

Name _____

DOB: _____

Today's Date: _____

NEW PATIENT QUESTIONNAIRE

Where is your pain **PRIMARYLY** located? Low Back Neck Mid-back Whole Body Other: _____

Does your pain radiate? No Yes it radiates to _____ (i.e. right leg, left arm, etc.)

How long ago did the pain start? More than 3 month ago Less than 3 months ago

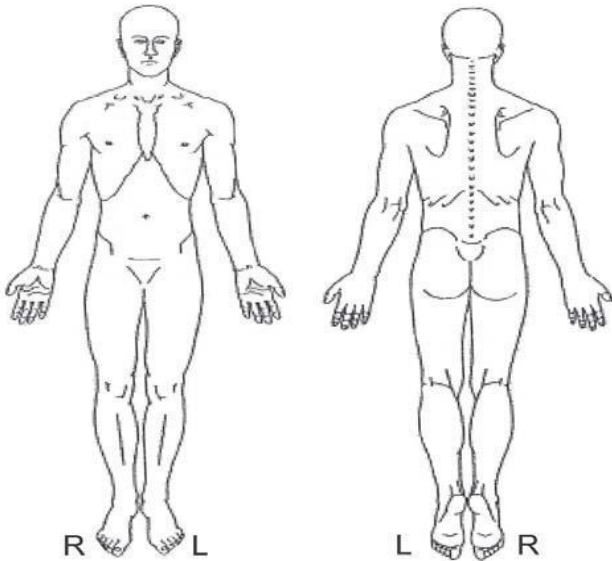
How did your pain develop? Gradually Suddenly

Did your pain develop following a trauma or work-related injury? No Yes (circle that apply)

Where is your pain? (Please shade **PRIMARY** area with arrows for **RADIATION**)

Do any additional symptoms occur with your **PRIMARY** pain? (Select all that apply)

- Numbness Tingling Weakness Urinary Retention Saddle Anesthesia



What is your **CURRENT** pain level?

(0—1—2—3—4—5—6—7—8—9—10)

(0= no pain, 10=pain so severe you can't even speak)

Have you ever been evaluated by a specialist for **THIS COMPLAINT?**

NO YES (please select all that apply and indicate the specific physician)

Neurology : _____

Neurosurgery: _____

Orthopedics: _____

Podiatry: _____

Rheumatology: _____

What do your symptoms feel like? (Select all that apply)

Burning Aching Throbbing

Cramping Stabbing Shooting Stinging

What maneuvers can make your symptoms **BETTER**? (Select all that apply)

Sitting Lying Flat Standing Leaning Forward

General Rest Other: _____

What maneuvers can make your symptoms **WORSE**? (Select all that apply)

Standing Walking Sitting General Activity

Other: _____

Have you ever been evaluated by a Pain Management Specialist for **ANY COMPLAINT?** (Please indicate which specific physicians you have seen)

NO YES: _____

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Previous Treatments

INTERVENTIONAL TREATMENTS

	Helpful	Not Helpful
Epidural Steroid	___	___
Radiofrequency Ablation	___	___
Spinal Cord Stimulation	___	___
Trigger Point Injections	___	___
Joint Injections	___	___
Other: _____	___	___

FUNCTIONAL TREATMENTS

	Helpful	Not Helpful
Home Exercise Program	___	___
Chiropractics	___	___
Myofascial Release	___	___
Physical Therapy	___	___
Other: _____	___	___

PSYCHOLOGICAL THERAPIES

	Helpful	Not Helpful
Cognitive Behavioral Therapy	___	___
Acupuncture	___	___
Tai Chi	___	___
Other: _____	___	___

OTHER THERAPIES

	Helpful	Not Helpful
TENS Therapy	___	___
Heat/Ice Therapy	___	___
Other: _____	___	___

