ECPC
PAIN
SPECIALISTS
Division of East Carolina Anesthesia Associates, PLLC

ECPC Pain Specialists
2430 Emerald Place, Suite 103
Greenville, NC 27834
252-561-8218

ECPC Pain Specialists complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

New Patient Evaluation

Date: _____

Patient Name: _____
First MI Last

Date of Birth: _____

Who referred you: _____

Primary Care Physician: _____

Pharmacy name and telephone number: _____

_____

Have you been seen at any other pain clinics? ☐ Yes ☐ No

Where? _____

When? _____

Have you ever signed an opioid agreement? ☐ Yes ☐ No

Patient Name: _____ DOB: _____

1. If you are a Female, please tell us your pregnancy status:

☐ Hysterectomy ☐ Post-Menopausal

☐ No Contraception Birth ☐ Birth Control Medication

☐ Other Contraception

2. When did your pain first begin, month and year: _____

3. What is the main cause of your pain?

☐ Unknown ☐ Normal Aging

☐ Fall ☐ Sporting Accident

☐ Motor Vehicle Accident ☐ Work Injury

4. What is the frequency of your pain?

☐ Fluctuating, but always present ☐ Fluctuating, but usually present ☐ Fluctuating, but rarely present ☐ Constant

5. What best describes your pain? Choose one or more:

☐ Aching ☐ Burning ☐ Cramping ☐ Dull

☐ Numb ☐ Sharp ☐ Stabbing ☐ Stinging

☐ Throbbing ☐ Tingling

Patient Name: _____ DOB: _____

6. What is your pain level most of the time:

☐ 0-No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
☐ 8 ☐ 9 ☐ 10-Severe Pain

7. What makes your pain worse? Choose one or more:

☐ Nothing
☐ Lying on side
☐ Bending or stooping
☐ Lying on back
☐ Standing
☐ From sitting to standing
☐ Lifting or carrying heavy loads
☐ Sitting
☐ Lifting or carrying small loads
☐ Walking

8. What makes your pain better? Choose one or more:

☐ Lying on side
☐ Sitting
☐ Walking
☐ Exercise
☐ Lying on back
☐ Standing
☐ Stretching
☐ Nothing

9. What does your pain interfere with? Choose on or more:

☐ Daily Chores
☐ Exercise
☐ House Chores
☐ Sleep
☐ Walking
☐ Employment
☐ Grooming
☐ Mood
☐ Relationships
☐ Nothing

Patient Name: _____ DOB: _____

10. Have you had any of the following Imaging/Tests to assist in the evaluation of your pain:

    MRI ☐ Yes ☐ No CT-Scan ☐ Yes ☐ No

    X ray ☐ Yes ☐ No EMG/Nerve Study ☐ Yes ☐ No

11. Have you had any of the following to assist in the evaluation of your pain? Choose one or more:

    ☐ Blood work related to pain syndrome ☐ Bone Scan

    ☐ Vascular Studies ☐ Bone Density

    ☐ Drug Screening ☐ Functional Capacity Exam

    ☐ Depression Screening

12. Have you had any of the following injections to assist with the treatment of your pain? Choose one or more:

    ☐ Spinal ☐ Joint ☐ Muscle ☐ None

13. Have you received any of the following related to your pain:

    ☐ Back Brace ☐ Neck Brace ☐ Tens Unit ☐ None

14. Have you had any of the following surgeries:

    ☐ Low Back ☐ Mid Back ☐ Neck ☐ Hip

    ☐ Knee ☐ Shoulder ☐ None

Patient Name: _____ DOB: _____

15. Have you tried any of the following therapies for the pain we are treating?

☐ Physical
Date _____
Location _____

☐ Chiropractic
Date _____
Location _____

☐ Aqua
Date _____
Location _____

☐ None

16. Have you had any of the following to assist you with your pain:

☐ Spinal Cord Stimulation
☐ Spinal Traction
☐ Cane
☐ Walker
☐ Exercise
☐ Weight Loss
☐ Intrathecal Pain Pump
☐ None

