New Patient Questionnaire

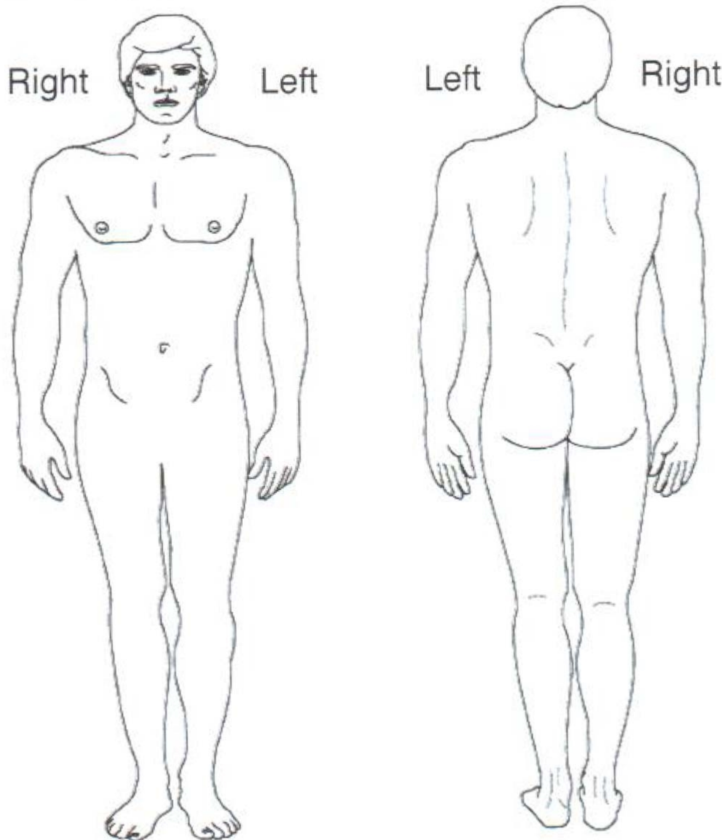
Patient Information

Name	**DOB**
Gender	
Date:	
Address:	
City:	**State:**
Zip:	**Home Phone**
Cell Phone	
Are you employed?	
Occupation	**Work Phone**
Email Address	
How did you hear about our clinic and physicians?	
If other, please specify	**Who is your primary care physician?**
Name and address of referring physician(s) you would like to receive copies of your evaluation:	
Pharmacy Name:	**Pharmacy Phone**
Pharmacy City:	**Pharmacy State:**

Details of Your Pain

How did your current episode begin?	
When did your current pain episode begin?	**What caused your current pain episode?**
Has the pain lessened, worsened, or stayed the same?	
Is this a work related injury?	
1. If Yes to "work related injury"	
a. Employer	**b. Date of Injury**
c. Litigation Pending?	
d. Case Manager name and number	
e. Have you had previous back pain before this injury?	
f. Have you had previous neck pain before this injury?	
g. Have you ever missed work because of your pain?	
If yes, when and how long?	
h. Have you been off work with this current episode?	
If yes, date you stopped working:	**Date you began modified: duty**
Is this a motor vehicle injury?	
If yes, date of injury	
Accident Information	
If your injury/pain is the result of an accident or other incident, please provide the following details:	
Date of injury, location, and treatment at the time of injury	
Describe how the injury occurred	
Patient Name	**Date of Birth**

Location of Pain

Location of Pain Use this diagram to indicate the location and type of pain. Mark the drawing with the following letters that best indicate your symptoms. "N" = Numbness "S" = Stabbing Pain "B" = Burning Pain "P" = Pins and Needles "A" = Aching Pain	
Pain Diagram  	
Please use the following scale to give us an estimate of your pain: 0: Pain Free 1: Very minor annoyance, occasional minor twinges 2: Minor annoyance, occasional strong twinges 3: Annoying enough to be distracting 4: Can be ignored if you are really involved in your work, but still distracting 5: Can't be ignored for more than 30 minutes 6: Can't be ignored for any length of time, but you can still go to work and participate in social activities 7: Makes it difficult to concentrate, interferes with sleep, you can still function with effort 8: Physical activity severely limited, you can read and converse with effort, nausea and dizziness set in as factors of pain 9: Unable to speak, crying out or moaning uncontrollably, near delirium 10: Unconscious, pain makes you pass out	
Pain Level Today Indicate below where your pain level is today	
Which number (0-10) describes your pain right now?	
Which number (0-10) is your worst pain?	
Which number (0-10) is your least pain?	
Which number (0-10) describes your average pain over the past week?	
Patient Name	**Date of Birth**

Information About the Pain

What does the pain feel like? (Check all the following that apply to the quality of your pain.