ANTI-INFLAMMATORY THERAPY

	Helpful	Not Helpful
Oral Steroids (<i>Prednisone</i>)	___	___
Ibuprofen (<i>Advil</i>)	___	___
Naproxen (<i>Aleve</i>)	___	___
Celecoxib (<i>Celebrex</i>)	___	___
Meloxicam (<i>Mobic</i>)	___	___
Other: _____	___	___

NEUROPATHIC MEDICATIONS

	Helpful	Not Helpful
Amitriptyline (<i>Elavil</i>)	___	___
Gabapentin (<i>Neurontin</i>)	___	___
Pregabalin (<i>Lyrica</i>)	___	___
Topiramate (<i>Topamax</i>)	___	___
Duloxetine (<i>Cymbalta</i>)	___	___
Nortriptyline (<i>Pamelor</i>)	___	___
Other: _____	___	___

SKELETAL MUSCLE RELAXANTS

	Helpful	Not Helpful
Baclofen	___	___
Cyclobenzaprine (<i>Flexeril</i>)	___	___
Tizanidine (<i>Zanaflex</i>)	___	___
Methocarbamol (<i>Robaxin</i>)	___	___
Other: _____	___	___

IMMEDIATE RELEASE OPIATES

	Helpful	Not Helpful
Tramadol (<i>Ultram</i>)	___	___
Hydrocodone (<i>Norco</i>)	___	___
Morphine (<i>MSIR</i>)	___	___
Oxycodone (<i>Percocet</i>)	___	___
Oxymorphone	___	___
Dilaudid	___	___
Tapentadol (<i>Nucynta</i>)	___	___
Other: _____	___	___

EXTENDED RELEASE OPIATES

	Helpful	Not Helpful
Morphine ER (<i>MSER</i>)	___	___
Oxycodone ER (<i>Oxycontin</i>)	___	___
Oxymorphone ER	___	___
Fentanyl Patch (<i>Duragesic</i>)	___	___
Methadone	___	___
Other: _____	___	___

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MEDICAL HISTORY

PAST MEDICAL HISTORY (Select all that apply)

- Glaucoma
- Migraines
- Seizures
- Neuropathy
- GERD
- Peptic Ulcer Disease
- Ulcerative Colitis
- Chrohn's Disease
- Coronary Artery Disease
- Atrial Fibrillation
- Myocardial Infarction (Heart Attack)
- Congestive Heart Failure
- Hypertension
- Diabetes
- Kidney Failure
- Kidney Stones
- Peripheral Vascular Disease
- Von Willebrands's Disease
- Factor V Lieden
- Pulmonary Embolism
- DVT
- Thrombocytopenia (Low Platelets)
- Cancer
- Liver Disease
- Obstructive Sleep Apnea
- COPD
- Bipolar Disorder
- Schizophrenia
- Obsessive Compulsive Disorder
- Depression
- Anxiety
- Alcoholism
- Opiate Dependency
- Rheumatoid Arthritis
- Systemic Lupus Erythematosis
- Fibromyalgia

Other: _____

MEDICATIONS (Please list dosage and frequency)

DRUG ALLERGIES

SURGICAL HISTORY (List procedure and year)

FAMILY HISTORY (Select all that apply)

Cancer Bleeding Disorder

Rheumatological Disease

Other: _____

SOCIAL HISTORY

Are you a smoker? NO YES

Do you use IV drugs? NO YES

Have you had a pneumococcal vaccine? NO YES

Date (Year/Month): _____

REVIEW OF SYSTEMS (Select all that apply)

Constitutional: chills fever weight loss

Skin: rash ulcers

HEENT: blurred vision ringing in ears vertigo

Resp: cough wheezing shortness of breath

CV: chest pain palpitations edema

GI: constipation diarrhea heartburn

Neuro: fainting seizures

Psychiatric: tired fogginess personality changes

Endocrine: sweating hot flash sexual dysfunction

Hematology: easy bruising easy bleeding nose

bleeds