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NEW PATIENT VISIT QUESTIONNAIRE

Name: _____ Sex: M / F Age: _____

Appointment Date: _____/_____/_____

Medical History

High Blood Pressure			Lung Cancer			Seizures		
High Cholesterol			Colon Cancer			Shingles		
Heart Disease			Breast Cancer			Osteoporosis		
Diabetes			Prostate Cancer			Osteoarthritis		
Heart Failure			Bone Cancer			Rheumatoid Arthritis		
Arrhythmia			Skin Cancer			Spondylosing Ankylosis		
Heart Attack			Blood Clot (DVT/PE)			Urinary Retention		
COPD			Bleeding Disorder			Urinary Incontinence		
Emphysema			Thyroid disease			Depression		
Asthma			Kidney Disease			Anxiety		
Stomach/Peptic Ulcers			Liver Disease			other:		
Gastrointestinal Bleeding			Stroke			other:		
Heartburn/Reflux (GERD)			Headaches			other:		

Surgical History

Name/Type	When

Hospitalizations

Where	When	Why

*Patient Name*_____

Allergies to Medications	yes	no
Penicillin	☐	☐
Sulfa	☐	☐
Lidocaine	☐	☐
Steroid	☐	☐
Other _____ _____		
_____ _____		

Allergies to Food	yes	no
Iodine	☐	☐
Dye	☐	☐
Shellfish ☐	☐	
Eggs	☐	☐
Nuts	☐	☐
Latex/Rubber/Tape	☐	☐

Social History

Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Smoking: Y N

☐ Quit When?_____
☐ Still Smoking ____Pack per Day How many years?_____

Alcohol: Y N

How many drinks per week?_____
☐ Quit When?_____

Marijuana: Y N ☐ Quit When?_____ ☐ Still Using How often_____
Cocaine Y N ☐ Quit When?_____ ☐ Still Using How often_____
Heroin Y N ☐ Quit When?_____ ☐ Still Using How often_____

Family History

	Alive	Heart	Diabetes	Stroke	Cancer	Arthritis	Migraines	Depression	Osteoporosis
Father									
Mother									
Brother(s)									
Sister(s)									
Son(s)									
Daughter(s)									

*Patient Name*_____

New Patient Visit Questionnaire cont.

Do you have a living will? Y N

Do you have a health care proxy? Y N

- If yes, please list contact information below:

Name: _____ Relationship: _____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone #: _____ Cell Phone#: _____

Work Phone#: _____ Email: _____

Current Medications
(including vitamins, herbal supplements and over-the-counter medications)

Medication (name)	Amount	Frequency Taken	Approximate start date of medication
Example: Metoprolol	25 mg	Once daily	2005

*Patient Name*_____

New Patient Visit Questionnaire cont.

Review of Systems

	Y	N
CONSTITUTIONAL		
Recent changes in weight?		
Fevers?		
Chills?		
Night sweats?		
Decreased appetite?		
Fatigue?		
Inability to sleep?		
EYES		
Recent change in vision?		
Double vision?		
Eye pain?		
EARS/NOSE/MOUTH/THROAT		
Hearing loss?		
Ringing in the ears?		
Pain in the ears?		
Nasal congestion?		
Runny nose?		
Nosebleeds?		
Sore throat?		
CARDIOVASCULAR		
Chest pains?		
Palpitations?		
Swelling in the legs or feet?		
Leg cramps with walking?		
Awakening feeling short of breath?		

	Y	N
GASTROINTESTINAL		
Nausea/Vomiting?		
Diarrhea?		
Blood in stool?		
Constipation?		
Abdominal pains or cramps?		
Reflux?		
Incontinence?		
GENITOURINARY		
Changes in frequency?		
Urgency?		
Incontinence?		
Pain with urination?		
Blood in urine?		
DERMATOLOGICAL		
New rashes or ulcers?		
Hair loss?		
Changes in skin color?		
ENDOCRINE		
Intolerance to heat?		
Intolerance to cold?		
NEUROLOGICAL		
Weakness?		
Seizures?		
Memory loss?		
Dizziness or fainting?		

*Patient Name*_____

New Patient Visit Questionnaire cont.