- ❑ Throbbing
- ❑ Stabbing
- ❑ Cramping
- ❑ Aching
- ❑ Other:
- ❑ Shooting
- ❑ Sharp
- ❑ Hot-Burning
- ❑ Tiring-Exhausting

If other, please specify

How does your pain change over time? (check the word or words which best describe the pattern of your pain)

- ❑ Continuous
- ❑ Intermittent
- ❑ Other

If other, please specify

Mark the effect of each of the following on your pain:

	Increases my pain	Decreases my pain	No change in my pain
Sitting	❑	❑	❑
Standing	❑	❑	❑
Rising for sitting	❑	❑	❑
Bending forward	❑	❑	❑
Bending backward	❑	❑	❑
Walking	❑	❑	❑
Climbing stairs	❑	❑	❑
Lying on your back	❑	❑	❑
Lying on your stomach	❑	❑	❑
Driving	❑	❑	❑
Coughing/sneezing	❑	❑	❑
Lifting objects	❑	❑	❑
Other factors	❑	❑	❑

Are there other details of your pain or medical condition we should know about?

Do you have:

- ❑ Weakness
- ❑ Bladder incontinence
- ❑ Bowel Incontinence
- ❑ Fever/Chills
- ❑ Nausea/Vomitting
- ❑ Other:

If yes to Weakness, where?	**If other, please specify**
Patient Name	**Date of Birth**

Treatment

Please mark all the following treatment you have used for pain relief:

	Helped pain	Worsened pain	No change
Massage therapy	❑	❑	❑
Hot or cold packs	❑	❑	❑
Biofeedback	❑	❑	❑
Physical therapy	❑	❑	❑
Chiropractic	❑	❑	❑
Acupuncture	❑	❑	❑
Traction	❑	❑	❑
Brace support	❑	❑	❑
TENS unit	❑	❑	❑
Injection therapy	❑	❑	❑
Medications	❑	❑	❑

Treatment for your pain:

Please mark all of the following physicians or specialists you have consulted: ONLY FOR PAIN RELIEF FOR THE CURRENT PROBLEM, NOT FOR OTHER PROBLEMS.

- ❑ Acupuncturist
- ❑ Anesthesiologist
- ❑ Chiropractor
- ❑ Dentist
- ❑ ENT Physician
- ❑ Endocrinologist
- ❑ Faith Healer
- ❑ General Physician
- ❑ Hypnotist
- ❑ Internist
- ❑ Neurologist
- ❑ Neurosurgeon
- ❑ Ophthalmologist
- ❑ Orthopedic Surgeon
- ❑ Pain Clinic
- ❑ Physical Therapist
- ❑ Plastic Surgeon
- ❑ Podiatrist
- ❑ Psychiatrist/Psychologist
- ❑ Rheumatologist
- ❑ Other:

If other, please specify

Recent Tests and Procedures

Indicate which, if any, of the following procedure you have had for your symptoms, as well as the date, location and surgeon.

	Back/Neck	Date of Test	Location	Surgeon
MRI				
CT				
Myelogram				
Surgery				
EMG				

Patient Name	**Date of Birth**

Medications / Vitamins / Herbs

Are you currently taking any medications?

Please list all medication you are presently taking, dosages and frequencies.

	Name	Dosage (i.e.: 10 mg)	Frequency (i.e.: 1 every day)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Allergies

Please list DRUG Allergies and Symptoms:

Medications / Vitamins / Herbs

Please list FOOD or ENVIRONMENTAL Allergies and Symptoms:	
Patient Name	Date of Birth

Medical History

Have you had Cancer?	
Type of Cancer	Year of diagnosis
Treatment	
Have you had a second Cancer diagnosis?	
Type of Cancer	Year of diagnosis
Treatment	
Cardiovascular ❑ CHF ❑ Coronary Artery Disease ❑ High Blood Pressure ❑ None	
Heart Attack(s) year(s)	Stent(s) year(s)
Have you ever had a Pacemaker, Defibrillator, or Blood thinner?	
If yes to Pacemaker, Defibrillator, or Blood Thinner, please specify which one and for what reason	
Please check all that apply: ❑ Heart murmur ❑ Stroke ❑ TIA ❑ Poor Circulation ❑ Murmur ❑ Mitral valve prolapse	
Diabetes	
Please select one of the following:	
Kidney Disease: ❑ Kidney Stones ❑ Hemodialysis ❑ Renal Failure ❑ Elevated BUN ❑ Other labs ❑ None	
If other labs, please specify	
Liver disease	
Please check all that apply: ❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C	
Mental Illness ❑ Depression ❑ Anxiety ❑ Sleep Disturbances ❑ Bipolar Disorder ❑ Suicidal thoughts ❑ Other ❑ None	
If other, please specify	
Neurologic ❑ Headaches ❑ Seizures ❑ Hearing Loss ❑ Epilepsy ❑ Tremors ❑ None	
If you selected hearing loss please select one of the following	
Pulmonary ❑ Asthma ❑ COPD ❑ Emphysema ❑ Recent Infections ❑ Tuberculosis ❑ Bronchitis ❑ None	
Infections	
If other, please specify	
Bleeding/Clotting Disorders	
If yes, please specify	
Have you ever had surgery?	
Surgeries:	

Medical History

Please list all past surgeries, year done and the name of the surgeon.

	Type of Surgery	Date of Surgery	Surgeon
1.			
2.			
3.			
4.			
5.			
6.			

