NEW PATIENT QUESTIONNAIRE

Last Name	First Name	Middle Name	Sex	Date of Birth
_____	_____	_____	_____	_____

Referring Physician: _____

Family Physician: _____

Past Medical History

Diabetes (high blood sugar): Yes No

Bleeding Disorder: Yes No

Cancer: Yes No Type: _____

Other Medical Conditions:

_____

_____

_____

_____

_____

Medication Allergies and Reaction:

_____

_____

_____

_____

_____

Current Medications / Dose / How often taken

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you on blood thinners? (Y/N)

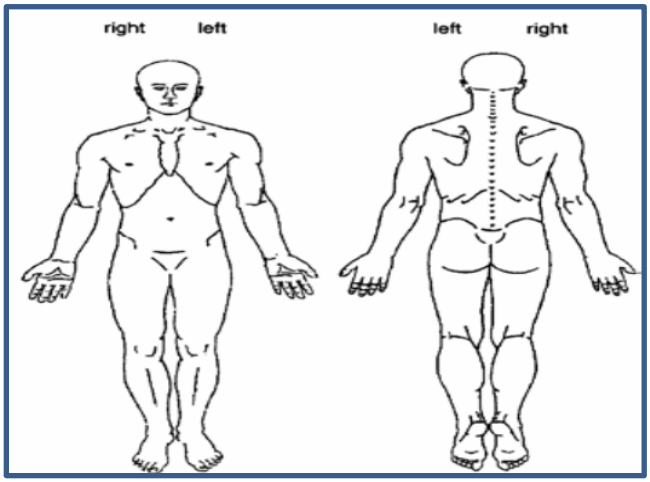
If yes, which one?

_____

When did your pain begin? _____

Was there an inciting event? _____

Shade the locations you have pain:



How would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

What makes your pain **better**? (i.e. sitting, lying down, heat, cold, standing, etc) _____

_____

What makes your pain **worse**? (i.e. movement, walking, bending over, weather, etc) _____

_____

Other Symptoms or Concerns:

_____

_____

_____

_____

_____

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_____	_____	_____	_____	_____

Family History

Circle any of the following that run in your family:

Similar pain	Arthritis	Cancer
Depression	Bleeding disorder	Substance abuse

Social History

Do you use tobacco products? YES / NO

Do you drink alcohol? YES / NO

Do you use illegal drugs? YES / NO

Previous Surgeries and Date of Surgery:

_____

_____

_____

_____

_____

PREVIOUSLY TRIED THERAPIES:

Physical Therapy: YES / NO
If yes where:_____

Chiropractic Care: YES / NO
Massage Therapy: YES / NO
Heat/Ice Pool Therapy: YES / NO
TENS unit: YES / NO
Brace/Orthotic: YES / NO

PREVIOUSLY TRIED PROCEDURES:

Epidural Steroid Injection: YES / NO
Facet joint/medial branch nerve block
Radiofrequency Ablation (RFA): YES / NO
Joint Injections: YES / NO
Trigger point injection: YES / NO
Spinal Cord Stimulation: YES / NO
Surgery: YES / NO

PREVIOUSLY TRIED MEDICATIONS:

Cymbalta/duloxetine: YES / NO
Amitriptyline/Elavil: YES / NO
Nortriptyline/Pamelor: YES / NO
Effexor or Venlafaxine: YES / NO

Membrane Stabilizers
Gabapentin: YES / NO
Lyrica/Pregabalin: YES / NO
Topamax/Topiramate: YES / NO

Muscle Relaxants
Tizanidine/Zanaflex: YES / NO
Flexeril/cyclobenzaprine: YES / NO
Robaxin/Methocarbamol: YES / NO
Baclofen: YES / NO

NSAIDS
Advil/Motrin/Ibuprofen: YES / NO
Celebrex: YES / NO
Mobic/meloxicam: YES / NO
Tylenol/acetaminophen: YES / NO

Opioids
Hydrocodone: YES / NO
oxycodone: YES / NO
tramadol: YES / NO
Butrans/Belbuca: YES / NO
morphine: YES / NO

Any other information you would like for our team to know:

_____

_____

_____

Patient Signature: _____

Date: _____ **Time: _____**

Provider Signature: _____

Date: _____ **Time: _____**