Weill Cornell Medicine
Pain Management

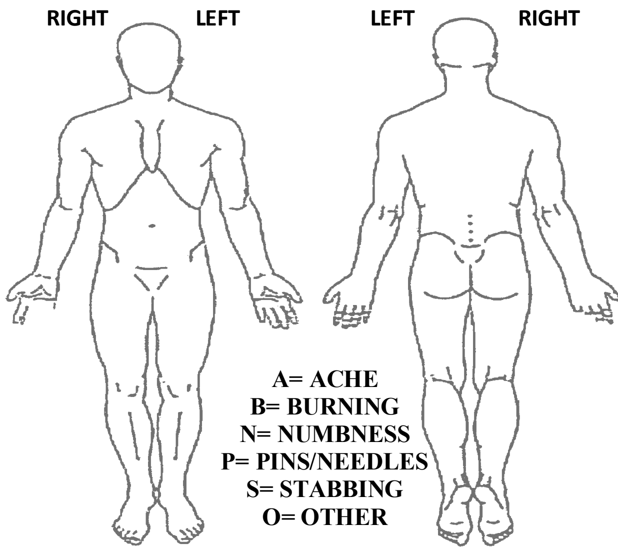
NEW PATIENT QUESTIONNAIRE

DATE: ________________

Patient Name:______________________________ **Date of Birth**:_____/_____/________ **Gender**: M or F
Phone Number: _____________________ **Address**:____
Referred by _____________________ **Insurance Carrier/ ID or Policy #** ______________________________________
Reason for Visit: ____
Have you had a history of accident or injury? If **yes**, please explain and answer the next questions:
____

- Was the accident at work? Yes or No
- Was the injury due to a car accident? Yes or No
- Are you using Workman's Compensation? Yes or No
- Are you currently involved in litigation? Yes or No

On the diagram below, please mark where you are feeling your symptoms with the appropriate letters.



Please note if other: ____________________

On a scale of 0 to 10, please circle your level of pain or discomfort 0 being none and 10 being unbearable for the following areas:

1. Neck Pain:	0	1	2	3	4	5	6	7	8	9	10
2. Left Shoulder Pain:	0	1	2	3	4	5	6	7	8	9	10
3. Right Shoulder Pain:	0	1	2	3	4	5	6	7	8	9	10
4. Left Arm Pain:	0	1	2	3	4	5	6	7	8	9	10
5. Right Arm Pain:	0	1	2	3	4	5	6	7	8	9	10
6. Back Pain:	0	1	2	3	4	5	6	7	8	9	10
7. Left Hip/Buttock Pain:	0	1	2	3	4	5	6	7	8	9	10
8. Right Hip/Buttock Pain:	0	1	2	3	4	5	6	7	8	9	10
9. Left Leg Pain:	0	1	2	3	4	5	6	7	8	9	10
10. Right Leg Pain:	0	1	2	3	4	5	6	7	8	9	10
11. Left Foot Pain:	0	1	2	3	4	5	6	7	8	9	10
12. Right Foot Pain:	0	1	2	3	4	5	6	7	8	9	10

If you are <u>not experiencing pain</u> as a symptom, please skip Questions 1-7.

1. When did the pain begin? ____________________

Duration of Pain: ____________________________

Overall the pain is:

Improved Worse Stable

2. Quality of Pain (check all that applies)?

Sore	Aching Burning	
Sharp	Dull	Tender
Stabbing	Tingling	Cramping
Shooting	Pulling	Radiating
Unsure	Throbbing	

3. What makes the pain better (check all that applies)?

Heat	Cold		Bend Forward
Bend Back	Change Position	Sitting	
Standing	Walking		Twisting
Movement	Change in weather		Lying Supine
Rest	Valsalva		Coughing/Sneezing
Nothing	Sex		N/A

4. What makes the pain worse (check all that applies)?

Heat	Cold		Bend Forward
Bend Back	Change Position	Sitting	
Standing	Walking		Twisting
Movement	Change in weather		Lying Supine
Rest	Valsalva		Coughing/Sneezing
Nothing	Sex		N/A

5. Pain interferes with:

Sleep, Appetite, Sex
Self-Care, Hobbies, Job Performance
Driving, Social Life, Exercise
Lifting, Traveling, Shopping
Household Chores, Cooking
Other _______________

6. When is the pain worst? (Circle one)

Morning Afternoon Evening Night

7. If pain limits activity, please full 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.

8. Do you experience weakness? Yes or No

If yes, please describe (include location)____________________________

Have you had any of the following imaging studies? If yes, please include the date.

