

# NEW PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Are you: Right handed Left handed (please circle)

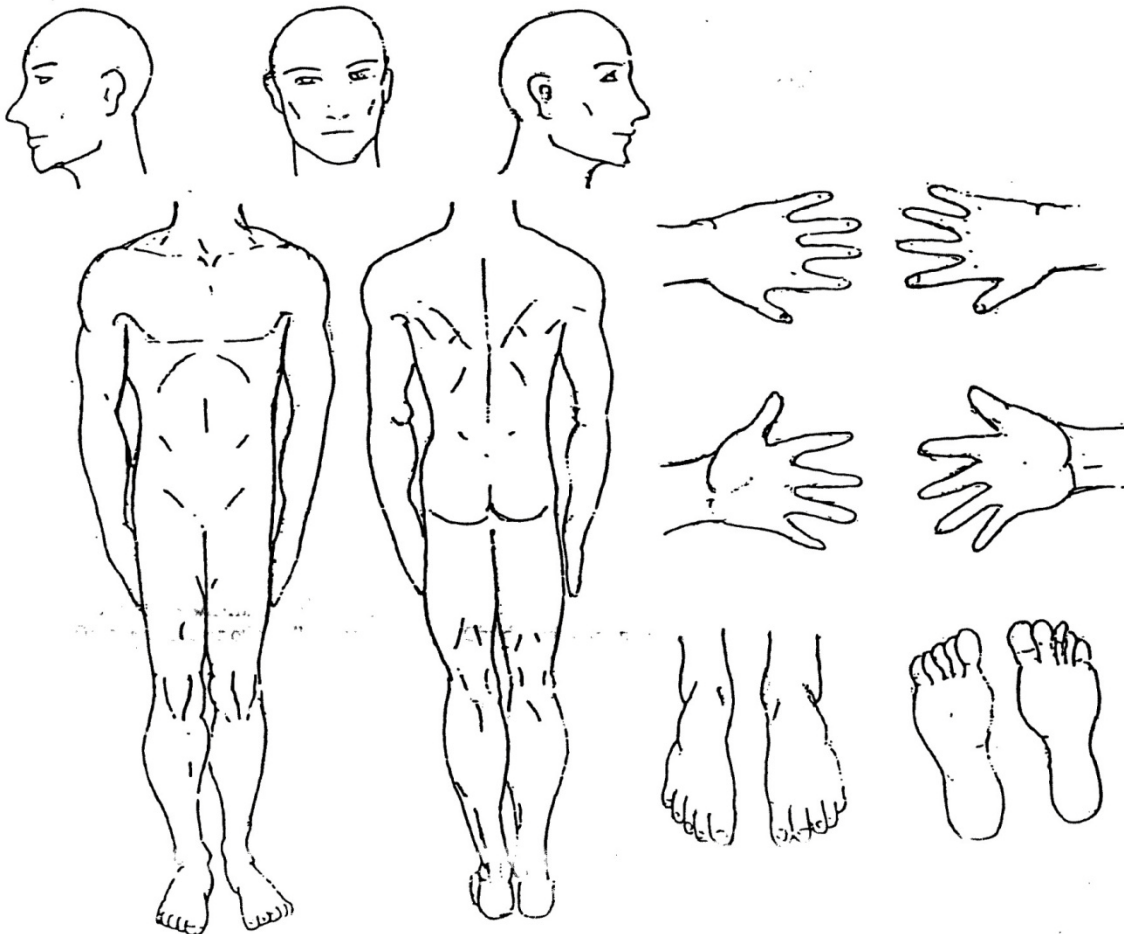
## HISTORY:

Chief Complaint: \_\_\_\_\_

Where is your pain located? \_\_\_\_\_

Describe your pain (circle all those that apply): sharp, burning, achy, twisting, pressure, lancinating, deep, dull, heavy, gnawing, shooting, electric, knife-like

Please mark the figure with the location of your symptoms: Pain=XX Numbness/Tingling=OO