17. Have you tried any of the Anti Inflammatory Medications below:

		☐ None Tried
Aspirin:	☐ Helpful	☐ Not Helpful
Indomethacin:	☐ Helpful	☐ Not Helpful
Celebrex®:	☐ Helpful	☐ Not Helpful
Ketroprofen:	☐ Helpful	☐ Not Helpful
Diclofenac:	☐ Helpful	☐ Not Helpful

Patient Name: _____ DOB: _____

Mobic®:	❐ Helpful	❐ Not Helpful
Daypro®:	❐ Helpful	❐ Not Helpful
Naproxen:	❐ Helpful	❐ Not Helpful
Duexis®:	❐ Helpful	❐ Not Helpful
Relafen®:	❐ Helpful	❐ Not Helpful
Etodalac:	❐ Helpful	❐ Not Helpful
Toradol®:	❐ Helpful	❐ Not Helpful
Prednisone:	❐ Helpful	❐ Not Helpful
Tylenol®:	❐ Helpful	❐ Not Helpful

18. Have you tried any of the muscle relaxer medications below:

❐ None tried

Baclofen:	❐ Helpful	❐ Not Helpful
Norflex™:	❐ Helpful	❐ Not Helpful
Cyclobenzaprine:	❐ Helpful	❐ Not Helpful
Parafon®:	❐ Helpful	❐ Not Helpful
Carisoprodol:	❐ Helpful	❐ Not Helpful
Skelaxin®:	❐ Helpful	❐ Not Helpful
Diazepam:	❐ Helpful	❐ Not Helpful
Tizanidine:	❐ Helpful	❐ Not Helpful
Methocarbamol:	❐ Helpful	❐ Not Helpful

Patient Name: _____ DOB: _____

19. Have you tried any of the narcotic medications below:

☐ None tried

Avinza:	☐ Helpful	☐ Not Helpful
Oxycontin®:	☐ Helpful	☐ Not Helpful
Codeine:	☐ Helpful	☐ Not Helpful
Oxycodone:	☐ Helpful	☐ Not Helpful
Duragesic®:	☐ Helpful	☐ Not Helpful
MS IR®:	☐ Helpful	☐ Not Helpful
Dilaudid®:	☐ Helpful	☐ Not Helpful
Methadone:	☐ Helpful	☐ Not Helpful
Hydrocodone:	☐ Helpful	☐ Not Helpful
Morphine ER:	☐ Helpful	☐ Not Helpful
Kadian®:	☐ Helpful	☐ Not Helpful
Tramadol:	☐ Helpful	☐ Not Helpful
Opana®:	☐ Helpful	☐ Not Helpful

20. Have you tried any of the following “other” medications below:

☐ None tried

Cymbalta®:	☐ Helpful	☐ Not Helpful
Lyrica®:	☐ Helpful	☐ Not Helpful
Clonidine:	☐ Helpful	☐ Not Helpful

Patient Name: _____ DOB: _____

Neurontin®:	☐ Helpful	☐ Not Helpful
Elavil®:	☐ Helpful	☐ Not Helpful
Savella®:	☐ Helpful	☐ Not Helpful
Keppra®:	☐ Helpful	☐ Not Helpful
Topamax®:	☐ Helpful	☐ Not Helpful
Klonopin®:	☐ Helpful	☐ Not Helpful
Trileptal®:	☐ Helpful	☐ Not Helpful
Lidoderm Patch®:	☐ Helpful	☐ Not Helpful
Zonegran®:	☐ Helpful	☐ Not Helpful
Horizant®:	☐ Helpful	☐ Not Helpful
Requip™:	☐ Helpful	☐ Not Helpful

21. Have you tried any Over-the-Counter Medications such as BioFreeze® or IcyHot®? ☐ Yes ☐ No

22. Have you tried any prescription creams such as EMLA Cream™ or Voltaren Gel®? ☐ Yes ☐ No

23. Have you tried a compound pain cream or scar cream? ☐ Yes ☐ No

24. Allergies: ☐ Yes ☐ No

Patient Name: _____ DOB: _____

List Allergies: _____

_____

_____

_____

_____

25. Past Medical History (check all that apply):

☐ Migraine headaches	☐ Head Injury	☐ Cirrhosis
☐ High blood pressure	☐ Emphysema	☐ Cancer
☐ Kidney disorder	☐ High cholesterol	☐ Asthma
☐ Hepatitis	☐ Fibromyalgia	☐ Depression
☐ Stroke	☐ Sleep Apnea	☐ Anxiety
☐ Gallbladder disease	☐ Osteoporosis	☐ Seizures
☐ Heart Attack	☐ Hiatal Hernia	☐ Pancreatitis
☐ Spine Disorder	☐ Alcoholism	☐ Addiction
☐ Heart Arrhythmia	☐ Reflux	☐ HIV
☐ Coronary artery Disease	☐ Peripheral Nerve Disease	☐ Bowel Disease
☐ Multiple Sclerosis	☐ Muscle disorder	

