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New Patient Questionnaire: Visit Date: _____ (Please Fill Out Both Sides)

Patient Name (first, middle, last): _____**DOB:** _____ **Age:** ____

Referring physician:_____ Prior Specialists:_____

Chief Pain Complaint: (what **one** place hurts the most)? ☐ right ☐ left: _____

My pain radiates into☐right, ☐left, ☐arm, ☐leg. How far (be specific)_____

Other pain complaints: ☐neck ☐mid-back ☐low-back ☐buttock ☐shoulder ☐arm ☐hip ☐knee ☐_____

History of Present Pain: *(in the last month)*

My pain is: ☐dull ☐aching ☐cramping ☐sharp ☐stabbing ☐throbbing ☐burning ☐tingling ☐numb

Severity of my pain is usually: (**0 = *no pain***) 0 1 2 3 4 5 6 7 8 9 10 (**10 = *unbearable pain***)

Pain interference with daily activities: (**0 = *none***) 0 1 2 3 4 5 6 7 8 9 10 (**10 =*bedridden***)

Percentage of the day I have pain: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

My pain is worse with: ☐certain movements/positions ☐ strain or cough ☐lying down ☐sitting

☐sit to stand ☐standing ☐walking ☐bending ☐lifting ☐no specific position or activity ☐_____

My pain is better with: ☐lying down ☐sitting ☐standing ☐walking ☐daily stretching ☐daily exercising

☐certain positions ☐no specific position or activity ☐_____

My pain is currently: ☐well controlled ☐adequately controlled ☐poorly controlled

Treatments (√ if effective and X if ineffective)? ☐heat ☐ice ☐compression garment ☐Tylenol ☐OTC NSAIDs ☐physical therapy ☐stretching exercises ☐strengthening (resistance) exercises ☐aerobic conditioning exercise ☐TENS ☐lumbar brace ☐wrist brace ☐traction ☐muscle relaxer ☐Rx NASIDs ☐anti-depressant ☐anti-convulsant ☐opioids ☐office injection ☐fluoroscopically guided injections. If you had a fluoroscopically guided spinal injection what percentage relief did you receive? _____ and how long did it last?_____

What is your current activity level with treatment (check all that apply/circle goals)?

☐bathing ☐dressing ☐feed myself ☐grooming(wash/comb hair) ☐meal preparation ☐toileting ☐driving ☐shopping ☐care for pets ☐go to church ☐do outdoor chores (list) _____

☐do household chores (list)_____ ☐volunteer work ☐return to work ☐continue working ☐hunting /fishing ☐aerobic exercise ☐sports activities ☐ Other_____

My pain started: _____ **It was caused by:** _____

Test(s) done for my pain: ☐MRI ☐CT ☐X-ray ☐EMG/NCS **When and where?** _____

Past Medical History: ☐migraine headaches ☐TIA / stroke ☐seizures ☐MS ☐neuropathy ☐high blood pressure ☐coronary artery disease ☐heart attack ☐A-fib ☐CHF ☐pacemaker ☐COPD ☐asthma ☐GERD ☐sleep apnea ☐ulcers ☐hepatitis ☐diabetes type I ☐diabetes type II ☐thyroid disease ☐kidney disorder ☐cancer _____ ☐HIV ☐Lupus ☐rheumatoid arthritis ☐gout ☐osteoarthritis _____ ☐carpal tunnel ☐fibromyalgia ☐peripheral vascular disease ☐blood clots ☐depression ☐anxiety ☐bipolar disorder ☐ADHD ☐OCD ☐schizophrenia ☐childhood sexual abuse ☐other_____

Past Surgical History: *please provide dates:* ☐tonsillectomy____ ☐appendectomy____ ☐gallbladder_____
☐coronary bypass graft____ ☐vascular stents____ ☐hysterectomy____ ☐spinal surgery (neck)_____
☐spinal surgery (low-back)_____ ☐total hip replacement____ ☐total knee replacement_____
☐other _____

Medications: *list all your current medication:* ☐see attached list.

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Allergies: *list all medications that have caused allergic or adverse reactions* ☐no known drug allergies/reactions
☐latex ☐penicillin ☐other(s) _____

Family Medical History: *list the medical conditions of your blood relatives*
☐cancer ☐COPD ☐depression ☐diabetes ☐heart disease ☐high blood pressure ☐stroke ☐ _____
Family History of Substance abuse: ☐none ☐ alcohol abuse ☐illegal drug use ☐prescription drug misuse

Social History:
Marital Status: ☐single ☐married ☐separated ☐divorced ☐widowed ☐w/ children ☐w/o children
Occupation: *include dates:* _____; ☐Regular duty ☐Limited duty work
☐unemployed_____ ☐retired____ ☐☐temporarily disabled____ ☐permanently disabled____ ☐ SSD/SSI___

Women only considering opioid treatment: is there any chance you could be pregnant? ☐yes ☐no.
Do you use a reliable form of birth control? ☐yes ☐no. If pregnant which MD would you go to?_____

Substance Use: ☐non-smoker ☐former smoker ☐smoker ☐no alcohol ☐occ alcohol use ☐regular alcohol use ☐alcohol abuse - remote ☐illegal drug use (current or past) ☐prescription drug misuse (current or past)
Legal Issues: Do you have any pending legal issues concerning pain (injury) or medications? ☐yes ☐no.
Have you ever been convicted of a crime involving drugs or alcohol? ☐yes ☐no.
Are you on probation? ☐yes ☐no. Have you ever had a DUI? ☐yes ☐no. How many? ____.

Review of Systems: *check any of the following problems you currently have:*
Const: ☐fatigue ☐change in appetite ☐sleeping problems ☐fevers ☐weight gain ☐unwanted weight loss
Eyes/HENT: ☐impaired vision ☐headaches ☐sore throat ☐hearing loss ☐swallowing difficulty
CV: ☐chest pain ☐irregular heartbeat ☐dyspnea on exertion ☐swelling of the feet or ankles ☐blood clot
Resp: ☐shortness of breath ☐wheezing ☐cough ☐sleep apnea ☐home oxygen use
GI: ☐nausea ☐diarrhea ☐constipation ☐heartburn ☐blood in stool ☐reflux ☐bowel incontinence
GU: ☐dysuria (painful urination) ☐hematuria (blood in urine) ☐bladder incontinence ☐kidney stones
Skin: ☐rash ☐itching ☐new skin lesions
Neuro: ☐weakness ☐tingling/numbness ☐seizures ☐tremors ☐falls ☐change in alertness ☐dizziness
M/S: ☐muscle pain ☐muscle cramps ☐painful joints ☐shoulder pain ☐hip pain ☐knee pain
Endo: ☐excessive thirst ☐excessive urination ☐cold/heat intolerance ☐decreased libido ☐increased appetite
Psych: ☐anxiety ☐depression ☐feeling confused ☐difficulty sleeping ☐withdrawn ☐panic attacks
Hem/Lym: ☐lightheadedness ☐easy bleeding ☐easy bruising ☐enlarged lymph nodes
All/Imm: ☐sinus allergy symptoms ☐frequent illness ☐food allergies
☐Other: _____

Patient Signature:_____ **Date**: _____