**New Patient Questionnaire**

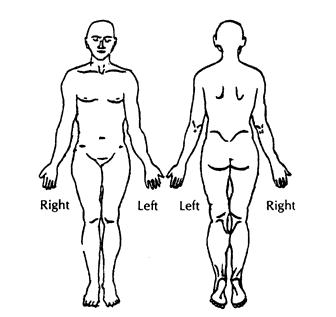
**Chief Complaint (reason for your visit):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pain Description (please rate your pain using a 0-10 scale with 10 indicating the worst pain):**

Current Pain Level: \_\_\_\_\_\_\_/10 Highest Pain: \_\_\_\_\_\_\_/10 Lowest Pain: \_\_\_\_\_\_\_/10

Average pain level SINCE your last visit: \_\_\_\_\_\_\_/10

**Please shade in the location of pain on the figure below:**

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**Does your pain radiate? If so where?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check all that describes your pain TODAY:**

|  |  |  |
| --- | --- | --- |
| * ACHING * DULL | * SHOOTING * STABBING | * SHOCK-LIKE * SHARP |
| * CRAMPING * THROBBING | * NUMBNESS * TINGLING | * SQUEEZING * TIRING |

**Which word would best describe the frequency of your pain:**

|  |  |  |
| --- | --- | --- |
| * Constant(all the time) | * Intermittent | * Random (no pattern) |

**Aggravating factors of your pain (what causes your pain or causes the pain to *increase*):**

|  |  |  |
| --- | --- | --- |
| * Bending * Twisting | * Sitting * Standing | * Others: |
| * Walking * Running | * Laying down * Coughing |  |

**Alleviating factors of your pain (what *decreases* your pain level):**

|  |  |  |
| --- | --- | --- |
| * Rest * Medication | * Physical Therapy * Exercise | * Chiropractic * TENS unit |
| * Standing * Laying down * Other: | * Stretching * Walking | * Injections * Massage |

**If currently on pain medication are you experiencing any side effects (circle one): YES NO**

If YES please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did your pain begin?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Explain what originally caused your pain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you seen other physicians for your pain (circle one): YES NO**

If YES please list what clinic, physician, and last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Past Medical History: | | | | | | |
| * Heart Disease | | * HIV or AIDS | | | Other (list below): | |
| * Kidney Disease | | * Cancer | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Asthma | | * Back/Spine Disorder | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Diabetes | | * Rheumatoid Arthritis | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Hepatitis | | * Fibromyalgia | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Head Injury | | * Migraines | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Psychiatric Disorder | | * Stroke | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * High Blood Pressure | | * Gastrointestinal | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Past Surgical History: | | | | | | |
| * Cataract | | * Vasectomy | | | Other (list below): | |
| * Hernia | | * Hysterectomy | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Tonsillectomy | | * Tubal Ligation | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Breast Surgery | | * Spinal Surgery (specify) | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Heart Surgery | | * Knee Surgery | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Gallbladder | | * Hip Surgery | | | * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Social History: | | | | | | |
| Do you use tobacco? | * YES | | * NO | * Smoke * Chew | | How much per day? |
| Alcohol use? | * YES | | * NO | Drinks per week? | |  |
| Illicit Drug Use? (including marijuana) | * YES | | * NO | What drug? How frequent? | |  |
| Hobbies/Interests |  | |  |  | |  |
| Are you currently employed? | * YES | | * NO | Occupation: | | Employer: |

|  |
| --- |
| **Family History:** |

Do you have a family history of: (check any that apply below and indicate which relative is affected)

|  |  |  |
| --- | --- | --- |
| * Diabetes   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Cancer   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Chronic Pain   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Epilepsy   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Stroke   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | * Asthma/Lung Disease   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| * Alcohol Abuse   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Kidney Disease   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | * Psychological Disorder   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| * Drug Abuse   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Heart Disease   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | * High Blood Pressure   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| --- |
| **Review of systems (please check to what applies to you TODAY, how you CURRENTLY feel):** |

|  |  |  |
| --- | --- | --- |
| **Constitutional** | **Cardiovascular** | **Neurologic** |
| * Fever * Chills * Fatigue * Difficulty Sleeping | * Chest Pain * Fainting * High Blood Pressure * Swelling in Extremities | * Numbness * Tingling * Weakness * Dizziness * Headaches |
| **Eyes** | **Respiratory** | **Musculoskeletal** |
| * Recent Vision Change | * Cough * Difficulty Breathing | * Back Pain * Neck Pain * Joint Pain |
| **HEENT** | **Gastrointestinal** | **Psychiatric** |
| * Difficulty Hearing * Allergies * Nosebleeds * Sore Throat * Ringing in Ears | * Constipation * Black Stool * Diarrhea * Nausea * Vomiting | * Anxiety * Depressed Mood * Suicidal Thoughts * Suicidal Planning |
| **Skin** |  |  |
| * Itching * Rash |  |  |

|  |
| --- |
| Please indicate treatments you have tried in the past for your pain and the effectiveness of the treatment: |

* **I have not had any prior treatments for my CURRENT pain complaints**

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment | No Relief | Moderate Relief | Excellent Relief |
| * Rest |  |  |  |
| * Home exercise |  |  |  |
| * Physical Therapy |  |  |  |
| * Chiropractic |  |  |  |
| * Bracing |  |  |  |
| * TENS unit |  |  |  |
| * Biofeedback |  |  |  |
| * Decompression Therapy |  |  |  |
| * Medication |  |  |  |
| * Topical Cream |  |  |  |
| * Anti-Inflammatory |  |  |  |
| * Muscle Relaxant |  |  |  |
| * Nerve Pain Medication |  |  |  |
| * Opioids |  |  |  |
| * Trigger Point Injections |  |  |  |
| * Medial Branch Block or Facet injections |  |  |  |
| * Epidural Steroid Injection |  |  |  |
| * Radiofrequency Ablation |  |  |  |
| * Spinal Cord Stimulator |  |  |  |
| * Surgery |  |  |  |
| * Other \_\_\_\_\_\_\_\_\_\_ |  |  |  |

|  |
| --- |
| **Medications and Allergies** |

**Please list known Allergies including reaction below:**

|  |  |
| --- | --- |
| Allergy To: | Reaction: |
|  |  |
|  |  |

**Please attach a copy of your CURRENT medications list OR fill list below:**

|  |  |  |
| --- | --- | --- |
| Medication Name: | Dosage: | Directions for use: |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Diagnostic Tests & Imaging (Mark all the following tests you have had RELATED to your pain): | | |
| * MRI of the\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_ | Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * X-ray of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_ | Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * CT scan of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_ | Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * EMG/NCV of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_ | Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_ | Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| **Work Status** | | |
| Are you receiving disability benefits? | YES NO | Date last worked: |
| Are you currently involved in a lawsuit? | YES NO | Please explain: |