# MUPRHY PAIN CENTER – NEW PATIENT EVALUATION

**Date:** _____ **DOB:** _____ **AGE:** _____

**NAME:** _____ **PHONE:** _____

**Referring Physician:** _____ **PHONE:** _____

**Primary Care Physician:** _____ **PHONE:** _____

**Is your pain a WORKMAN's COMP case?** ☐ YES ☐ NO **Is your pain due to MVA?** ☐ YES ☐ NO

**Please provider your EMAIL Address:** _____

## HISTORY OF PRESENT ILLNESS

1. **Please describe your pain in one sentence (ex: "My back hurts."):**

   _____

2. **What caused your pain?**

   ☐ Work-related accident ☐ Accident at home ☐ Work-related, not accident ☐ Motor Vehicle Accident

   ☐ Following Surgery ☐ Following Illness ☐ Pain began, no reason

   ****If work related, please describe how:** ☐ injury from repetitive activity ☐ struck by falling object

   ☐ fall ☐ lifting object ☐ pushing Other: _____

3. **Date your pain began:**

   ☐ Past 2 weeks ☐ 3-6 months ☐ 1-2 years ☐ > 5 years
   ☐ 2 wks – 3 months ☐ 6 mo – 1 year ☐ 2-5 years

4. **Location of your pain (check all that apply):**

   ☐ Head ☐ (R) Hand ☐ (R) Leg ☐ Anterior Chest Wall
   ☐ Neck ☐ (L) Hand ☐ (L) Leg ☐ Abdominal Pain
   ☐ (R) Shoulder ☐ Upper Back ☐ (R) Knee ☐ Testicular Pain
   ☐ (L) Shoulder ☐ Lower Back ☐ (L) Knee
   ☐ (R) Wrist/Arm ☐ (R) Hip ☐ (R) Ankle/Foot
   ☐ (L) Wrist/Arm ☐ (L) Hip ☐ (L) Ankle/Foot

5. **Describe your pain (check all that apply):**

   ☐ Sharp ☐ Numbness ☐ Cramping ☐ Nagging
   ☐ Dull/Aching ☐ Pressure ☐ Spasm
   ☐ Throbbing ☐ Electric/Shooting ☐ Penetrating
   ☐ Pins/Needles ☐ Burning ☐ Tender
   ☐ Stabbing ☐ Stinging ☐ Gnawing

**6. Please rate your pain:**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Good Day: | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |
| Bad Day: | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |
| Current: | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |

**7. Is your pain always the same?** ☐ **YES** ☐ **NO**

**8. Duration of your pain:** ☐ Rare ☐ Occasional ☐ Frequent ☐ Constant

**9. What makes your pain worse (check all that apply):**

| | | |
|---|---|---|
| ☐ Heat | ☐ Quiet | ☐ Massage |
| ☐ Cold | ☐ Sitting | ☐ Lifting |
| ☐ Activity | ☐ Standing | ☐ Bending |
| ☐ Rest | ☐ Walking | ☐ Activities of daily living |
| ☐ Lying Down | ☐ Medication | ☐ Weight bearing activities |

**10. What makes your pain better (check all that apply):**

| | | |
|---|---|---|
| ☐ Heat | ☐ Quiet | ☐ Massage |
| ☐ Cold | ☐ Sitting | |
| ☐ Activity | ☐ Standing | |
| ☐ Rest | ☐ Walking | |
| ☐ Lying Down | ☐ Medication | |

**11. CHECK any of the treatment therapies listed below that you have had in the past; then**

****CIRCLE the treatment(s) that were HELPFUL****

| | | |
|---|---|---|
| ☐ Acupuncture | ☐ Herbal Remedies | ☐ Psychiatrist/Psychologist |
| ☐ Bed Rest | ☐ Hypnosis | ☐ RFTC |
| ☐ Biofeedback | ☐ Injected Medication | ☐ SI Joint Injection |
| ☐ Bracing | ☐ IV Injections | ☐ Spinal Cord Stimulator |
| ☐ Carpal Tunnel Injections | ☐ Joint Injections | ☐ Spinal Pain Pump |
| ☐ Celiac Plexus Injection | ☐ Massage Therapy | ☐ Sympathetic Blocks |
| ☐ Chiropractor | ☐ Magnet Therapy | ☐ TENS |
| ☐ Epidural Blocks | ☐ Marijuana | ☐ Topical Ointments |
| ☐ Facet Injections | ☐ Narcotic Pain Medication | ☐ Traction |
| ☐ Group Therapy | ☐ Nerve Blocks | ☐ Trigger Point Injections |
| ☐ Heat therapy | ☐ Physical Therapy | ☐ Ultrasound |
| | ☐ Piriformis Injection | ☐ **NONE** |