Social History

Marital Status	
Please select one of the following:	
Caffeinated beverages?	
How many per day?	
Do you smoke cigarettes?	
Packs per day	# of years
Do you smoke cigars?	
Cigars per day	# of years
Do you use chewing tobacco?	
Times per day	# of years
Do you use illicit drugs?	
History of drug or alcohol rehab?	
Current Alcohol intake: ❑ Beer ❑ Wine ❑ Liquor	
Amount per week	Occupation
Hours per week	
Current stresses in your life	
Highest level of education	Patient Name
Date:	

Family History

Please indicate which family members have the following medical problems below:
Headaches
Which family member(s)?
Heart disease
Which family member(s)?
Stroke
Which family member(s)?
Diabetes
Which family member(s)?
High blood pressure
Which family member(s)?
Increased cholesterol
Which family member(s)?
Arthritis
Which family member(s)?
Rheumatoid arthritis
Which family member(s)?
Kidney problems
Which family member(s)?
Liver problems

Family History

Which family member(s)?	
Seizsures	
Which family member(s)?	
Osteoporosis	
Which family member(s)?	
Cancer	
Which family member(s)?	
Other medical problems?	
Please specify other medical problems	Which family member(s)?
Patient Name	DOB

Review of Systems

Check CURRENT symptoms - in the past MONTH

Systemic
- ❑ Feeling poorly
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Recent weight increase or decrease
- ❑ None

Head
- ❑ Headache
- ❑ Mouth sores
- ❑ Hearing loss
- ❑ None

Neck
- ❑ Neck pain
- ❑ Neck stiffness
- ❑ Lumps
- ❑ Swelling in neck
- ❑ None

Eyes
- ❑ Impaired vision
- ❑ Glasses/Contacts
- ❑ Blind spots
- ❑ Blurred vision
- ❑ Double vision
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Discharge from eye
- ❑ Itching
- ❑ Eye pain
- ❑ Bright light intolerance
- ❑ None

Otolaryngeal
- ❑ Bleeding from the nose
- ❑ None

Review of Systems

Cardiovascular
- ❑ Chest pain
- ❑ Palpitations
- ❑ Fast heart rate
- ❑ Irregular heart rate
- ❑ Congestive heart failure
- ❑ Coronary artery disease
- ❑ High blood pressure
- ❑ Shortness of breath while lying down
- ❑ Shortness of breath with inactivity
- ❑ Ankle swelling
- ❑ None

Respiratory
- ❑ Labored breathing
- ❑ Cough
- ❑ Coughing up blood
- ❑ Wheezing
- ❑ Recent upper respiratory infection
- ❑ None

Gastrointestinal
- ❑ Difficulty or discomfort with swallowing
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomitting
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Blood in stool
- ❑ Constipation
- ❑ None

Genitourinary
- ❑ Blood in urine
- ❑ Increased urinary frequency
- ❑ Pain with urination
- ❑ Incontinence
- ❑ Genital sores/pain
- ❑ Infections
- ❑ Pelvic pain
- ❑ Menstrual difficulties
- ❑ Prostate problems
- ❑ Testicular pain
- ❑ None

Endocrine
- ❑ Excessive thirst
- ❑ Excessive hunger
- ❑ Excessive urination
- ❑ Excessive sweating
- ❑ Hot flashes
- ❑ None

Hematologic
- ❑ Bleeds easily
- ❑ Bruises easily
- ❑ Poor leg circulation
- ❑ None

Review of Systems

Neurologic

- ❑ Dizziness - feeling faint or weak
- ❑ Vertigo - feeling of objects around you are moving
- ❑ Fainting / Loss of consciousness
- ❑ Balance difficulties
- ❑ Drags one foot
- ❑ Falls frequently
- ❑ Lack of Coordination
- ❑ Unsteady gait
- ❑ Weakness
- ❑ Tremors
- ❑ Seizures
- ❑ Numbness
- ❑ Tingling
- ❑ Change in thought patterns
- ❑ Confused
- ❑ Difficulty concentrating
- ❑ Memory problems
- ❑ Headaches (migraine/tension)
- ❑ Speech difficulties
- ❑ None

Psychological

- ❑ Anxiety
- ❑ Depression
- ❑ Sleep disturbances
- ❑ Changes in personality
- ❑ Difficulty coping
- ❑ Irritable
- ❑ Nervousness
- ❑ Suicidal thoughts
- ❑ None

Skin

- ❑ Itching
- ❑ Lesions
- ❑ Change in mole
- ❑ Cracks
- ❑ Growths
- ❑ Hives
- ❑ Lumps
- ❑ Painful areas
- ❑ Skin discolor
- ❑ Sores
- ❑ Ulcers
- ❑ None

Musculoskeletal

- ❑ Back ache
- ❑ Joint inflammation
- ❑ Joint redness
- ❑ Joint swelling
- ❑ Muscle atrophy
- ❑ Muscle pain
- ❑ Muscle swelling
- ❑ Muscle weakness
- ❑ Reduction of motion in a joint
- ❑ None

Thank you for completing this questionnaire.