How severe is your pain (scale 0-10)? \_\_\_\_\_

**0** Absent (No pain); **1-2** Tolerable (tolerate without medications); **3-4** Bearable (some activities restricted/prevented, requires medication); **5-6** Nearly intolerable (sedentary, only able to watch TV, read, etc.); **7-8** Intolerable (Can't read, watch TV, use the phone, need to visit ER for pain killers); **9-10** Devastating (need hospitalization for pain control)

0-----|-----10 (please draw a line through where you feel your pain is best represented)

How long have you had your pain? \_\_\_\_\_

When do you have your pain? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

Are you having difficulty with sleep because of your pain? \_\_\_\_\_

How long can you: Sit \_\_\_\_\_ Stand \_\_\_\_\_ Walk \_\_\_\_\_

Have you lost any control over bowel or bladder functions? YES NO (please circle)

Is your pain related to a specific injury? YES NO (please circle)

If yes, please describe: \_\_\_\_\_

Is the injury/pain work related? YES NO (please circle)

Is the injury/pain motor vehicle related? YES NO (please circle)

If yes, what was the date of your accident? \_\_\_\_\_

Is there a lawsuit (pending or considered)? N/A YES NO (please circle)

Have you been treated by other clinicians for this problem? YES NO (please circle)

If Yes, please list name, date seen, and treatment given: \_\_\_\_\_

Have you had any physical therapy (PT)? YES NO (please circle)

How many sessions? \_\_\_\_\_ Has PT helped? YES NO (please circle)

Have you had epidural or facet injections? YES NO (please circle)

How many? \_\_\_\_\_ Did they help? YES NO (please circle)

Have you had a previous back or neck surgery? YES NO (please circle)

Have you had diagnostic tests performed (CT, MRI, EMG, etc.)? YES NO (please circle)

If Yes, please list: \_\_\_\_\_

What do you hope we can accomplish today? \_\_\_\_\_

### **WORK HISTORY:**

Are you working? YES NO (please circle)

If so, Full-time \_\_\_\_\_ Part-time \_\_\_\_\_ Restricted Duty \_\_\_\_\_

If restrictions, please describe: \_\_\_\_\_

If not, date last worked: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ How long in position? \_\_\_\_\_

PAST MEDICAL HISTORY

Illness/ Condition			Is your Primary Care Doctor the Treating Physician		If No, please list Treating Physician Name	Is problem Stable/ Well Controlled		If No, Please Explain
	Yes	No	Yes	No		Yes	No	
Anxiety								
Depression								
Psychiatric Problem								
Asthma								
Pneumonia								
Lung Disease								
Pulmonary Embolism								
Heart Disease								
Heart Murmur								
Heart Attack								
High Blood Pressure								
Anemia								
High Cholesterol								
Bleeding Disorder								
Deep Vein Thrombosis								
GERD								
Ulcers								
Rheumatic Fever								
Liver Disease/Hepatitis								
Alcoholism								
Arthritis								
Muscle Disease								
Thyroid Disorder								
Gout								
Diabetes								
Migraines								
Seizure Disorder								
Stroke								
Cancer								
HIV/AIDS								
Kidney Disease								
Tuberculosis								
Rheumatoid Arthritis								
Psoriasis								
MRSA								
Osteoporosis								
Other								

**MEDICATIONS:**

List all medications that you are currently taking: \_\_\_\_\_

List medications that you have taken in the past and if they did or did not help: \_\_\_\_\_

Medication allergies? YES NO (please circle)

Please list: \_\_\_\_\_

Do you have any other known allergies? YES NO (please circle)

Please list: \_\_\_\_\_

### **PAST SURGICAL HISTORY:**

Please list any previous surgeries: \_\_\_\_\_

### **FAMILY HISTORY:**

Please list any medical illnesses that the following blood relatives have a history of:

Grandparents: \_\_\_\_\_ Living or deceased \_\_\_\_\_

Father: \_\_\_\_\_ Living or deceased \_\_\_\_\_

Mother: \_\_\_\_\_ Living or deceased \_\_\_\_\_

Brothers/Sisters: \_\_\_\_\_ Living or deceased \_\_\_\_\_

### **SOCIAL HISTORY:**

Marital Status: Single Married Divorced Separated Widow (please circle)

Number of children \_\_\_\_\_ Ages \_\_\_\_\_

Do you smoke? No Yes How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Previous Smoker? No Yes When did you quit? \_\_\_\_\_

Do you drink alcohol? No Yes How many drinks per week? \_\_\_\_\_

Do you use recreational drugs? No Yes If yes, what type: \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please mark an "X" for Yes and leave blank for No.