**12 What time of day is your pain worse?** _____

**13. What time of day is your pain least?** _____

**14. Does your pain interrupt your sleep and how often?** _____

**15. Previous Diagnostic Studies (check all that apply):** ☐ **NONE**

| | | |
|---|---|---|
| ☐ MRI | ☐ Bone Scan | ☐ Urine Drug Screen |
| ☐ CT | ☐ Discogram | ☐ EMG |
| ☐ Myelogram | ☐ Blood test | ☐ Other _____ |

**16. Please list any surgery you have had that is related to your current pain:** ☐ **NONE**

_____

**17. Who was your surgeon?** _____

**18. Did surgery help your pain?** ☐ **YES** ☐ **NO**

**19. Have you been treated by another pain management physician?** ☐ **NO** ☐ **YES**

**20. Please list name of pain physician and why you left?** _____

_____

**21. Please list medications you have trialed but are no longer taking (check all that apply):** ☐ **NONE**

| | | | | |
|---|---|---|---|---|
| ☐ Actiq | ☐ Darvocet | ☐ Lunesta | ☐ Oxycontin | ☐ Skelaxin |
| ☐ Aleve | ☐ Dilaudid | ☐ Lyrica | ☐ Oxyfast | ☐ Stadol Nose Spray |
| ☐ Ambien | ☐ Duragesic | ☐ Methadone | ☐ Paxil | ☐ Talwin |
| ☐ Aspirin | ☐ Effexor | ☐ Mexilitine | ☐ Percocet | ☐ Tegretol |
| ☐ Avinza | ☐ Elavil | ☐ Mobic | ☐ Prednisone | ☐ Topamax |
| ☐ Baclofen | ☐ Embeda | ☐ Morphine | ☐ Prozac | ☐ Tylenol |
| ☐ Celebrex | ☐ Flexeril | ☐ Naproxyn | ☐ Relafen | ☐ Ultram |
| ☐ Clonazepam | ☐ Hydrocodone | ☐ Neurontin | ☐ Remeron | ☐ Valium |
| ☐ Clonidine | ☐ Kadian | ☐ Nortriptyline | ☐ Robaxin | ☐ Zanaflex |
| ☐ Codeine | ☐ Lidoderm | ☐ Nucynta | ☐ Soma | ☐ Zoloft |
| ☐ Cymbalta | ☐ Lortab | ☐ Opana | ☐ Savella | |

## MEDICATIONS & ALLERGIES ☐ NONE

**1. Please list all PAIN medication(s) (If more space needed, please make list & bring to appointment):**

| NAME | STRENGTH(mg) | TIMES per DAY |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**2. Please list all NON-PAIN medication (include herbal medications & vitamins)**

| NAME | STRENGTH(mg) | TIMES per DAY |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**3. MEDICATION ALLERGIES:** _____

**4. ENVIROMENTAL/FOOD ALLERGIES:** _____ _____

**PHARMACY (Name, Address, Phone):** _____

## HISTORY:

**1. Do you have any of the following medical conditions? (Check all that apply): ☐ NONE**

| | | |
|---|---|---|
| ☐ Anemia | ☐ Gastric Ulcers | ☐ Lupus |
| ☐ Asthma | ☐ Gastritis | ☐ Nerve Damage |
| ☐ Bronchitis | ☐ Glaucoma | ☐ Osteoarthritis |
| ☐ Cancer | ☐ Hearing Loss | ☐ Poor Vision |
| ☐ Cirrhosis | ☐ Heart Disease | ☐ Rheumatoid Arthritis |
| ☐ Colitis | ☐ Hepatitis | ☐ Sarcoidoisis |
| ☐ COPD | ☐ HIV/AIDS | ☐ Sleep Apnea |
| ☐ Diabetes (insulin controlled) | ☐ Hypertension | ☐ Thyroid (high) |
| ☐ Diabetes (oral medications) | ☐ Irritable Bowel | ☐ Thyroid (low) |
| ☐ Epilepsy | ☐ Kidney Disease | ☐ **PACEMAKER** |
| ☐ Fibromyalgia | ☐ Kidney Stones | ☐ **Internal Defibrillator** |

