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NEW PATIENT QUESTIONNAIRE

PART 1

Name _____ Date of Birth _____ Today's Date _____
Primary Care Provider _____ Check One: ☐ Right-Handed
☐ Left-Handed

Reason for today's visit_____
What are your goals in seeking help with this problem? _____

Date problem began _____ Onset was (check one): ☐ Sudden
☐ Gradual

Is problem the result of accident or injury? ☐ YES ☐ NO
If yes, check applicable: ☐MVA ☐Job injury ☐ Other: _____
If this is the result of an injury did you have similar symptoms at any time before the injury?_____

If your visit does <u>not</u> address a painful condition, skip to PART 2 on page 3

On the diagrams, mark the areas on your body where you feel the described sensations with the symbols on the left

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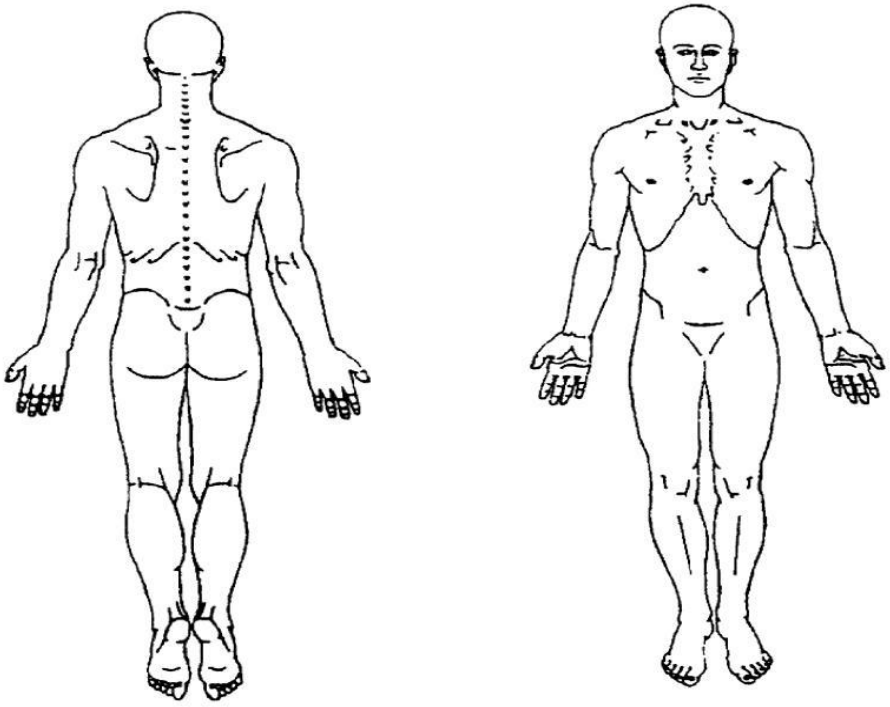
----- Numbness

○○○
○○○ Pins & Needles

xxx
xxx Burning

///
/// Stabbing

+++
+++ Aching



PART 1 - Continued

Distribution of pain – what % of pain is back/neck? _____

What % of pain is shoulder/arm or buttocks/leg?

_____

Rate your pain on the scale with an **X.** 0= no pain 10=worst possible pain

Pain today

0----------10

Least pain in last 2 weeks

0----------10

Worst pain in last 2 weeks

0----------10

Is your pain (circle one):

always present

comes and goes

Do you have loss of strength? YES NO If YES, where? _____
Do you have loss of feeling or touch? YES NO If yes, where? _____
Do you lose control of your bladder? YES NO
Do you lose control of your bowels? YES NO

How do these activities affect your pain?

	Decrease	Increase	No Effect
Turning your head	☐	☐	☐
Lifting arms	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Lying Down	☐	☐	☐
Sexual activity	☐	☐	☐
Work	☐	☐	☐
Bending forward	☐	☐	☐

What activities does the pain keep you from doing?_____

Please list all x-rays, MRI's, bone scans, EMG/nerve conduction studies, blood tests, related to current problem:

Name of test	Date	Place

Please list any pain medications you have **tried** in the past but are **not** currently taking.

