New Patient Questionnaire

Patient Name: _____

History of Present Illness

What is your main health concern? _____

How many physicians have you seen regarding your pain problem? _____

How do you rate your pain? (Circle the number that applies)

1 2 3 4 5 6 7 8 9 10

No Pain Slight Moderate Severe Extreme

Would you describe your pain as: burning? ▫ yes ▫ no sharp? ▫ yes ▫ no
aching? ▫ yes ▫ no throbbing? ▫ yes ▫ no
shooting? ▫ yes ▫ no
other (describe) _____

Does your pain travel to other parts of your body? ▫ yes ▫ no
If yes, where? _____

Which statement best describes your pain?

▫ Always present, always the same intensity ▫ Always present, intensity varies, ▫ Usually present, but have short periods without pain ▫ Often present, but have pain free periods lasting for one to several hours ▫ Occasionally present for brief periods, a few seconds to minutes ▫ Rarely present, have pain every few days or weeks

What time of day is your pain worse?

- ▫ Morning on arising
- ▫ Later in the morning
- ▫ Afternoon
- ▫ Evening
- ▫ Bedtime
- ▫ Night
- ▫ Pain always same
- ▫ Varies, not worse at any time

Do you have:

- ▫ Numbness?
- ▫ Tingling, pins/needles?
- ▫ Weakness?
- ▫ Skin discoloration?
- ▫ Coldness?
- ▫ Increased sweating?
- ▫ Muscle spasm/tightness?
- ▫ Bowel/Bladder problems?

Does pain interrupt your sleep? ▫ yes ▫ no

When you are feeling pain, do any of the following items help to decrease your pain? (Check all that apply)

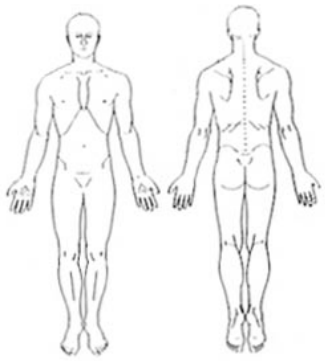
▫ lying down	▫ tens unit	▫ cool compress	▫ massage	▫ watching TV
▫ sitting	▫ alcohol	▫ medication	▫ getting away	▫ nothing
▫ standing	▫ work	▫ socializing	▫ changing position	
▫ walking	▫ activity	▫ heating pad	▫ warm bath	

Check the items that increase your pain:

▫ physical activity	▫ sitting	▫ standing	▫ lying down	▫ walking
▫ loud noises	▫ damp weather	▫ warm weather	▫ financial worries	▫ massage
▫ stress	▫ anger	▫ other people	▫ cold weather	▫ cough/sneeze

Where is your pain located?

- ▫ low back
- ▫ mid back
- ▫ upper back
- ▫ neck
- ▫ chest
- ▫ abdomen
- ▫ groin
- ▫ left buttock
- ▫ rt. Buttock
- ▫ left thigh
- ▫ right thigh
- ▫ left ankle/foot
- ▫ right ankle/foot
- ▫ left shoulder
- ▫ right shoulder
- ▫ left arm
- ▫ right arm
- ▫ left hand/wrist
- ▫ right hand/wrist
- ▫ right calf
- ▫ left calf
- ▫ head
- ▫ face
- ▫ other (list) _____



Please shade where your pain is located

When did you first notice your pain?

Month _____ Day _____ Year _____

Under what circumstances did your pain begin? (check one)

- ▫ accident at work
- ▫ accident at home
- ▫ pain just began, no reason
- ▫ motor vehicle accident
- ▫ at work, but not an accident
- ▫ other (describe) _____
- ▫ following surgery
- ▫ following illness

If pain began at work, please answer the following questions:

Place of employment where pain began _____

Date of injury: Month _____ Day_____ Year _____

How long have you been employed there? _____

Type of work _____

How did the injury occur?

- ▫ fall
- ▫ lifting
- ▫ pushing
- ▫ struck by falling object
- ▫ struck by object
- ▫ injury from repetitive activity
- ▫ Other (describe) _____

If pain resulted from motor vehicle accident, were you:

- ▫ driving
- ▫ passenger
- ▫ driving motorcycle
- ▫ motorcycle passenger
- ▫ pedestrian

Describe details _____

When did you first see a doctor for the pain you now have?

Month _____ Day _____ Year _____

Have you been hospitalized for your pain? ▫ yes ▫ no

If yes, please list: Hospital Dates admitted

_____ _____

_____ _____

Have you had nerve blocks (injections) for pain relief? ▫ yes ▫ no

If yes, by what doctor? _____ Did they relieve pain? ▫ yes ▫ no

If yes, how long did you get relief? _____

Have you had an epidural? ▫ yes ▫ no

If yes, by what doctor? _____ Did they relieve pain? ▫ yes ▫ no

If yes, how long did you get relief? _____

Have you had tests done to evaluate your problem? ▫ yes ▫ no

Test	Area tested	Date of test	Where test performed
▫ Plain X-Ray			
▫ Arthrogram			
▫ MRI			
▫ Myelogram			
▫ Bone Scan			
▫ EMG			
▫ CAT Scan			
▫ Other			

