New Patient Worksheet

Date of Visit_____ MRN_____

Patient Full Name_____ Date of Birth _____ Age _____ Height_____ Weight_____

Who referred you to our office? _____ Primary Care Physician? _____

Reason Today's Visit: _____

When did your current symptoms begin or injury occur? _____

Are your current symptoms related to an injury? Yes ____ No _____

If your symptoms are related to an injury, do you have a lawyer? Yes_____ No_____

If yes, please provide attorneys information: Name _____ Phone _____

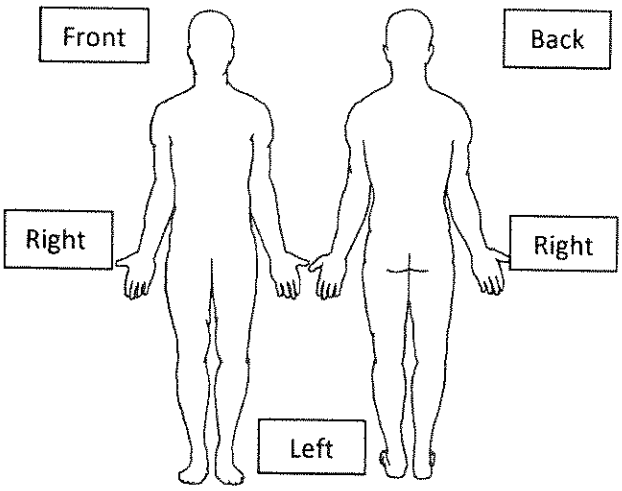
How would you describe your pain now?

__ Intermittent ___ Sharp ___ Throbbing
__ Constant ___ Aching ___ Stinging
__ Burning ___ Dull

Pain is: ___ Equal on both sides ___ Worse on right side
___ Worse on left side

Female Only: Last Menstrual Period_____
Are you currently pregnant? Yes ____ No ____
Do you suspect you are pregnant? Yes ____ No _____

Mark areas below where you are having **pain with an X** and **numbness/tingling with an O**



Please rate your pain NOW:

No Pain 1 2 3 4 5 6 7 8 9 Worst Ever

Please rate your pain AT ITS WORSE:

No Pain 1 2 3 4 5 6 7 8 9 Worst Ever

What makes your pain WORSE?

__ All Activity __Lifting __Coughing
__Sitting __Bending __Sneezing __Standing
__Twisting __Lying Down __Walking __Nothing
__The pain wakes you from your sleep
__ Other _____

What makes your pain better?

__Nothing __All activity __Walking __Lying down
__Exercise __Twisting __Ice __Heat __Sitting
__Bending forward __Bending backward __Standing
Other_____
Have you had: __Inability to urinate __Arm or Leg Weakness __Loss of balance while walking __Falls

What is your current work status? __Full duties __Light duties __Out of work __Retired

Occupation or previous occupation:

_____

List anything else you can not do or have had to change because of your symptoms:

_____

Who else have you seen for this problem?

_____

What test have you had for this problem?

__ CT Scan __Myelogram __ EMG/Nerve Conduction

__Blood Work __ X-Rays __ MRI

Where/Date? _____

Have you tried any of the following? Chiropractor ____

Acupuncture __ Physical Therapy__ Massage Therapy_

What medications have you tried? _____

_____

Have you had any injections? Yes___ No ___

If yes, what kind? _____

Provider Notes:

Provider Signature_____Date_____