

Please note which department or physician you are requesting to see: _____
Neurosurgery Neurology Pain Management Physiatry/Rehab Medicine

NEW PATIENT QUESTIONNAIRE

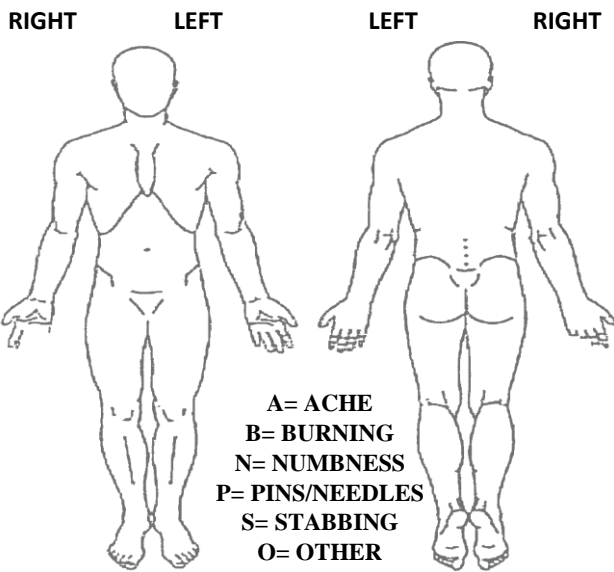
DATE: _____

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 three questions:

- Was the accident at work? 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 not experiencing pain 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)?

- | | | |
|-----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Sore | <input type="checkbox"/> Aching | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Tender |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Pulling | <input type="checkbox"/> Radiating |
| <input type="checkbox"/> Unsure | <input type="checkbox"/> Throbbing | |

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

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Bend Forward |
| <input type="checkbox"/> Bend Back | <input type="checkbox"/> Change Position | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Movement | <input type="checkbox"/> Change in weather | <input type="checkbox"/> Lying Supine |
| <input type="checkbox"/> Rest | <input type="checkbox"/> Valsalva | <input type="checkbox"/> Coughing/Sneezing |
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Sex | <input type="checkbox"/> N/A |

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

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Bend Forward |
| <input type="checkbox"/> Bend Back | <input type="checkbox"/> Change Position | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Movement | <input type="checkbox"/> Change in weather | <input type="checkbox"/> Lying Supine |
| <input type="checkbox"/> Rest | <input type="checkbox"/> Valsalva | <input type="checkbox"/> Coughing/Sneezing |
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Sex | <input type="checkbox"/> N/A |

5. Pain interferes with:

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

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 _____ Steroid Injections _____
 Physical Therapy _____ Psychotherapy _____
 Acupuncture _____ Surgery _____
 Chiropractic _____ Failed Medications _____
 Other _____

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

<p>REVIEW OF SYSTEMS:</p> <p>GENERAL Fatigue <input type="checkbox"/> NO <input type="checkbox"/> YES Weight loss <input type="checkbox"/> NO <input type="checkbox"/> YES Weakness <input type="checkbox"/> NO <input type="checkbox"/> YES Swollen Lymph nodes <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>HEAD Visual problems <input type="checkbox"/> NO <input type="checkbox"/> YES Ear pain, decreased hearing <input type="checkbox"/> NO <input type="checkbox"/> YES Difficulty swallowing <input type="checkbox"/> NO <input type="checkbox"/> YES Other _____</p> <p>CHEST, HEART, AND LUNGS Shortness of breath <input type="checkbox"/> NO <input type="checkbox"/> YES Chest pain or pressure attacks <input type="checkbox"/> NO <input type="checkbox"/> YES Frequent cough <input type="checkbox"/> NO <input type="checkbox"/> YES Swollen ankles <input type="checkbox"/> NO <input type="checkbox"/> YES Valve disorder <input type="checkbox"/> NO <input type="checkbox"/> YES Sleep Apnea <input type="checkbox"/> NO <input type="checkbox"/> YES DVT <input type="checkbox"/> NO <input type="checkbox"/> YES Stents <input type="checkbox"/> NO <input type="checkbox"/> YES Other _____</p>	<p>ENDOCRINE Thyroid condition <input type="checkbox"/> NO <input type="checkbox"/> YES Diabetes <input type="checkbox"/> NO <input type="checkbox"/> YES Other _____</p> <p>KIDNEY Difficulty in passing urine <input type="checkbox"/> NO <input type="checkbox"/> YES Getting up at night to urinate <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>GASTROINTESTINAL Poor appetite <input type="checkbox"/> NO <input type="checkbox"/> YES Indigestion or vomiting <input type="checkbox"/> NO <input type="checkbox"/> YES Change in bowel habits <input type="checkbox"/> NO <input type="checkbox"/> YES Pass blood from rectum <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>MUSCULOSKELETAL Decreased Range of Motion <input type="checkbox"/> NO <input type="checkbox"/> YES Joint Swelling <input type="checkbox"/> NO <input type="checkbox"/> YES Joint Stiffness <input type="checkbox"/> NO <input type="checkbox"/> YES Muscle Aches/Pains <input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<p>NEUROLOGICAL Dizziness/Vertigo <input type="checkbox"/> NO <input type="checkbox"/> YES Headaches <input type="checkbox"/> NO <input type="checkbox"/> YES Strokes <input type="checkbox"/> NO <input type="checkbox"/> YES Seizures <input type="checkbox"/> NO <input type="checkbox"/> YES Tremor <input type="checkbox"/> NO <input type="checkbox"/> YES Numbness <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>PSYCHOLOGICAL Anxiety <input type="checkbox"/> NO <input type="checkbox"/> YES Depression <input type="checkbox"/> NO <input type="checkbox"/> YES Other _____</p> <p>History of Cancer? Yes No If yes, type: _____</p> <p>Chemo: Yes No Radiation: Yes No</p> <p>Please notify the MD/NP/PA/RN if you are pregnant: Yes No</p>
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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) drugs?** Yes or No **Type(s):** _____ **Last used:** _____
5. **Marital Status:** Single Married Cohabiting 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 _____