**CONSTITUTIONAL: I have none of the symptoms listed \_\_\_\_\_**

Fever\_\_\_\_\_ Chills\_\_\_\_\_ Fatigue\_\_\_\_\_ Night Sweats\_\_\_\_\_

Unexplained weight Gain/Loss\_\_\_\_\_

**SKIN: I have none of the symptoms listed \_\_\_\_\_**

Rashes\_\_\_\_\_ Nail changes\_\_\_\_\_ Easy Bruising\_\_\_\_\_ Color changes\_\_\_\_\_

Jaundice\_\_\_\_\_ Infections\_\_\_\_\_

**EYES/EARS/NOSE/THROAT: I have none of the symptoms Listed \_\_\_\_\_**

Vision changes\_\_\_\_\_ Hearing Loss\_\_\_\_\_ Dizziness/Vertigo\_\_\_\_\_ Ringing in the ear\_\_\_\_\_

Hoarseness\_\_\_\_\_ Difficulty Swallowing\_\_\_\_\_ Discharge/Drainage\_\_\_\_\_

**CARDIOVASCULAR: I have none of the symptoms listed \_\_\_\_\_**

Chest Pain\_\_\_\_\_ Palpitations\_\_\_\_\_ Leg Swelling\_\_\_\_\_

**RESPIRATORY: I have none of the symptoms listed \_\_\_\_\_**

Coughing up blood\_\_\_\_\_ Wheezing\_\_\_\_\_ Shortness of Breath\_\_\_\_\_ Cough\_\_\_\_\_

Sputum Production\_\_\_\_\_ Recent Infection\_\_\_\_\_

**GASTROINTESTINAL: I have none of the symptoms listed \_\_\_\_\_**

Abdominal pain\_\_\_\_\_ Vomiting w/wo blood\_\_\_\_\_ Nausea\_\_\_\_\_ Blood in stool\_\_\_\_\_

Constipation\_\_\_\_\_ Diarrhea\_\_\_\_\_

**GENITOURINARY: I have none of the symptoms listed \_\_\_\_\_**

Painful urination\_\_\_\_\_ Blood in urine\_\_\_\_\_ Venereal Disease\_\_\_\_\_ Difficult urination\_\_\_\_\_

Sexual problems\_\_\_\_\_ Menstrual Problems\_\_\_\_\_ Pregnant\_\_\_\_\_ Menopausal\_\_\_\_\_

**MUSCULOSKELETAL: I have none of the symptoms listed: \_\_\_\_\_**

Joint swelling\_\_\_\_\_ Stiffness\_\_\_\_\_ Cramping\_\_\_\_\_ Infection\_\_\_\_\_

**ENDOCRINE: I have none of the symptoms listed \_\_\_\_\_**

Changes in urination\_\_\_\_\_ Changes in heat or cold intolerance\_\_\_\_\_

Changes in appetite/thirst/sweating\_\_\_\_\_

**PSYCHIATRIC: I have none of the symptoms listed \_\_\_\_\_**

Depression\_\_\_\_\_ Anxiety\_\_\_\_\_ Suicidal Thoughts\_\_\_\_\_ Mood Changes\_\_\_\_\_

**PATIENT SIGNATURE**\_\_\_\_\_

**Date:**\_\_\_\_\_

**PHYSICIAN SIGNATURE**\_\_\_\_\_

**Date:**\_\_\_\_\_

Date Reviewed: \_\_\_\_\_ Signed: \_\_\_\_\_

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