

NEW PATIENT QUESTIONNAIRE

Date _____

Referring Physician's Name _____

Referring Physician's Telephone _____

Pharmacy Name _____ Telephone _____

Name _____ DOB _____ Age _____

Height _____ Weight _____ Gender: M F

Marital Status: Single Married Cohabiting Separated Divorced Widowed

With whom do you live: Alone Spouse Child (Children) Parent(s) Others _____

List all medical problems:

Do you have stomach ulcers? Yes No kidney problems? Yes No

Do you have psychological problems? Yes No If yes, please explain:

List all surgeries and dates:

Could you be pregnant? Yes No N/A LMP _____ (if this changes, notify MD or NP)

Do you smoke? Yes No packs per day _____ per year _____

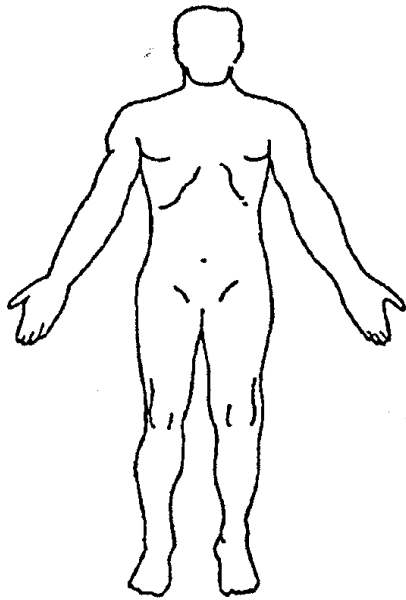
Do you drink alcohol? Yes No How much: _____ How often: _____

Do you use illicit (street drugs)? Yes No drug(s) _____ last used _____

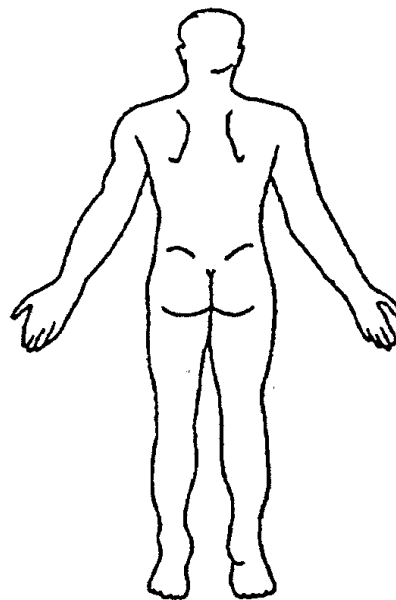
Allergies to Medications	Reaction
1.	
2.	
3.	
4.	

PAIN HISTORY

On the drawings below, shade in the areas in which you are having pain. Indicate the worst area with an X.



Front



Back

When did the pain start and how long has the pain been present in this area?

Did an accident or other event precipitate your pain? If yes, please describe:

Describe the pain? Circle all that apply:

Burning Sharp Shooting Throbbing Aching Pins/Needles
Numbness Cutting Cramps Gripping Electrical Dull Other: _____

When is the pain worst? Circle all that apply:

Morning Afternoon Evening Night Changing positions Other: _____

Does your pain interfere with ...? Circle all that apply:

Appetite Sleep Sex Cooking Social life Self-care Family life
Job performance House chores Shopping Driving Hobbies/exercise

If pain limits your activities, please fill in all that apply:

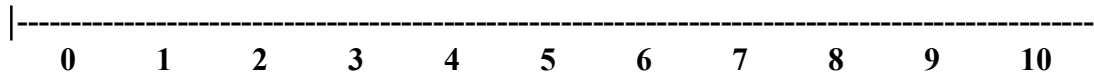
I can't tolerate **walking** more than _____ blocks.
I can't tolerate **sitting** more than _____ minutes.
I can't tolerate **standing** more than _____ minutes.
I can't tolerate **lying** more than _____ minutes.

How frequently do you have your pain? Circle all that applies:

_____ times (daily weekly monthly) AND lasts _____ (minutes hours).

How do you rate the severity of your pain?

On the line below, please mark with an **X**, how much pain you are having right now. With an **L**, when the pain is at its **least**. With a **W**, when the pain is at its **worst**.



NO PAIN

WORST PAIN

What makes your pain better?

Describe all failed treatments and failed medications: N/A

Please list **ALL** current medications with dosages. Start with pain medications, include herbal and OTC medications.

Medication	Dosage & Frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

Please circle any treatments you have had for pain:

	Dates	Was the treatment helpful?
Nerve Blocks (Injections)	_____	_____
Electrical Stimulation	_____	_____
Physical Therapy	_____	_____
Psychotherapy	_____	_____
Biofeedback/Hypnosis	_____	_____
Chiropractic Manipulation	_____	_____
Accupuncture	_____	_____
Other	_____	_____

Please circle the tests you have undergone:

Xray CT Scan MRI scan Bone Scan EMG Other: _____

Were you injured on the job? Yes No

Are you currently involved in litigation? _____ **If yes, please explain:**

Are you currently working? _____ **If no, when did you stop?** _____ **Why?**

