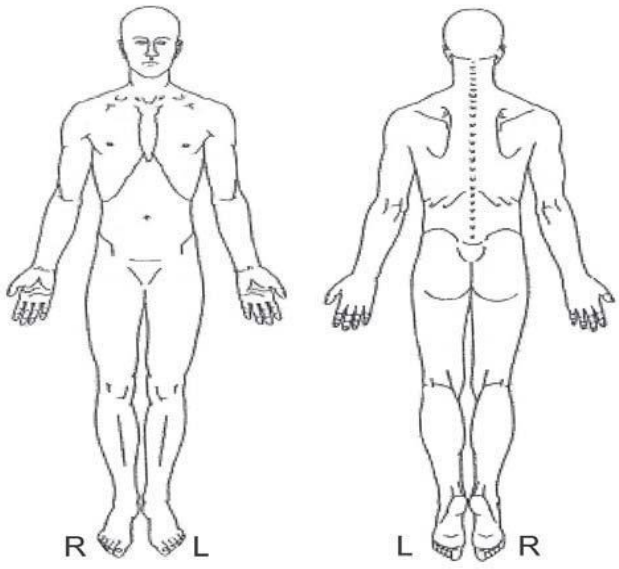
Name_____ DOB:_____ Today's Date:_____

NEW PATIENT QUESTIONNAIRE

Where is your pain **PRIMARILY** 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**)



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: _____

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:_____

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

__NO __YES: _____

Have you had any imaging related to this complaint within the pa
MRI:_____
CT:_____
X-ray:_____
EMG/NCV:_____

Name_____ DOB:_____ Today's Date:_____

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: _____		

PSYCHOLOGICALTHERAPIES

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

OTHER THERAPIES

	Helpful	Not Helpful
TENS Therapy	___	___
Heat/Ice Therapy	___	___
Topical Treatments	___	___
Medical Cannabis	___	___
Other:_____	___	___

ANTI-INFLAMATORY THERAPY

	Helpful	Not Helpful
Oral Steroids (*Prednisone*)	___	___
Ibuprofen (*Advil*)	___	___
Naproxen (*Aleve*)	___	___
Celecoxib (*Celebrex*)	___	___
Meloxicam (*Mobic*)	___	___
Sulindac (*Clinoril)*	___	___
Diclofenac (*Voltaren*)	___	___
Other:_____	___	___

NEUROPATHIC MEDICATIONS

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

SKELETAL MUSCLE RELAXANTS

	Helpful	Not Helpful
Baclofen	___	___
Cyclobenzaprine (*Flexeril*)	___	___
Tizanadine (*Zanaflex*)	___	___
Methocarbamol (*Robaxin*)	___	___
Orphenadrine (Norflex)	___	___
Other:_____	___	___

Name_____ DOB:_____ Today's Date:_____

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