☐ OTHER _____

**2. Please list surgeries you have undergone in your lifetime: ☐ NONE**

_____

_____

_____

**3. Please list any medical conditions in your family and identify the family member (i.e. mother – heart disease ; father – hypertension; sister – anemia and etc.)**

**FATHER** _____ **NONE ☐**

**MOTHER** _____ **NONE ☐**

**SISTER(S)** _____ **NONE ☐**

**BROTHER(S)** _____ **NONE ☐**

**OTHER** _____

**4. Does anyone in your family have a history of drug or alcohol abuse? ☐ NO ☐ YES**

_____

**5. Who lives with you presently:**

☐ Live alone ☐ Live with spouse ☐ Live with life partner

☐ Live with friend/roommate ☐ Live with children ☐ Live with grown children

**6. What is your current occupation?**

_____

☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Not working (due to pain) ☐ Disabled (due to pain)

**7. What is your highest level of education?**

☐ Some High School ☐ GED ☐ Graduate Degree (Masters)

☐ High School Graduate ☐ Some College ☐ Graduate Degree (Doctorate)

☐ Vocational School ☐ College Degree

**8. Have you ever been arrested or incarcerated? ☐ YES ☐ NO**

_____

**9. Tobacco Use:** ☐ **NEVER** smoked ☐ **Former** Smoker ☐ **Current** every day smoker

☐ **Current** some day smoker ☐ **Heavy** daily smoker ☐ **Light** daily smoker

**Total number of years smoked: _____ # Packs/day _____**

**10. Alcohol Use: ☐ NEVER ☐ Occasionally ☐ Often**

**Average drinks per day: _____ Type _____**

**Do you ever drink to relieve your pain?** ☐ Never ☐ Occasionally ☐ Often

**11. Do you have a personal history: DRUG Abuse? ☐ YES ☐ NO ALCOHOL Abuse? ☐ YES ☐ NO**
**Have you ever been in rehab? ☐ YES ☐ NO**

_____

**12. Are you now suing; have you ever sued; or do you plan to sue because of your pain?** ☐ NO ☐ YES

If you answered yes, please explain: _____

_____

**13. Have you received or are receiving any form of financial compensation for your pain?** ☐ NO ☐ YES

☐ Worker's Compensation ☐ Government Disability ☐ Insurance ☐ Accrued Sick Leave ☐ Lump Sum Payment

**NEW PATIENT INFORMATION CERTIFICATION**

I certify that I have answered truthfully all questions on the New Patient Evaluation form and have not knowingly withheld any information concerning any of the above problems, either past or present.

I understand that the physicians and staff of Murphy Pain Center will only be evaluating my condition as it relates to my pain. Any condition which is not specifically pain-related must be followed and evaluated by my primary care physician.

I understand that the procedures and medications which may be prescribed by Murphy Pain Center can potentially have adverse effects on the status of one's fertility as well as a developing fetus. I will notify my Murphy Pain Center physician if there is any change in my fertility status or pregnancy status.

I understand that the procedures and medications which may be prescribed by Murphy Pain Center can potentially impair my ability to drive and operate machinery. I pledge to never drive impaired.

I understand that it may be at times difficult to obtain prompt consultation with the physicians or staff of Murphy Pain Center. If there is ever a significant deterioration on my function or progression of symptoms, I will seek prompt Medical attention elsewhere.

_____ _____

**Your Signature** **DATE**

_____

**Print Name**

*Thank you,*

_____ _____

**Practitioner** **DATE**

**Office Use Only:**

**Review by:**_____ **Date:**_____