

New Patient Questionnaire

Patient Name: _____ DOB: _____ Date: _____

Where is your pain located? _____

Did it start gradually or suddenly? _____

SEVERITY:

On a scale of 0 to 10, with **0** being no pain and **10** being the worst possible pain imaginable.

Please rate your pain. _____

History of Pain:

1. How long have you had this pain? _____

2. How did your pain start? _____

3. Check the one(s) that describe your pain:

- constant pain always present
- intermittent pain not present all the time

What tests have been done to try to diagnose your pain?

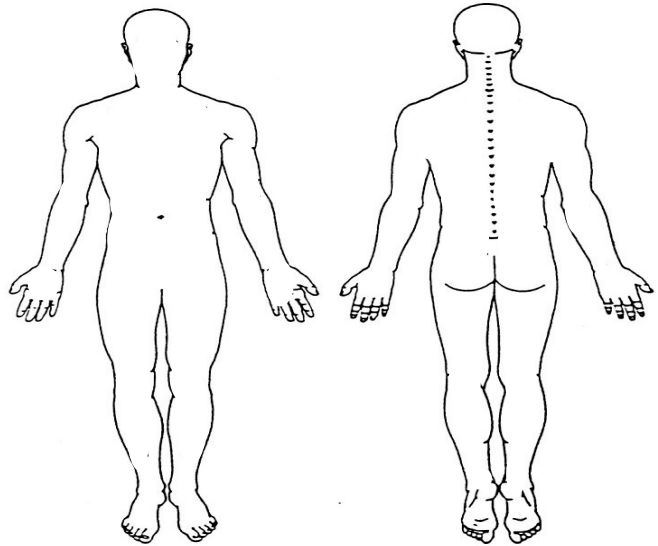
- X-rays
- MRI scan
- CT scan
- Myelogram
- Bone Scan
- Blood work
- Ultrasound
- Other: _____

Findings (if known): _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

- Ache** ^ ^ ^ ^
- Numbness** o o o o
- Pins and Needles** = = = =
- Burning** X X X X
- Stabbing** / / / /

Does the pain travel, spread, or radiate from its primary location to another part of the body? _____



What **consistently** makes your pain worse?

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Stress | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Morning | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Night | <input type="checkbox"/> Touching Skin |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bending Backwards |
| <input type="checkbox"/> Damp Weather | <input type="checkbox"/> Cold Weather | |
| <input type="checkbox"/> Work | <input type="checkbox"/> Bending Forward | |
| <input type="checkbox"/> Other: _____ | | |

What makes your pain less?

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Pain Pills |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Anti-inflammatory agents |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Ice |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Other: _____ | |

Check sensations that most describe your pain:

- | | |
|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Deep |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Grinding |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Stinging |
| <input type="checkbox"/> Squeezing | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Cold |
| <input type="checkbox"/> Other: _____ | |

Have you had loss of control of your bladder or bowels associated with this condition?

- Yes No

Previous Treatments for this Condition?

- | Check Previous Treatments | Did it help or not? | |
|--|------------------------------|-----------------------------|
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Injections or Nerve Blocks | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Psychology Counseling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Biofeedback/relaxation Techniques | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

What medications have you taken for pain (please list any medicines you can remember trying for this pain)?

Did any of these treatments or medications seem to help your pain?

- No Yes, If so, which ones? _____



INTEGRATIVE
PAIN & SPINE

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ Phone#: _____ Fax#: _____
to release healthcare information of the patient named above to:

Name: Integrative Pain & Spine - Dr. Shamim Badiyan, M.D.

Address: 4461 Coit Rd, Ste 411

City: Frisco State: TX Zip Code: 75035

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____
- All healthcare information
- Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhoea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.