

NEW PATIENT VISIT

Name _____ Date of Visit: _____ DOB: _____

Height _____ Weight _____

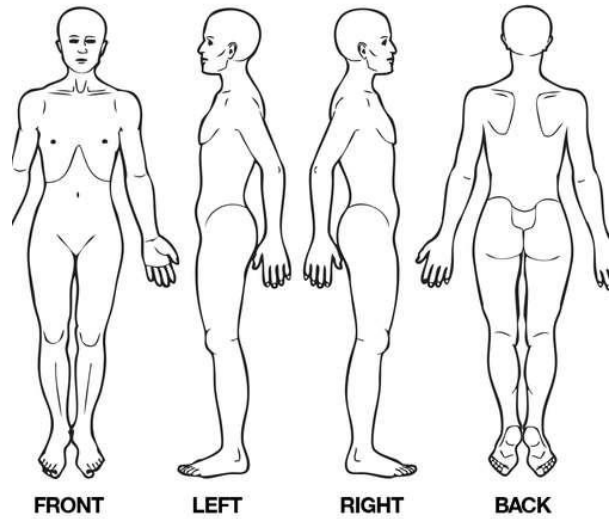
What is the main problem for which you are seeking treatment? _____

1. Where is your pain located? (Show on diagram)

2. How long have you had this pain? _____

3. How did it start? _____

4. Is it constant or intermittent? (Please Circle)



5. How do you describe the pain? (Please check)

- | | | | | |
|-----------------------------------|---|--|------------------------------------|------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Electric Shock | <input type="checkbox"/> Pins/Needles | <input type="checkbox"/> Shooting | <input type="checkbox"/> Tightness |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Heavy | <input type="checkbox"/> Pressure-Like | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Knife-Like | <input type="checkbox"/> Pounding | <input type="checkbox"/> Stinging | |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Numbness | <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing | |

6. Where does the pain radiate to? Left: Right: Both:

- | | | | | |
|-----------------------------------|-------------------------------|-------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Buttocks | <input type="checkbox"/> Arm | <input type="checkbox"/> Hip | <input type="checkbox"/> Knees | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hand | <input type="checkbox"/> Legs | <input type="checkbox"/> Ankle | <input type="checkbox"/> Toes |

7. Severity of pain at its worst? 0 1 2 3 4 5 6 7 8 9 10

8. Severity of average pain? 0 1 2 3 4 5 6 7 8 9 10

9. What makes the pain worse?

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Defecation | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sit-to-stand Transfers | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Bowel Movements | <input type="checkbox"/> Driving | <input type="checkbox"/> Looking Up | <input type="checkbox"/> Sitting too long | <input type="checkbox"/> Turning Left |
| <input type="checkbox"/> Changing Positions | <input type="checkbox"/> Going downstairs | <input type="checkbox"/> Menses | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Turning Right |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Heat | <input type="checkbox"/> Movement | <input type="checkbox"/> Standing too long | <input type="checkbox"/> Turning Side-to-side |
| <input type="checkbox"/> Cold Weather | <input type="checkbox"/> Increased Activity | <input type="checkbox"/> Physical Activity | <input type="checkbox"/> Standing straight up | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Laying Flat | <input type="checkbox"/> Sexual Activity | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Weather Change |

10. What makes the pain better?

- | | | | | |
|--|--|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Assistive devices | <input type="checkbox"/> Hot Baths | <input type="checkbox"/> Leaning back | <input type="checkbox"/> Pool therapy | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Ice | <input type="checkbox"/> Massage | <input type="checkbox"/> Rest | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Change in positions | <input type="checkbox"/> Injections | <input type="checkbox"/> Medications | <input type="checkbox"/> Squatting | <input type="checkbox"/> TENS Unit |
| <input type="checkbox"/> Cold pack | <input type="checkbox"/> Inversion Table | <input type="checkbox"/> Moving Around | <input type="checkbox"/> Stretching | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Exercising | <input type="checkbox"/> Leaning Forward | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Sitting | <input type="checkbox"/> Laying Down |