Patient Name: _____ DOB: _____

26. Past Surgical History: _____

_____

27. Family Medical History (check all that apply):

☐ Migraine headaches	☐ Head Injury	☐ Cirrhosis
☐ High blood pressure	☐ Emphysema	☐ Cancer
☐ Kidney disorder	☐ High cholesterol	☐ Asthma
☐ Hepatitis	☐ Fibromyalgia	☐ Depression
☐ Stroke	☐ Sleep Apnea	☐ Anxiety
☐ Gallbladder disease	☐ Osteoporosis	☐ Seizures
☐ Heart Attack	☐ Hiatal Hernia	☐ Pancreatitis
☐ Spine Disorder	☐ Alcoholism	☐ Addiction
☐ Heart Arrhythmia	☐ Reflux	☐ HIV
☐ Coronary artery Disease	☐ Peripheral Nerve Disease	☐ Bowel Disease
☐ Multiple Sclerosis	☐ Muscle disorder	

28. What is your marital status:

☐ Single	☐ Married	☐ Separated
☐ Divorced	☐ Widowed	

Patient Name: _____ DOB: _____

29. Who resides in your home and/or assists you if needed:

☐ Alone ☐ Spouse ☐ Children

☐ Parents ☐ Skilled Nursing, Facility/Hospice House
Name of it: _____

30. Smoking Status:

☐ Every day smoker ☐ Occasional smoker ☐ Former smoker

☐ Non-smoker

31. Alcohol Use:

☐ Rarely ☐ Occasionally ☐ Regularly

☐ None

32. Do you use street drugs: ☐ Yes ☐ No

33. Preventative Medicine: Falls Risk Screening:

IF YOU ARE 65 OR OLDER PLEASE CHECK ALL THAT APPLY

☐ No falls in the past year

☐ One fall with injury in the past year

☐ One fall without injury in the past year

☐ Two or more falls with injury in the past year

☐ Two or more falls without injury in the past year

Patient Name: _____ DOB: _____

34. Review of systems (Mark all that apply):

General	**HEENT**	**Respiratory**
☐ Weight loss	☐ Headache	☐ Chronic Cough
☐ Weight gain	☐ Facial pain	☐ Wheezing
☐ Fever	☐ Sinusitis	☐ Shortness of Breath
☐ Night sweats	☐ Loss of vision	☐ Sleep Apnea
☐ Fatigue	☐ Hearing loss	☐ Home Oxygen Use
☐ Many infections	☐ Teeth/Gum problems	☐ C-Pap

Cardiology	**GI**	**Genitourinary**
☐ Chest Pain	☐ Appetite loss	☐ Painful urination
☐ Mumur	☐ Chronic Anemia	☐ Blood in urine
☐ Congestive Failure	☐ Heartburn	☐ Bladder control loss
☐ Abnormal EKG	☐ Constipation	☐ Enlarge Prostate
☐ High Blood Pressure	☐ Testicular pain	☐ Diarrhea

Patient Name: _____ DOB: _____

Endocrine/Hemat	Musculosketal	Neurology
☐ Abnormal Blood sugars	☐ Joint pain	☐ Drowsiness
☐ Easy bruising/ bleeding	☐ Muscle spasm	☐ Dizziness
☐ Dizziness	☐ Neck pain	☐ Blackouts
☐ Thyroid Problems	☐ Back pain	☐ Tremors
	☐ Carpel Tunnel	☐ Numbness
	☐ Gout	☐ Memory Loss
	☐ Swollen Joints	☐ Balance Difficulty

Psychiatric	Vascular	Skin
☐ Panic Attack	☐ Poor circulation	☐ Rash
☐ Insomnia	☐ Current blood clot	
☐ Depression	☐ Swelling in legs	