IF SO, PLEASE FORWARD A COPY OF THE REPORT TO THE OFFICE PRIOR TO YOUR APPOINTMENT

X-ray ________________________ Bone Scan_____________________ MRI______________________________
CT scan ______________________ EMG ________________________

Below, indicate past treatments for your neck/back condition and include the date of treatment:

Nerve Block___________________________
Physical Therapy_______________________
Acupuncture___________________________
Chiropractic___________________________
Other__________________________________
Steroid Injections_____________________________
Psychotherapy_________________________________
Surgery_______________________________________
Failed Medications_____________________________

If surgery is recommended, what would be your timeframe available for scheduling? ___________________________

REVIEW OF SYSTEMS:

GENERAL
Fatigue □ NO □ YES
Weight loss □ NO □ YES
Weakness □ NO □ YES
Swollen Lymph nodes □ NO □ YES

HEAD
Visual problems □ NO □ YES
Ear pain, decreased hearing □ NO □ YES
Difficulty swallowing □ NO □ YES
Other_________________________

CHEST, HEART, AND LUNGS
Shortness of breath □ NO □ YES
Chest pain or pressure attacks □ NO □ YES
Frequent cough □ NO □ YES
Swollen ankles □ NO □ YES
Valve disorder □ NO □ YES
Sleep Apnea □ NO □ YES
DVT □ NO □ YES
Stents □ NO □ YES
Other_________________________

ENDROCRINE
Thyroid condition □ NO □ YES
Diabetes □ NO □ YES
Other___________________________

KIDNEY
Difficulty in passing urine □ NO □ YES
Getting up at night to urinate □ NO □ YES

GASTROINTESTINAL
Poor appetite □ NO □ YES
Indigestion or vomiting □ NO □ YES
Change in bowel habits □ NO □ YES
Pass blood from rectum □ NO □ YES

MUSCULOSKELETAL
Decreased Range of Motion □ NO □ YES
Joint Swelling □ NO □ YES
Joint Stiffness □ NO □ YES
Muscle Aches/Pains □ NO □ YES

NEUROLOGICAL
Dizziness/Vertigo □ NO □ YES
Headaches □ NO □ YES
Strokes □ NO □ YES
Seizures □ NO □ YES
Tremor □ NO □ YES
Numbness □ NO □ YES

PSYCHOLOGICAL
Anxiety □ NO □ YES
Depression □ NO □ YES
Other____________________________

History of Cancer? Yes No
If yes, type: __________________________
Chemo: Yes No
Radiation: Yes No

Please notify the MD/NP/PA/RN if you are pregnant: Yes No

Current Medication:	Dosage:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Any allergies to: Shellfish Iodine Latex Contrast/IV dye

Allergies	Reaction
1.	
2.	
3.	

Social History:

1. **Are you a:** Current Smoker / Never Smoker / Former Smoker **Quit Date:** _______________
   Type: ______________ **Packs/day**:_____________ **Years:** _____________
2. **Do you use chewing and/or smokeless tobacco?** Yes or No **Have you quit?** Yes or No

When? _______________

3. **Do you drink alcohol?** Yes or No **Type(s):** ______________ **Amount**: ___________ **How often**:__________
4. **Do you use illicit (street) drug**s? Yes or No **Type(s):** ______________ **Last used**:__________________
5. **Marital Status**: Single Married Cohabitating Separated Divorced Widowed
6. **Who do you live with**? Alone Spouse Children Parents Other:___________________
7. **What is your occupation**? ________________________
8. **Are you disabled**? Yes or No **If yes, note disability**: _____________________________

Medical/Personal History:

Are you right- or left-handed? Right Left Ambidextrous
Past Medical History:

____
____

Past Surgical History and Dates:

____
____

Family Medical History:

____

Please share any other information you would like us to know:

____

____

Preferred Pharmacy:

Name:___________________________________ Phone Number:____________________________________

Address:____

If this form was completed by someone other than the patient, please list the name, relation to the patient and the reason that the patient was unable to complete the form.

Form Completed by____ Date________________________