NEW PATIENT INFORMATION QUESTIONAIRE

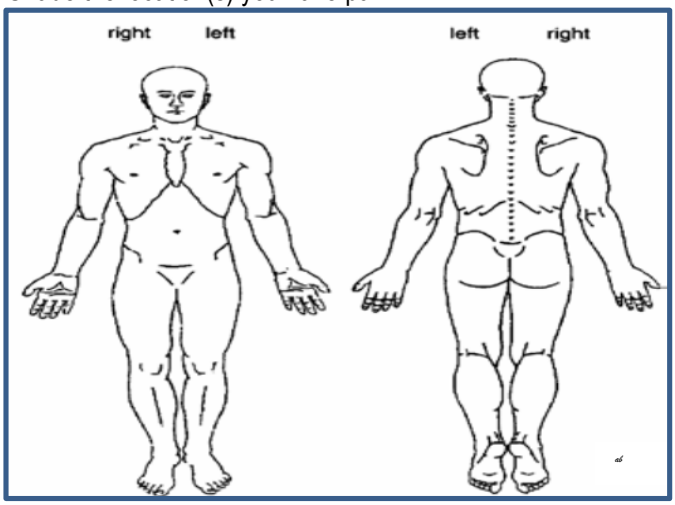
Last Name	First Name	Middle Name	Male/Female	Age
_____	_____	_____	_____	_____

Referring Physician
Physician's Name:_____
Practice Name:_____

Family Physician
Physician's Name:_____
Practice Name:_____

When did your pain begin?_____
Was there an inciting event?_____
Has the pain changed?_____

Shade the location(s) you have pain:



Circle the words below that describe your pain:

Burning	Aching	Sharp	Constant
Electric	Throbbing	Stabbing	Occasional
Prickling	Dull	Shooting	Frequent
Numbing	Cramping	Stinging	Rare

Circle the number that describes your average pain

|----------|----------|

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

Anything make it **better**? (heat, cold, lying down Sitting, walking, coughing) **Worse**? (heat, cold, lying down sitting, walking, coughing

Circle activities affected by your pain. (sleep, leisure, Household chores, work/school, social interaction, Sexual activity) Explain_____
_____

List all prior treating physicians:_____
_____

Circle all prior medications used:

Tramadol	Hydrocodone	Percocet	Dilaudid
Oxycodone	Oxycontin	Morphine	MS Contin
Duragesic	Methadone	Tapentadol	Opana
Exalgo	Neurontin	Lyrica	topamax
Effexor	Cymbalta	Mobic	Celebrex

List adverse reactions to above:_____
_____
_____

List Physical Therapy location/dates:_____
_____
_____

Circle previous treatments you have had for pain:

Acupuncture	Biofeedback	Brace
Chiropractor	Epidural	Exercise
Physical therapy	Facet block	Hypnosis
Massage	Nerve block	Psychotherapy
Surgery	TENS	Trigger points

_____
HR:____ BP:____ RR:____ Sat___ Wt____ T____

Provider Notes:

Provider Signature:_____ **Date:**_____

Past Medical History

List all allergies:_____

List current medications including dose if not already reviewed during visit_____
_____
_____
_____

List all medical conditions if not already reviewed during visit:_____
_____
_____
_____

List all prior surgeries with dates:_____
_____
_____
_____
_____

Circle the number to describe your average daily function

|----------|----------|----------|

0 1 2 3 4 5 6 7 8 9 10

In Bed — Hi Function

Social History

Do you use tobacco products?_____
If yes what type?_____ How often?_____
If former smoker quit date?_____
Do you use alcohol?_____ Type and number weekly?
_____
Do you use illegal drugs?_____
Who lives at home with you?_____
Are you married/single/divorced/widowed?_____
What is your occupation?_____
Do you have disability or pending legal case?_____
Highest grade level completed?_____

Family History

Please circle any of the following that run in your family:

Similar Pain	Arthritis	Cancer
Lupus	Depression	Stroke
Heart Disease	Diabetes	Bleeding D/O
Substance Abuse	Other:	

Patient Signature: _____

Date:_____ **Time:**_____

Provider Signature:_____ **Date:**_____

Review of Systems

Circle all past/present signs or symptoms

Constitutional

Change in Appetite	Chills	Sweating
Fever	Fatigue	Weight Change

HENT

Facial Swelling	Neck pain	Neck stiffness
Ear discharge	Hearing loss	Ear Pain
Congestion	Sinus Pressure	Sore Throat

Eyes

Eye Pain	Eye Redness	Photophobia
Visual disturbance		

Respiratory

Apnea	Chest tightness	Cough
Shortness of breath	Wheezing	

Cardiovascular

Chest pain	Pacemaker	Palpitations
Anticoagulation	Hypertension	Cardiac Stent

Gastrointestinal

Abdominal Pain	Diarrhea	Nausea/vomiting
Ulcers	Constipation	Rectal Pain

Endocrine

Heat intolerance	Cold Intolerance	Increased urination
High glucose	Thyroid disease	

GU

Difficulty urinating	Hesitancy	Flank pain
Frequency	Urgency	Incontinence

Musculoskeletal

Arthralgia	Back Pain	Gait Disturbance
Joint Swelling	Myalgia	Fibromyalgia

Skin

Color Changes	Rash	Pallor
Wounds	Pain to light touch	Swelling

Allergy/Immune

Tape allergies	Food allergies	immunocompromised

Neuro

Headache	Lightheadedness	Numbness
Seizures	Dizziness	Weakness
Tremors	Speech Changes	Confusion

Hematologic

Anticoagulation Coumadin/plavix	HIV	Bleeding disorder

Psychiatric

Agitation	Suicidal thoughts	Confusion
Dec. Concentration	Sleep disturbance	Hallucinations
Substance abuse	Nervous	Depression

Specific Question/Concern:_____
_____
_____
_____