PainMedicine SpecialtyGroup

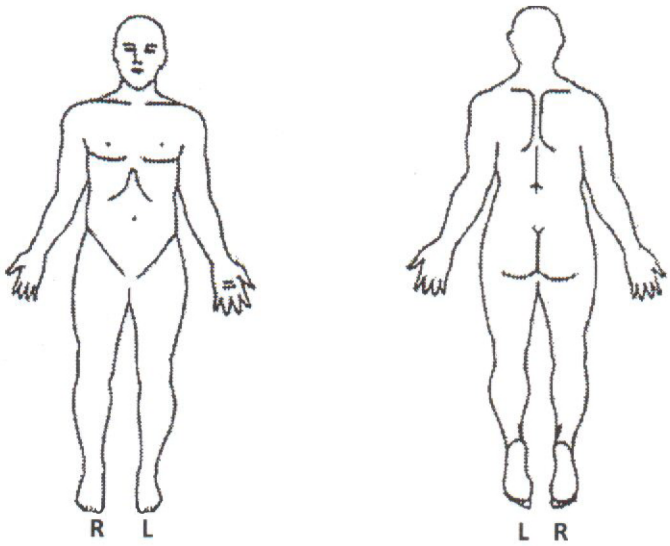
NEW PATIENT QUESTIONNAIRE

Patient Name _____ DOB_____ Date _____

Primary Care Physician _____ Referring Physician _____

Chief Complaint (reason for visit) _____

On the diagram, shade in the areas where you feel pain



The onset of your pain was ☐ suddenly following an injury ☐ suddenly without an injury ☐ gradually following an injury ☐ gradually without an injury ☐ after a work related injury ☐ after a motor vehicle accident

Your pain has been occuring for how many _____ ☐ days ☐ weeks ☐ months ☐ years

Your pain occurs: ☐ intermittent ☐ continuous ☐ occasional ☐ rare

Describe your pain: ☐ throbbing ☐ dull ☐ aching ☐ shooting ☐ stabbing ☐ burning

Is your pain: ☐ mild ☐ moderate ☐ severe ☐ unbearable

Pain level today 1 2 3 4 5 6 7 8 9 10 (0 = no pain 10 = unbearable pain)

Over the last 2 weeks, please identify your pain levels below

Severe pain level 1 2 3 4 5 6 7 8 9 10

Average pain level 1 2 3 4 5 6 7 8 9 10

Do you experience: ☐ numbness ☐ weakness ☐ tingling ☐ pins/needles ☐ burning ☐ swelling

What activities increase your symptoms:

- ☐ sitting
- ☐ standing
- ☐ walking
- ☐ lifting
- ☐ bending forward
- ☐ bending backward
- ☐ bending to the right
- ☐ bending to the left
- ☐ driving
- ☐ cold/damp weather
- ☐ coughing/sneezing

What activities decrease your symptoms:

- ☐ nothing
- ☐ sitting
- ☐ standing
- ☐ walking
- ☐ rest
- ☐ avoiding strenuous activity
- ☐ lying with pillow between legs
- ☐ heat
- ☐ ice application
- ☐ stretching
- ☐ pain medication
- ☐ massage
- ☐ chiropractic manipulation
- ☐ acupuncture
- ☐ swimming

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Medications tried:

- ☐ Oral NSAIDS (Ibuprofen/prescription strength Motrin)
- ☐ Over the counter agents (Tylenol/Aspirin)
- ☐ Muscle relaxants (Flexeril/Skelaxin)
- ☐ Prescription pain medications (Vicodin/Dilaudid)
- ☐ Prescription nerve medications (Lyrica/Cymbalta)
- ☐ Prescription topical agents (Voltaren gel/Lidoderm patch)

Previous conservative measures:

- ☐ physical therapy
- ☐ chiropractic treatment
- ☐ cortisone injections
- ☐ surgical intervention
- ☐ bracing
- ☐ massage
- ☐ acupuncture

ALL CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER (please list): _____

_____

_____

_____

ALLERGIES (include allergies/side effects to medications or seafood): _____

_____

PAST MEDICAL HISTORY: Please check any of the following conditions you have or have had:

☐ headaches ☐ stroke	☐ thyroid disease	☐ cancer	☐ lung disease/asthma		☐ blood clots
☐ high blood pressure	☐ peripheral vascular disease	☐ heart attack	☐ coronary artery disease		☐ diabetes
☐ gastrointestinal disease	☐ stomach ulcers	☐ kidney disease	☐ hepatitis A	☐ hepatitis B	☐ hepatitis C
☐ arthritis	☐ neurologic disorders	☐ pinched nerves	☐ seizures		☐ HIV/AIDS

Please list any other past or present medical conditions you have: _____

Please indicate any prior accidents or work injuries: _____

PAST SURGICAL HISTORY: _____

_____

FAMILY HISTORY: ☐ None ☐ Unknown

Please list all medical conditions that are common in your family: _____

SOCIAL HISTORY:

Occupation: _____

Marital Status: ☐ S ☐ M ☐ W ☐ D

Tobacco use: ☐ Yes ☐ No If yes, how much? _____ Former smoker: ☐ Yes ☐ No

Alcohol use: ☐ Yes ☐ No If yes, how much? _____

Do you have problems with drug or alcohol use or dependency? ☐ Yes ☐ No

REVIEW OF SYMPTOMS: Check all that apply:

☐ Fever	☐ Involuntary Urine Loss	☐ Anxiety	☐ Shortness of Breath
☐ Constipation	☐ Depression	☐ Leg Swelling	☐ Joint Swelling
☐ Sleep Disturbance	☐ Poor Balance	☐ Weight Loss	☐ Easy Bleeding

The above information is accurate to the best of my knowledge:

Patient Signature: _____ Date: _____