Have you had any of the following for relief of pain?		**Did it relieve it?**
Hypnosis	▫ yes ▫ no	▫ yes ▫ no
Biofeedback	▫ yes ▫ no	▫ yes ▫ no
Tens unit	▫ yes ▫ no	▫ yes ▫ no
Acupuncture	▫ yes ▫ no	▫ yes ▫ no
Chiropractic treatment	▫ yes ▫ no	▫ yes ▫ no
Heat therapy	▫ yes ▫ no	▫ yes ▫ no
Bedrest	▫ yes ▫ no	▫ yes ▫ no
Traction	▫ yes ▫ no	▫ yes ▫ no
Ostopathic treatment	▫ yes ▫ no	▫ yes ▫ no
Psychotherapy/psychiatric	▫ yes ▫ no	▫ yes ▫ no
Other _____	▫ yes ▫ no	▫ yes ▫ no

Since your pain began, has it: ▫ increased ▫ decreased ▫ stayed the same

Please list all your current medications:

Medication Dosage How long and for what reason Side Effects?

_____

_____

_____

_____

List all allergies: _____

_____

Surgical History: (check all that apply) ▫ none

Operation	Surgeon	Where Performed	Date

<u>Review of Systems</u> (check all that apply now or in the past) ▫ none apply

▫ Recent weight change	▫ Short of breath with walking	▫ Swollen joints	▫ Cough/wheezing
▫ Blurry vision	▫ Swollen ankles or feet	▫ Neck/back pain	▫ Palpitation
▫ Double vision	▫ Poor circulation	▫ Leg/arm pain	▫ Fever
▫ Loss of vision	▫ Frequent headaches	▫ Diarrhea/constipation	▫ Difficulty urinating
▫ Blackouts/seizures	▫ Loss of hearing	▫ Change in bowel function	
▫ Chest pain with taking a breath		▫ Nervous exhausting	▫ Weight loss
▫ Loss of memory	▫ Ringing in ears	▫ Stomach pain	▫ Depression/anxiety
▫ Weakness of arms/legs	▫ Difficulty swallowing	▫ Ulcers	▫ Rashes
▫ Poor balance	▫ Easy bruising/bleeding	▫ Frequent infections	▫ Heart/chest pain

Medical History (check all that apply):

- ▫ Heart attack
- ▫ Heart failure
- ▫ Angina (chest pain)
- ▫ High blood pressure
- ▫ Stroke
- ▫ Diabetes
- ▫ High cholesterol
- ▫ Phlebitis
- ▫ Glaucoma
- ▫ Rheumatic fever
- ▫ Heart condition
- ▫ Cancer of _____
- ▫ Rheumatoid arthritis
- ▫ Osteoporosis
- ▫ Pneumonia
- ▫ Asthma
- ▫ Bronchitis
- ▫ Emphysema
- ▫ Blood vessel disease
- ▫ Sciatica
- ▫ Vascular disease
- ▫ Headache
- ▫ Hearing/ear disorder
- ▫ Mental illness
- ▫ Gout
- ▫ Bleeding disorder
- ▫ Kidney stones
- ▫ Kidney failure
- ▫ Transplants
- ▫ Alcohol dependence
- ▫ Alzheimer's
- ▫ Nerve disorder
- ▫ Anemia
- ▫ Hepatitis
- ▫ Other _____
- ▫ Blood clots in legs
- ▫ Stomach ulcers
- ▫ Ankylosing spondylitis
- ▫ Sickle cell disease
- ▫ Epilepsy
- ▫ Arthritis
- ▫ Kidney disease
- ▫ Osteoporosis
- ▫ Thyroid problem
- ▫ Liver trouble

Social History

Married?		▫ yes ▫ no	Children?	▫ yes ▫ no	Number of children: _____	
Mother	Alive?	▫ yes ▫ no	Healthy?	▫ yes ▫ no		
Father	Alive?	▫ yes ▫ no	Healthy?	▫ yes ▫ no		
Brother(s)	Alive?	▫ yes ▫ no	Healthy?	▫ yes ▫ no	Number of brothers: _____	
Sister(s)	Alive?	▫ yes ▫ no	Healthy?	▫ yes ▫ no	Number of sisters: _____	

Work Status Occupation: _____

▫ Working ▫ Not Working ▫ Retired ▫ Disabled ▫ Veteran ▫ Homemaker ▫ Student

Alcohol Use ▫ Never ▫ Rare ▫ Frequent, Drinks per week _____

▫ Alcohol dependent ▫ Recovered alcoholic

Drug Use ▫ Never ▫ Past ▫ Currently

Tobacco Use (check all that apply) ▫ Never

- ▫ Cigarettes – I have smoked _____packs of cigarettes a day for _____ years total.
- ▫ Cigars – I have smoked _____cigars per day for _____ years total.
- ▫ I quit smoking on (date) _____.

Family History (check all that apply) ▫ None apply

Condition	Which family member?	Condition	Which family member?
▫ Heart disease		▫ Scoliosis	
▫ Stroke		▫ Spine problems	
▫ High blood pressure		▫ Bleeding disorders	
▫ Diabetes		▫ Cancer	
▫ Osteoporosis		▫ Osteoarthritis	
▫ Rheumatoid arthritis		▫ Other (list)	

My signature confirms that the answers to the above questions are accurate to the best of my ability.

_____ Date: _____

Patient/Guardian (if under 18) signature:

_____ Date: _____