suffer from physical abuse or safety hazards in your current living situation?
		If yes, please explain:
		Were you a victim of childhood sexual abuse?

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Psychological History

Please check yes or no to the following:

Yes	No	
		Have you ever attempted suicide?
		Do you have suicidal thoughts?
		Have you ever been hospitalized for psychiatric issues?
		If yes, please explain:
		Are you currently under the care of a psychiatrist? **Who?**
		Have you been diagnosed with or suffer from Attention Deficit Disorder (ADD)?
		Have you been diagnosed with or suffer from Obsessive Compulsive Disorder (OCD)?
		Have you been diagnosed with or suffer from Bipolar disorder?
		Have you been diagnosed with or suffer from Schizophrenia?
		Have you been diagnosed with or suffer from Anxiety?
		Have you been diagnosed with or suffer from Depression?

Medications

Please list all the medications you currently take including vitamins/herbs/supplements.
Please be sure to **BRING IN YOUR MEDICATION BOTTLES** to your appointment.

Medication Name	Dose (mg, mcg, etc)	Route it is taken (by mouth, injected, etc)	Frequency it is taken (once a day, twice a day, etc)

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Notes:

For clinic use only:

_____
_____
_____
_____
_____
_____
_____