Name of medication	Strength (mg)	How many tablets at one time?	How many times a day?	How long did you take this?	On scale of 0-10, how much relief did this provide?	Why did you stop taking this?

PART 2 - Review of Systems

During the past year, have you had any of the following symptoms?

Symptoms: **Explanation:**

□ Persistent Fevers _____
□ Night Sweats _____
□ Appetite loss or Weight loss _____
□ Joint Aching Stiffness or Pain _____
□ Rash / Non-healing sore _____
□ Sleep difficulty_____
□ Fatigue _____
□ Dizziness or Vertigo_____
□ Depression, suicidal thoughts _____
□Vision loss or double vision _____
□ Easy bruising/excessive bleeding _____
□ Persistent Diarrhea/ Constipation _____
□ Dark stools/blood in stools _____
□ Urinary incontinence_____
□ Blood in the urine _____
□ Trouble breathing _____
□ Memory problems _____
□ Frequent falls _____
□ Seizures _____
□ Headaches _____

PART 3 – Past Medical History

Please (√) all the conditions which you either currently have or have had:

□ Heart Attack/Angina □High Blood Pressure □ Stroke □Diabetes
□ Ulcers □ Thyroid Disease □ Kidney Disease □ Liver Disease
□ Arthritis □Cancer (type :_____)
□ Depression, Anxiety □ PTSD or Bipolar disorder □ Physical/Psychological l Abuse

LIST ALL SURGERIES AND DATES

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

LIST ALL MEDICATIONS YOU TAKE (including non-prescription)

Medication	Dosage	Medication	Dosage
1.		5.	
2.		6.	
3.		7.	
4.		8.	

PART 4 – Social History

Habits: Please check (√) all that apply

Do you have an exercise program? □No □Yes _____

Do you smoke or use tobacco? □No □Yes – How many packs per day? _____

Do you drink caffeinated beverages (Coffee, tea, cola)? # Per day _____

Do you drink alcohol? □No □Yes - Age started ____ # drinks per week____

Have you tried alcohol to help your pain? □No □Yes

Do you use Marijuana? □No □Yes

Do you have a Medical Marijuana card? □No □Yes

Have you ever used illegal/street drugs in the past? □No □Yes

Do you now? □No □Yes

Did you ever have a problem with drinking excessive amounts of alcohol? □No □Yes

If yes, did you quit drinking? □No □Yes If yes, when? _____

Have you ever abused or been addicted to pain pills □No □Yes

Marital Status?

□Single □Married □Domestic Partner □Divorced □Separated □Widow/Widower

Do you have children at home? □No □Yes

If you have children at home list their ages: _____

Education: (Check the highest level you completed)

□Grade School □High School □GED □Trade School □College Degree □PostGrad Degree

PART 5- Work History

Are you:

□Currently working □Permanently Disabled

□Retired _____ □Temporarily Disabled

Describe:

_____

_____

Have you applied for disability benefits? □Yes □No

Current/Recent Employer: _____ Length of time with Employer _____

Last Day Worked _____ Usual Occupation _____

Physical Demands of Your Job:

□Very Heavy (lift >100 lbs) □Heavy (lift >50 lbs) □Moderate (lift >35 lbs) □Light (lift 15-25 lbs)

□Repetitive Hand Tasks □Sedentary (No lifting)

PART 6 – Family History

	Living?	State of Health	Age/Cause of Death
Mother	□Yes □No	□Good □Fair □Poor	_____
Father	□Yes □No	□Good □Fair □Poor	_____

Family history of Disease? (List): _____

_____

_____

Is anyone in your family on disability? (List): _____

_____

Does anyone in your family abuse drugs or alcohol? (List): _____

_____