



Alaska Center  
for Pain Relief

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### New Patient Health Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ SS# \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Insurance: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

How long have you had your current problem? \_\_\_\_\_

Please describe in your own words the nature of your pain:

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What is your pain level today on a scale of 0-10 (0 being None and 10 being the worst): \_\_\_\_\_

Circle the words that best describe your pain: Aching Constant Cramping Dull Burning  
Numbness/Tingling Pressure Sharp Shooting Spasms Stabbing Throbbing Weakness  
Other: \_\_\_\_\_

List any aggravating factors: \_\_\_\_\_

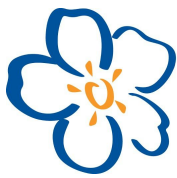
List any alleviating factors: \_\_\_\_\_

Who is your Primary Care Provider and their address:

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Who is your Primary Pharmacy/Location:

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**Please List any drug allergies and their reactions:**

Name	Reaction

**Please list your Medications:**

Name	Dosage(s)	How Often

**Is there a history of any of the following in a blood relative? (Please check if yes)**

- Alcoholism       Breast Cancer       Stroke       Psychiatric Illness  
 High blood pressure       Chronic Pain       Depression       Heart Attack  
 Migraine       Disability       Diabetes       Colon cancer  
 Other: \_\_\_\_\_

**Social History:**

Are you right or left handed? \_\_\_\_\_

Marital Status (check one or more):  Single  Married  Widowed  Divorced  Living together

Tobacco use currently?  Yes  No How Much? \_\_\_\_\_

Previous smoker?  Yes  No Quit date: \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_

Alcohol Intake:  None  Occasional  Moderate  Heavy

Do you drive?  Yes  No Do you wear a seat belt?  Yes  No  Sometimes

Do you have difficulty walking or climbing stairs?  Yes  No

Do you have difficulty dressing or bathing?  Yes  No

Do you have difficulty doing errands alone?  Yes  No

Who do you work for currently? \_\_\_\_\_

Do you live alone or with others? \_\_\_\_\_ If others, who? \_\_\_\_\_



**Please list any Surgeries you have had in the past:**

Surgery	Date

Have you had any Imaging done for what we are seeing you for today ? \_\_\_ Yes \_\_\_ No

Where? \_\_\_\_\_ When? \_\_\_\_\_

**General Medical History:** Check any conditions you have ever had:

- |   |   |
|---|---|
| <input type="checkbox"/> AIDS/HIV                 | <input type="checkbox"/> Glaucoma             |
| <input type="checkbox"/> Acid Reflex              | <input type="checkbox"/> Gout                 |
| <input type="checkbox"/> Angina                   | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Anxiety Disorder         | <input type="checkbox"/> Heart Attack         |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Heart Disease        |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Atrial Fibrillation      | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Back Pain                | <input type="checkbox"/> High Cholesterol     |
| <input type="checkbox"/> Bipolar Disorder         | <input type="checkbox"/> History of MRSA      |
| <input type="checkbox"/> Bleeding Disorder        | <input type="checkbox"/> Hypertension         |
| <input type="checkbox"/> Blood Clots              | <input type="checkbox"/> Kidney Disease       |
| <input type="checkbox"/> Bowel Obstruction        | <input type="checkbox"/> Liver Disease        |
| <input type="checkbox"/> COPD                     | <input type="checkbox"/> Lung Problems        |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Multiple Sclerosis   |
| <input type="checkbox"/> Compression Fracture     | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Congestive heart Failure | <input type="checkbox"/> Psychiatric Illness  |
| <input type="checkbox"/> Coronary Artery Disease  | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Substance Abuse      |
| <input type="checkbox"/> Endometriosis            | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Trigeminal Neuralgia |
| <input type="checkbox"/> GERD                     | <input type="checkbox"/> Ulcerative Colitis   |
|   | <input type="checkbox"/> Vascular Disease     |



# Alaska Center for Pain Relief

Please review the following Review of Systems and check all that apply currently:

## Constitutional

- Fever
- Night Sweats
- Weight Gain (\_\_\_lbs)
- Weight Loss (\_\_\_lbs)
- Exercise intolerance

## Psychiatric

- Depression
- Sleep disturbance
- Restless sleep
- Alcohol abuse
- Anxiety
- Suicidal thoughts

## Allergic/Immunologic

- Runny nose
- Sinus pressure
- Itching
- Hives
- Frequent sneezing

## ENMT

### **Ear**

- Difficulty hearing
- Ear pain

### **Nose**

- Frequent nosebleeds
- Nose problems
- Sinus problems

### **Mouth/Throat**

- Sore throat
- Bleeding gums
- Snoring
- Dry mouth
- Oral abnormalities
- Mouth ulcers
- Teeth abnormalities

### **Eyes**

- Dry eyes
- Irritation
- Vision change

## Respiratory

- Cough
- Wheezing
- Shortness of breath
- Coughing up blood
- Sleep apnea

## Cardiovascular

- Chest pain
- Rapid heart rate

## Gastrointestinal

- Abdominal Pain
- Vomiting
- Change in appetite
- Black or tarry stool
- Frequent diarrhea
- Vomiting blood
- Dyspepsia
- GERD

## Musculoskeletal system

- Muscle aches
- Muscle weakness
- Arthralgias/Joint pain
- Back pain
- Swelling in the extremities
- Muscle spasms
- Grating sensation felt
- Muscle tightness
- Neck stiffness

## Neurological symptoms

- Weakness
- Numbness
- Seizures
- Dizziness
- Frequent or severe headaches
- Migraines
- Restless legs
- Tremor

## Hematologic symptoms

- Easy bruising
- Excessive bleeding

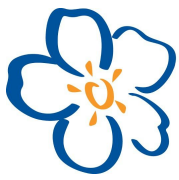
## Endocrine

- High blood sugar trend

## Integumentary

- Abnormal mole
- Jaundice
- Rash
- Itching
- Dry skin
- Growth/lesions
- Laceration

Signature of Patient/Legal Patient Representative: \_\_\_\_\_ Date: \_\_\_\_\_



Please use the appropriate symbol(s) to mark your pain on the Diagram below. Include all affected areas.

Numbness n n  
Cramping ...

Pins & Needles OOO  
Burning xxxx

Aching \_\_\_\_  
Stabbing ///