11. Associated Symptoms

- | | | | |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Difficulty with sleep | <input type="checkbox"/> Need for sleeping pills | <input type="checkbox"/> Restricted activities | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Feeling Blue | <input type="checkbox"/> Non restful sleep | <input type="checkbox"/> Unable to fall asleep | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Frustrated | <input type="checkbox"/> Fevers | <input type="checkbox"/> Unable to stay asleep | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Loss of bowel/bladder function | <input type="checkbox"/> Chills | <input type="checkbox"/> Waking up | |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Sweats | <input type="checkbox"/> Weakness | |

12. Do you feel numbness and or pins & needles in association with your pain?

No: If Yes: Numbness
 Pins and needles

13. Do you have weakness? No: If yes check boxes below:

Arms: Right: Left:

Legs: Right: Left:

Do you drop objects? No: Yes:

Have you fallen recently? No: Yes:

Do you have balance problems? No: Yes:

14. How many blocks can you walk?

- Less than 1
- 2
- 3
- 4 or more

15. How often during the day do you have to rest because of the pain?

- Never
- Seldom
- Sometimes
- Often
- Constantly

16. Sleep Disturbance

Do you have difficulty falling asleep? No: Yes:

Do you have difficulty remaining asleep? No: Yes:

Are you ever awakened by pain? No: Yes:

On average how many hours do you sleep? _____ hrs

17. How long can you sit?

- Less than 15 minutes
- Up to 30 minutes
- Up to 1 hour
- 1 – 2 hours
- 2 hours or more

19. How long can you stand?

- Less than 15 minutes
- Up to 30 minutes
- Up to 1 hour
- 1 – 2 hours
- 2 hours or more

18. To assist walking, I use a:

- No assistance device
- Cane
- Walker
- Wheelchair

20. Which activities of daily living are affected by your pain? (check all that apply)

- Socialize with friends
- Participate in recreational activities
- Go to work
- Dress, or bath
- Perform household chores
- Exercise
- Other: _____

21. Do you have any of the following (Please check)

Dizziness/vertigo: Fibromyalgia:

22. Who have you seen for this pain? _____

Have you seen a neurosurgeon? If yes, who and when? _____

23. What tests/imaging have you undergone? _____

24. What treatment have you tried in the past for your pain (Please check your response to all treatments you have tried)

Physical Therapy	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
TENS Therapy	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Pool Therapy	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Biofeedback	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Pain Management	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Psychiatric Therapy	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Epidurals	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Acupuncture	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Chiropractic Manipulations	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Spine Surgery	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Nerve Blocks	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Other: _____	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Other: _____	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Other: _____	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief

25. Do you experience any of the following?

Constitutional

- Fever Chills Hot Flashes Night Sweats Weight Loss
-

Eyes

- Blurred Vision Double Vision Photophobia
-

HENT

- Loss of Balance Syncope Deafness/hearing loss Head injuries
-

Cardiovascular

- MI Chest Pain Irregular Heartbeat High BP Limb Swelling
 Phlebitis DVT PVD Angina CHF
-

Respiratory

- Shortness of breath COPD/Emphysema Sleep Apnea Asthma
-

Gastrointestinal

- Heart Burn Nausea/Vomiting Diarrhea Constipation Bloody Stool
 Ulcers GERD Jaundice/Hepatitis
-

Genitourinary

- Blood in Urine Kidney Failure Bladder problems Kidney Stones Problem Urinating
-

Musculoskeletal

- Muscle Pain Muscle cramps Muscle twitches Neck pain Loss of muscle bulk
 Back pain Joint pain Joint stiffness Joint swelling Tremors
 Fractures Arthritis Limitation of joint movement Night cramps Posture abnormalities
-

Neurological

- Headache Seizures Blackouts Trouble W/Memory Trouble Concentrating
 Decrease in Cognitive skills Stroke Involuntary movements Speech Difficulties Spasticity
-

Psychological

- Depression Anxiety Family History of Psychiatric Disorder
-

Hematologic

- Abnormal Bleeding Anemia Blood Clotting DVT/PE High/low Blood Counts
-

Endocrine

- Hypothyroidism Hyperthyroidism Diabetes
-

28. Past Medical History / Problem List

Mark all conditions/diseases that **YOU** have been **DIAGNOSED** with:

