**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:**

****

**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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

|  |
| --- |
| **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: |