University Pain Centers
University Pain Physicians

NEW PATIENT EVALUATION FORM

Patient Information

Date: ____/____/____/

Full Name: ______________________

DOB: ____/____/____/

Gender: ☐ Male ☐ Female

SSN: ______________________

Address: ______________________

City: __________ State: ___ Zip: ______

Phone (Home/Cell): ______________

Referral & Chief Complaint

Chief Complaint: ______________________

Treatment Requested (MD only):
____

Referring Physician: ______________________

Phone: ______________

Address: ______________________

City: __________ State: ___ Zip: ______

Referred By: ☐ Patient ☐ Physician ☐ Other

Insurance Information

Primary Insurance: ☐ HMO ☐ PPO ☐ Other

Policyholder Name: __________________

Relation: __________ DOB: ____/____/____/

Group #: ______________

Effective Date: ____/____/____/

Verified By: ______________

Secondary Insurance: ☐ HMO ☐ PPO ☐ Other

Group #: ______________

Injury & Legal Information

Work/Personal Injury: ☐ Yes ☐ No

Claim #: ______________

Date of Injury: ____/____/____/

Claim Adjustor: ______________

Phone: ______________

Rehabilitation Nurse:
____

Attorney (if litigated):
____

Phone: ______________

Medical History

Past Pain Center Treatment: ☐ Yes ☐ No

Substance Abuse History: ☐ Yes ☐ No

Current Narcotics Use: ☐ Yes ☐ No

Prescribed By: __________________

Diabetic (Insulin/Pills): ☐ Yes ☐ No

Taking Blood Thinners: ☐ Yes ☐ No

Fasting Before Visit: ☐ Yes ☐ No

Emergency & Records

Emergency Contact:
____

Relation: __________ Phone: __________

Available Records: ☐ MRI ☐ X-Ray ☐ Other

Previous Surgeries: ☐ Yes ☐ No

Bleeding Disorder: ☐ Yes ☐ No

Allergies: ☐ Yes ☐ No

Driver Accompanying: ☐ Yes ☐ No

Appointment Details

Date: ____/____/____/____ Time: ☐ AM ☐ PM

Doctor: ______________

Ensure all details are accurate before submission.

Revision; 02/2025