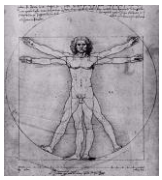

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New Patient Questionnaire

Date Revised: 06/30/2010

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Please complete this questionnaire to the best of your ability and either email it, fax it or bring it to your first appointment. If you need more space, please attach additional sheets. Please bring any MRI/CT scan or X-ray reports or doctor's office notes you may have in your possession, or ask your referring doctor to fax them to our office.

A. Identifying data:

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
	Age:	**SSN:**
Marital status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**		

Home Address: **Home Phone:**

Business Address: **Business Phone:**

E-mail address: **Cell Phone:**

B. Referral Information:

Who is the Referring Physician:

Office address: **Phone**

Who is your Primary Physician
Office address: **Phone**

Is this a workman's compensation case? Y/N **Is this a litigation case (legal)? Y/N**

Do you have a case manager? Y/N **Or a legal representative Y/N**

If so please provide name, address, and telephone number of your case manager or legal representative:

C. Pain History:

What would you like us to do for you?

What do you believe it the cause or diagnosis of your pain?

Did you discuss with your referring doctor your treatment options?

What are they?

How long have you had your pain?

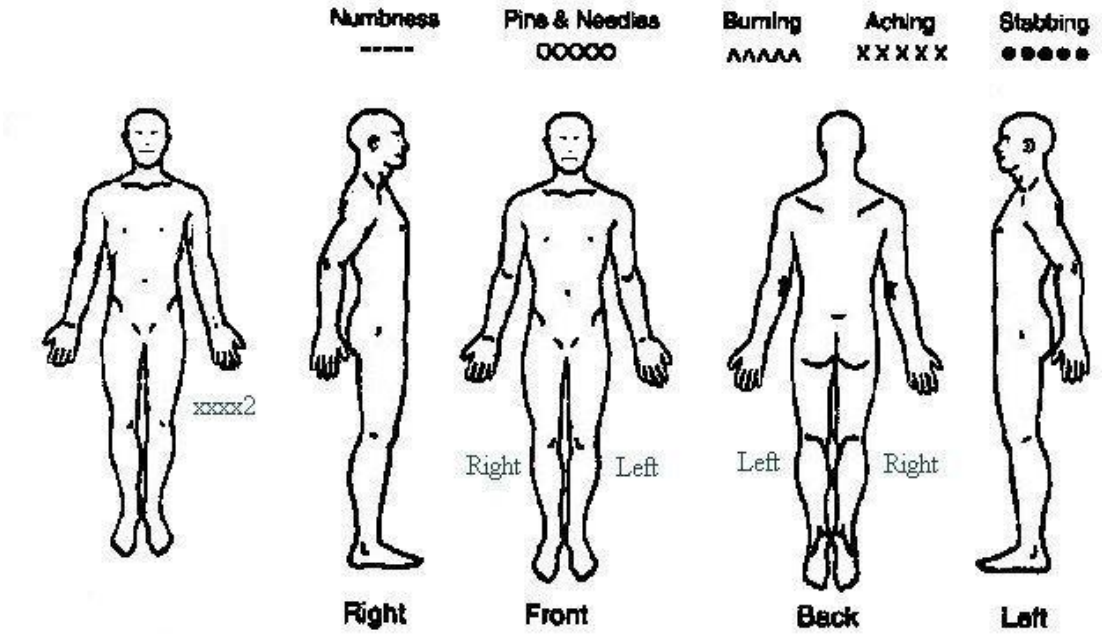
What activity do you think triggered your pain?

How did your pain begin (e.g. motor vehicle accident, injury at work, all by itself, lifting, etc.)?

How often does your pain occur?

Where your main pain is mostly located? Please diagram below

Please use the diagram below to illustrate where your pain is located



Can you describe your pain? (i.e. Burning, stabbing, electrical, shooting, pressure-like, etc.)

Please rate the intensity of your pain on a scale of 0 - 10; 0 = no pain; 10 = worst pain ever

Circle one

Worst **0….1…2…3…4…5…6…7…8…9…10**
Best **0….1…2…3…4…5…6…7…8…9…10**

Pain experienced:

Right now: **When the pain is at its worst:** **When my pain is at its best:**

What medications, in what doses are you currently taking for your pain?

What medications have you tried in the recent past to treat your pain?

What other treatments have you had in the past for your pain (e.g. injections, surgery, etc.)?

Please list the names of the Physicians or Surgeon who you have seen seeking treatment for your current pain.	
Please list the year (s) you were a patient of each doctor	
Name	**year**
Name	**year**
Name	**year**
Name	**year**

Does your pain limit your ability to work? If so, explain how so?

When did you last work?

What makes you pain worse? (i.e., what activity, what position, etc.)

What makes your pain better? (i.e., what activity, what position, etc.)

Does your pain interfere with sleep on a regular basis?

Do you feel sad or depressed because of your pain? Y/N

Have you had any recent bladder or bowel problems (within the last six months) relating to your pain? Y/N

Have you had any focalized loss of strength, or sensation in any of your limbs (arms, hands, legs, and feet) related to your pain? Please describe:

Please list any MRI/ CT scans or X-ray you have had within the past two years relating to your pain problem:

PERSONAL HEALTH HISTORY

Allergies to medications

Name the Drug	Reaction you had

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Are you currently taking any BLOOD THINNERS (e.g. coumadin, lovenox, plavix, and ticlid)? Y/N. If so, please list:

Do you have any chronic medical conditions (e.g. diseases of the heart, lungs, liver, kidneys, joints, endocrine organs, such as diabetes, thyroid disease, etc, bleeding disorders, neurological disease, or psychiatric conditions? Y/N. If so, please circle below:

Yes	No		Yes	No		Yes	No	
		Asthma			**High blood pressure**			**Arthritis**
		Bronchitis/Emphysema			**Heart attack**			**Diabetes**
		Shortness of breath			**Chest pain/angina**			**Neuropathy**
		Chronic cough			**Heart murmur**			**MS**
		Pneumonia			**Palpitations**			**Parkinson's**
		Stomach/Bowel			**Bleeding tendencies**			**Thyroid problems**
		Cardiac Pacemaker			**Epilepsy/ Convulsions**			**Kidney/Bladder**
		Sickle Cell Disease/Trait			**Fainting**			**Irregular/ heartbeats**
		Are you pregnant?			**HIV or Exposure**			**Hepatitis/jaundice**
								Stroke
								Glaucoma

What surgeries have you had? Please list surgeon's name and month/year of surgery

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

HEALTH HABITS				
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.				
Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	If yes, what kind?			
	How many drinks per week?			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – packs./day	☐ Pipe - #/day		☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?		☐ Yes	☐ No
Pregnancy	Are you pregnant?		☐ Yes	☐ No

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT PAIN PROBLEMS		AGE	SIGNIFICANT PAIN PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	

OTHER PROBLEMS		
Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

SOCIAL HISTORY
What is you occupation?
Are you currently working? Y/N If not working from what type of work, and when you retired ?
Highest level of education:
How many children do you have?

_____

Signature Date