Cardiovascular/Hematologic

- Anemia
- Coronary Artery Disease
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Hypertension
- Mitral Valve Prolapse
- Pacemaker/Defibrillator
- Poor Circulation
- Stroke

Gastrointestinal

- Bowel Incontinence
- Constipation
- Gastrointestinal Bleeding
- GERD (Acid Reflux)

General Medical

- Cancer- Type _____
- Diabetes- Type _____
- HIV/AIDS

Head/Eyes/Ears/Nose/Throat

- Glaucoma
- Headaches
- Head Injury
- Hyperthyroidism
- Hypothyroidism
- Migraines

Hepatic-list active inactive unsure

- Hepatitis A B C
- active inactive unsure

I HAVE NO SIGNIFICANT MEDICAL HISTORY

Musculoskeletal

- Amputation/Phantom Limb Pain
- Bursitis
- Carpal Tunnel Syndrome
- Chronic Low Back Pain
- Chronic Joint Pain
- Chronic Neck Pain
- Fibromyalgia
- Joint Injury _____
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Tennis Elbow
- Vertebral Compression Fracture

Nephrology/Genitourinary

- Bladder/Kidney Infections
- Dialysis
- Kidney Stones
- Kidney Disease
- Liver Disease
- Urinary Incontinence

Neuropsychological

- Alcohol Abuse
- Alzheimer Disease
- Anxiety
- Bipolar Disorder
- Depression
- Epilepsy
- Multiple Sclerosis
- Neuropathy
- Paralysis
- Prescription Drug Abuse

- Schizophrenia
- Seizures
- Reflex Sympathetic Dystrophy (RSD)/ Chronic Regional Pain Syndrome (CRPS)
- Spinal Cord Injury
- Traumatic Brain Injury (TBI)

Respiratory

- Asthma
- Bronchitis
- Chronic Obstructive Pulmonary Disease (COPD)
- Emphysema
- Pneumonia
- Tuberculosis (TB)
- Valley Fever

Other diagnosed conditions:

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? Yes No

If so, have you ever had any adverse reaction to anesthesia? Yes No

Which type of anesthesia did you react adversely to? Please check all that apply.

- Local anesthesia Epidural General anesthesia IV sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

- Local anesthesia Epidural General anesthesia IV sedation

29. Past Surgical History:

Please indicate any surgical procedures you have had done in the past, including the date, type or other pertinent details:

Abdominal Surgery

- Gallbladder removal _____
- Appendectomy _____
- Other _____

Heart Surgery

- Aneurysm repair _____
- Stent placement _____
- Valve replacement _____
- Other _____

Other Common Surgeries

- Hemorrhoid surgery _____
- Hernia repair _____
- Thyroidectomy _____
- Tonsillectomy _____
- Vascular surgery _____

Joint Surgery

- Hip _____
- Knee _____
- Shoulder _____
- Other _____

Spine/Back Surgery

- Discectomy (levels) _____
- Laminectomy _____
- Spinal Fusion (levels) _____
- Other _____

Other?

- Other _____
- Other _____
- Other _____

30. Do you drink alcohol? Yes: No: If yes how often? _____

31. Smoke cigarettes? Yes: No: If yes how much? _____

Former Smoker? Yes: No: If yes, how many years? _____

32. Do you use nonprescription drugs? If yes, which ones? _____

33. Have you ever had a history of drug or substance abuse? Yes: No:

34. Marital status? _____

35. Are you currently working? Yes: No: What kind of work do you do? _____

Are you on disability? Yes: No: Are you pregnant? Yes: No:

36. Does anyone in your family have a history of related medical problems? What Problems?

37. Preferred Pharmacy

Pharmacy Name: _____ **Phone:** _____

Address: _____ **City/State/Zip:** _____

38. Are you currently involved in litigation or a lawsuit related to your pain?

PATIENT SIGNATURE: _____ **DATE:** _____