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

Do you have **low back pain**?

	Yes		No
If no, please skip to page 2			

When did your **low back pain** start? __________

How did your **low back pain** start?

	Work related injury		Motor Vehicle Accident		Fall
	No known cause		Other		

How often do you experience your **low back pain**?

	Constantly		Frequently		Intermittently		Occasionally

Describe what your **low back pain** feels like.

	Burning		Aching		Electrical		Sharp
	Throbbing		Spasms		Other:		

What makes your **low back pain** worse?

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

What makes your **low back pain** better?

	Medication		Massage		Heat		Ice
	Traction		Lying flat on back		Other:		

Does your **low back pain** extend into your legs?

	Yes		No
If no, please skip to page 2			

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

	Constantly		Frequently		Intermittently		Occasionally

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

	Burning		Shooting		Numbing
	Aching		Electrical		Other:

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 have any other areas of pain?

	Yes		No

If yes, please proceed below. If no, please proceed to the bottom of page 3.

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

Do you have **neck pain**?

	Yes		No
If no, please skip to the bottom of page 3			

When your **neck pain** start? ______________

How did **your neck pain** start?

	Work related injury		Motor Vehicle Accident		Fall
	No known cause		Other		

How often do you experience **your neck pain**?

	Constantly		Frequently		Intermittently		Occasionally

Describe what **your neck pain** feels like.

	Burning		Aching		Electrical		Sharp
	Throbbing		Spasms		Other:		

What makes **your neck pain** worse?

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

What makes **your neck pain** better?

	Medication		Massage		Heat		Ice
	Traction		Lying flat on back		Other:		

Does **your neck pain** extend into **your arms**?

	Yes		No
If no, please go to page 3			

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

	Constantly		Frequently		Intermittently		Occasionally

If yes, what does **your arm pain** feel like?

	Burning		Shooting		Numbing
	Aching		Electrical		Other:

Do you have **headaches** that occur **as a result of your neck pain**?

	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		

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

Do you have any other areas of pain? ☐ Yes ☐ No

If yes, please list: ___________________________________

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:		

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 check mark next to the activities that 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

Have you filed any legal claims related to your pain problems? ☐ Yes ☐ No

Does your pain keep you up at night? ☐ Yes ☐ No

Revised 8/2017

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

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

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

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:

Social History Continued

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?
		Have you ever been in a detoxification program for drug abuse?
		Have you ever been treated at a Methadone clinic?
		Have you ever abused pain, sleep, anxiety, cold, psychiatric, diet or any other prescription medications?
		Has a parent, sibling or child abused alcohol or been diagnosed with alcoholism?
		Has a parent, sibling or child used illegal drugs?
		Has a parent, sibling or child ever abused pain, sleep, anxiety, cold, psychiatric, diet or any other prescription medications?
		Does anyone sharing the home take prescription pain medication?
		Does anyone sharing the home abuse, misuse, or sell prescription or illicit drugs?
		Do you suffer from physical abuse or safety hazards in your current living situation?
		If yes, please explain:
		Do you have a history of physical or emotional abuse?
		Were you a victim of childhood sexual abuse?
		Have you used drugs other than those required for medical reasons?
		Do you abuse more than one drug at one time?
		Are you always able to stop using drugs when you want to? ***(If you never use drugs answer 'Yes')***
		Have you had 'blackouts' or 'flashbacks' as a result of drug use?
		Do you ever feel bad or guilty about your drug use? ***(If you never use drugs, choose 'No')***
		Does your spouse (or parents) ever complain about your involvement with drugs?
		Have you neglected your family because of drugs?
		Have you engaged in illegal activities in order to obtain drugs?
		Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking your drugs?
		Have you ever had medical problems as a result of your drug use (memory loss, hepatitis, convulsions, bleeding, etc)?

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

Please mark the most appropriate answer for each question:

		0		1		2		3		4
How often do you have a drink containing alcohol?		Never		Monthly or less		2-4 times per month		2-3 times per week		4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?		1 or 2		3 or 4		5 or 6		7, 8, or 9		10 or more
How often do you have 6 or more drinks on one occasion?		Never		Less than monthly		Monthly		Weekly		Daily or almost daily
How often during the last year have you found that you were not able to stop drinking once you had started?		Never		Less than monthly		Monthly		Weekly		Daily or almost daily
How often during the last year have you failed to do what was normally expected of you because of drinking?		Never		Less than monthly		Monthly		Weekly		Daily or almost daily
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?		Never		Less than monthly		Monthly		Weekly		Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?		Never		Less than monthly		Monthly		Weekly		Daily or almost daily
How often during the last year have you been unable to remember what happened the day before because you had been drinking?		Never		Less than monthly		Monthly		Weekly		Daily or almost daily
Have you or someone else been injured as a result of your drinking?		No		Yes, but not in the last year (2)				Yes, during the last year (4)		
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?		No		Yes, but not in the last year (2)				Yes, during the last year (4)		

Standard Drink Equivalents:

- 12 oz. of Beer (~5% alcohol) = 1 drink
- 8-9 oz. of Malt Liquor (~7% alcohol) = 1 drink
- 5 oz. of Table Wine (~12% alcohol) = 1 drink
- 1.5 oz. of 80 proof Spirits (hard liquor) (~40% alcohol) = 1 drink

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

Psychological History

Please check yes or no to the following:

Yes	No	
		Have you ever accidentally overdosed on medications?
		Have you ever attempted suicide?
		If yes, did the attempted suicide involve intentional overdose on medications?
		Do you have suicidal thoughts?
		Have you ever been hospitalized for psychiatric issues?
		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 Obsessive Compulsive Disorder (OCD)?
		Have you been diagnosed with Bipolar disorder?
		Have you been diagnosed with Schizophrenia?
		Have you been diagnosed with Post Traumatic Stress Disorder (PTSD)?
		Have you been diagnosed with Borderline Personality Disorder?
		Have you been diagnosed with Antisocial Personality Disorder?
		Have you been diagnosed with or suffer from Anxiety?
		Have you been diagnosed with or suffer from Depression?

Please mark the most appropriate answer to the following questions:

Over the past *2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself-or that you're a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or, the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have those problems mad it for you to do your work, take care of things at home, or get along with other people?

	Not difficult at all		Somewhat difficult		Very difficult		Extremely difficult

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

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				

Review of Systems

Please check all that apply to your health within the last 6 months:

	Fever		Unintentional weight loss		Night sweats		Recent illness
	Double vision		Blurry vision		Vertigo		Sore throat
	Runny nose		Chest pain		Rapid heart rate		Palpitations
	Cough		Shortness of breath		Wheezing		Nausea
	Vomiting		Diarrhea		Constipation		Incontinence
	Painful urination		Swelling		Muscle pain		Joint pain
	Rash		Bruising		Skin breakdown		Dizziness
	Weakness		Headaches		Frequent urination		Excessive thirst
	Anemia		Heat or cold intolerance		Bruising easily		Bleeding problems

Please list all the Physicians that are currently treating you:

Name	Specialty	Location

Allergies

Please list all the **allergies** you currently have including to vitamins/herbs/supplements.

Medication Name	**Reaction**

Revised 8/2017

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

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)