For Office Use Only			
Height	BP	HR	Allergies
Weight	PO2	Temp	Ref. Physician

New Patient Questionnaire

Patient Name:_____ Today's Date:_____

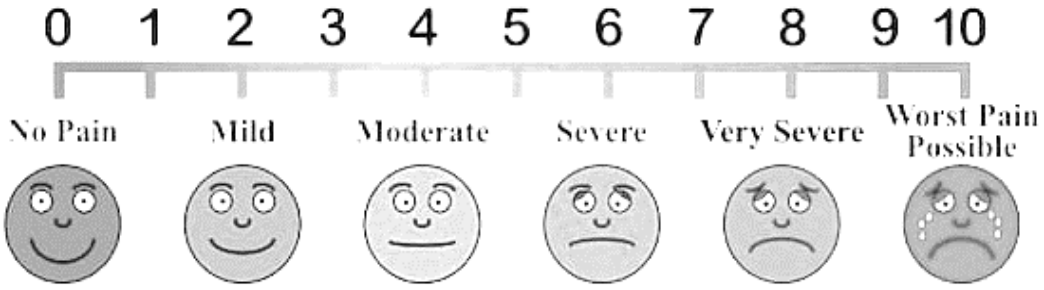
Date of Birth:_____ Where is your pain?_____

How long have you had this pain?_____

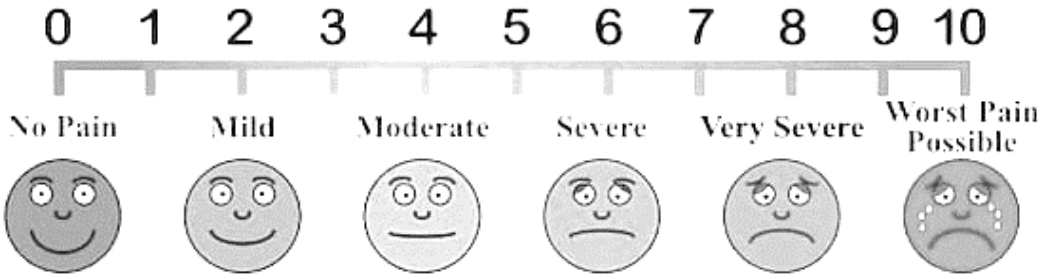
Does your pain shoot or radiate anywhere?_____ If **Yes**, where?_____

Did your pain occur ☐ gradually or ☐ suddenly? Is the pain ☐ continuous or ☐ occasional?

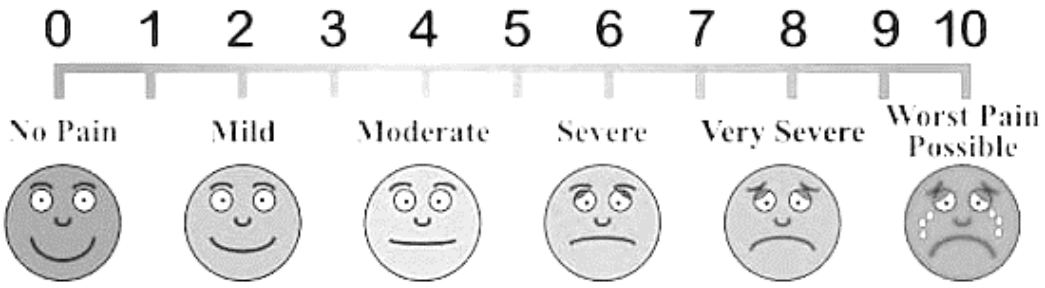
Circle the number for your level of pain at its **WORST** from 0-10:



Circle the number for your level of pain at its **BEST** from 0-10:



Circle the number for your **CURRENT** level of pain from 0-10:



Check all the words that **MOST** describe your pain:

	Constant		Burning		Achy		Pressure
	Sharp		Nagging		Occasional		Tender
	Shooting		Electric		Crampy		Tingling
	Throbbing		Stabbing		Numbness		Other
	Dull		Pins/Needles				

Check all the following that make your pain **WORSE**:

	Walking		Increased Activity		Lifting
	Sitting		Turning Side to Side		Lying Flat
	Bending		Going Upstairs		Coughing
	Prolonged Standing		Going Downstairs		Standing Straight Up
	Morning		Movement		Driving
	Evening		Sneezing		Lying on Affected Side
	Driving		Turning on Affected Side		Other

Check all the following that make your pain **BETTER**:

	Lying Down		Resting		Ice		Physical Therapy
	Sitting		Walking		Heat		Medications
	Changing Positions		Injections		Standing		Lying Flat
	Massage		Exercise		Manipulations		Nothing

Do you have a history of falls? ___Yes ___No

Have you been diagnosed with Fibromyalgia? ___Yes ___No

Do you use any type of Mobility Device? ___Yes ___No

If **YES**, what kind?_____

Check all the previous care givers you have visited for this specific issue:

	Family Physician		Neurosurgeon		Neurologist
	Physical Therapist		Orthopedic		Psychiatrist
	Chiropractor		Podiatrist		Rheumatologist
	Pain Management		ER		Urgent Care
	Other:_____				

Check all the medications you have tried in the past:

	NSAIDS		Voltaren (Oral/Topical)		Lyrica
	Oxycontin		Celebrex		Flexeril
	Oxycodone		MS Contin		Mobic
	Soma		Morphine		Percocet
	Naproxen		Baclofen		Methadone
	Vicodin		Ibuprofen		Zanaflex
	Fentanyl		Tramadol		Cymbalta
	Robaxin		Marijuana		Dilaudid
	Elavil		Neurontin		Valium
	Topamax		Other:_____		

Check all the treatments you have tried in the past:

	Physical Therapy		Epidural Injections		Sacroiliac Injections
	Massage		Brace		Facet Injection/RFA
	Joint Injection		Spinal Cord Stimulator		Acupuncture
	Implanted Pump		Trigger Point Injection		Ice/Heat
	Other:_____				

If you had physical therapy in the past year, how many sessions have you completed?_____

If you received psychiatric treatment in the past, who was your treating physician?_____

Have you had any spinal surgeries? ___Yes ___No If **YES**, When?_____

What kind?_____ Name of Surgeon:_____

Imaging done within the last 12 months:

MRI: What area?_____ Facility?_____

X-Ray/CT Scan: What area?_____ Facility?_____

EMG: What area?_____ Facility?_____

Past Medical History: Check **ALL** that apply

	High Blood Pressure		Diabetes		Heart Disease
	Pacemaker		Liver Problems		Kidney Disease
	Thyroid Disease		Lung Disease		Seizure Disorder
	Osteoporosis		Stomach Ulcers		Prostate Problems
	Spinal Stenosis		Glaucoma		MRSA
	HIV		Stroke		Hepatitis
	Depression		Anxiety		GERD
	C-Diff		Blood Transfusion		Bleeding Problems
	Other:_____				

Have You Ever Been Diagnosed with Cancer? ____Yes ____No

What Kind?_____

Are you in remission? ____Yes ____No

If **FEMALE**, are you or could you be pregnant? ___Yes ___No

Check all the previous surgeries you have had:

	Tonsillectomy		Appendectomy		Kidney Stones
	Gallbladder		Heart Bypass		Hysterectomy
	Hernia Repair		Knee Surgery		Shoulder Surgery
	Hip Surgery		Knee Replacement		Hip Replacement
	Eye Surgery		Carpal Tunnel		
	Other:_____				

Please List **ALL** Allergies:

1. _____ 4. _____
2. _____ 5._____
3. _____ 6._____

Please List **ALL** current Medications:

1. _____ 6._____
2. _____ 7._____
3. _____ 8._____
4. _____ 9._____
5. _____ 10._____

Social History

Do you **CURRENTLY** smoke, or have you **EVER** smoked? ____ Yes ____No

If You **CURRENTLY** Smoke, do you smoke: ____Daily ____Weekly ____Monthly ____Rarely

How many cigarettes do you smoke in the time period you checked off above? _____

Do you **CURRENTLY** drink alcohol? ____Yes ____No

If you replied **YES**, do you drink: ____Daily ____Weekly ____Monthly ___Rarely

How many alcoholic beverages do you drink in the time period you checked off above?_____

Have you **EVER** used illicit substances? ____Yes ____No

If you answered **YES** above: ____Currently Using ____Quit, Last Used:_____

What is your work status? ___Employed ___Unemployed ___Disabled ___Retired

What was/is your occupation? _____

Family History: Check All that Apply

	Hypertension	High Cholesterol	Diabetes	Heart Disease	Cancer	Lung Disease
Mother						
Maternal Grandmother						
Maternal Grandfather						
Father						
Paternal Grandmother						
Paternal Grandfather						
Sister						
Brother