35. List all medications you are currently taking:

_____

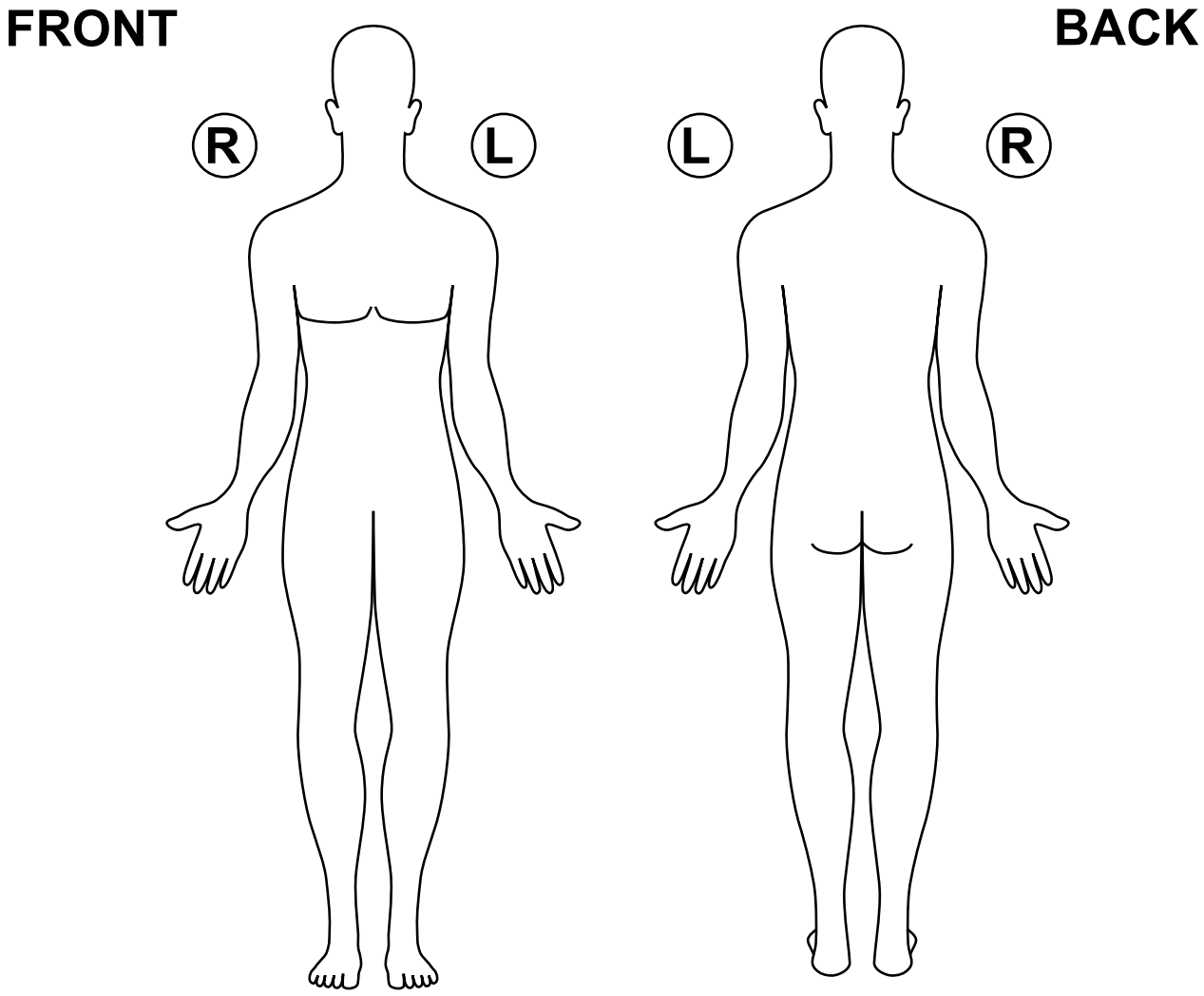
_____

_____

_____

_____

On the diagram below, shade in the areas where you feel pain. Put an ‘X’ on the area that hurts the most. Draw a line if the pain moves from one area to another area.



ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 252-561-8218.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 252-561-8218.