

NEW PATIENT QUESTIONARE

NAME: _____ DOB: _____ SS# _____

ADDRESS: _____

REFERRED BY: _____ PRIMARY PHYSICIAN: _____

*When did your pain problems begin ____/____/____ *HOW? Gradually: ____ Accident/injury

*Describe briefly the incident that led to your pain.

*What types of testing have been done?

X-ray____ CT____ MRI____ Bone Scan____
EMG____ Discogram____ Myelogram____ or other____

*What treatment has there been?

Anti-inflammatory medications____ muscle relaxant medications____
Anti-depressant medications____ Narcotic pain medications____
Exercise____ Cold/heat____ Ultrasound____ TENS____
Back brace____ Traction____ Massage____ Chiropractic____
Biofeedback/relaxation____ Counseling____ Work hardening____
Epidural injection____ Acupuncture____ Surgery____
Pain management program____ Trigger point injections____

*SINCE the beginning, is your pain better____ worse____ unchanged____

*IS the pain constant____ or are there pain free periods____

*When is your pain the worst?

Morning____ Afternoon____ Evening____ Night____

*WHAT is your least and greatest pain levels (circle appropriate numbers)

None 1-2-3-4-5-6-7-8-9-10-Unbearable

*Which of the following makes your pain better or worse?

Better: sitting____ standing____ lying____ walking____ lifting____ bending____ coughing/sneezing____
Worse: sitting____ standing____ lying____ walking____ lifting____ bending____ coughing/sneezing____

*Do you also have: weakness____ bowel or bladder problems____ diminished appetite____
anxiety____ weight loss or gain____ depression____ fatigue____ poor sleep____ headaches____
unexplained fevers/chills____ heart problems (irregular heart beats, heart failure, chest pain)____ lung
problems (asthma, COPD)____ stomach problems (ulcer, reflux, gastritis)____ bleeding
disorders____ current infection____ swollen joints____ rashes____

Patient Name: _____

Date: _____

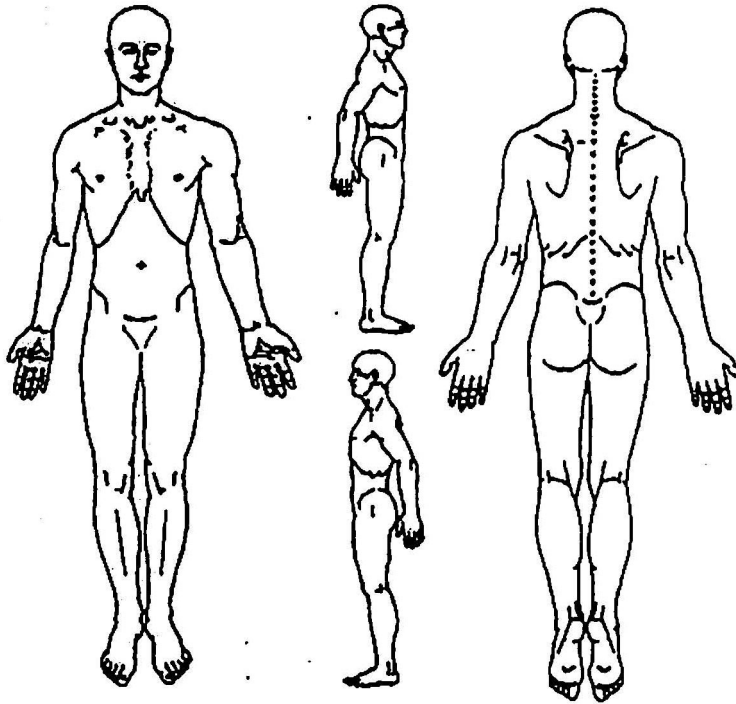
Date of Birth: _____

Primary Doctor: _____

Please show the location of your pain by drawing on the figures below:

Allergies: _____

Current Medications:



How severe is your pain on average? (0=no pain, 10=worse pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

Social History:

Do you smoke (if yes, how many packs per day)

Do you drink alcohol:

Do you have a history of drug or alcohol abuse:

Married:

Children:

Occupation:

Family History:

Heart Disease:

Cancer:

Diabetes:

Surgical History: _____