Psychosocial History

	yes	no
Have you filed any legal claims related to your pain?	☐	☐
Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your pain?	☐	☐

Have you ever considered suicide? ☐ ☐

Are you suffering from currently or have a history of alcoholism? ☐ ☐

Have you ever been in a detox program for drug abuse? ☐ ☐

DESCRIBE YOUR PAIN

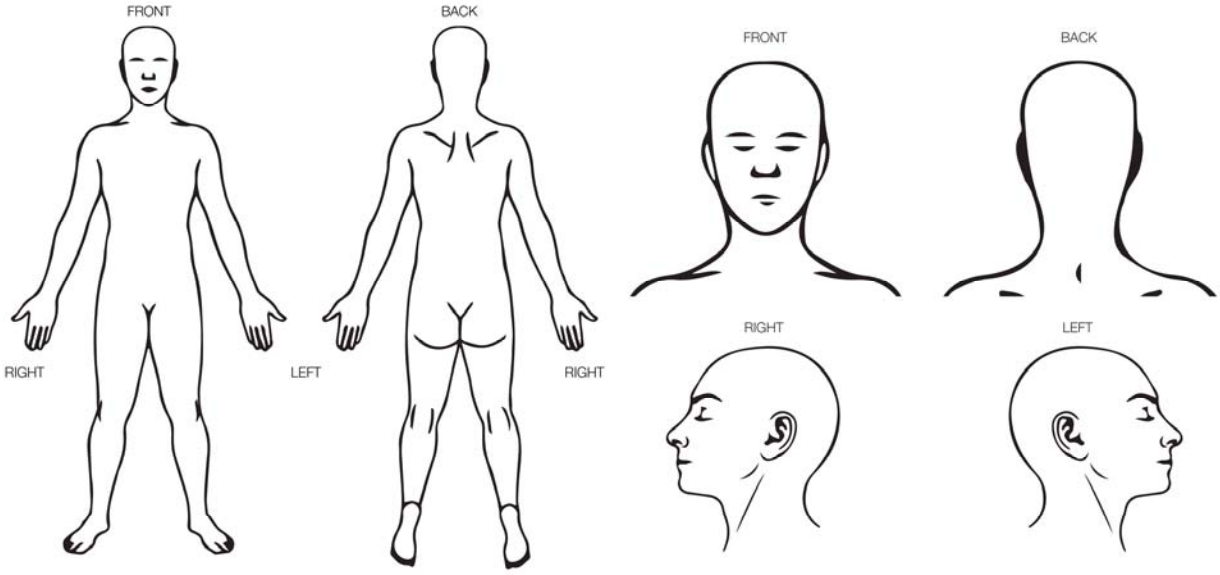
(1) What is the main problem or area of pain that your are seeking treatment for?

_____

_____

_____

Please mark the area(s) where your pain is located:



*Patient Name*_____

Initial Visit Pain Questionnaire cont.

ONSET & DURATION

(2) Please describe the onset of the your pain. How did it begin?

_____

_____

_____

(3) When did it begin? (Approximate date): _____

QUALITY AND INTENSITY

	None	Mild	Moderate	Severe
Throbbing	0)_____	1)_____	2)_____	3)_____
Shooting	0)_____	1)_____	2)_____	3)_____
Stabbing	0)_____	1)_____	2)_____	3)_____
Sharp	0)_____	1)_____	2)_____	3)_____
Cramping	0)_____	1)_____	2)_____	3)_____
Gnawing	0)_____	1)_____	2)_____	3)_____
Hot-Burning	0)_____	1)_____	2)_____	3)_____
Aching	0)_____	1)_____	2)_____	3)_____
Heavy	0)_____	1)_____	2)_____	3)_____
Tender	0)_____	1)_____	2)_____	3)_____
Splitting	0)_____	1)_____	2)_____	3)_____
Tiring-Exhausting	0)_____	1)_____	2)_____	3)_____
Sickening	0)_____	1)_____	2)_____	3)_____
Fearful	0)_____	1)_____	2)_____	3)_____
Punishing-Cruel	0)_____	1)_____	2)_____	3)_____

*Patient Name*_____

Rate the intensity of your pain on the two scales below. Make a mark on the line to indicate where your pain falls between *NO PAIN* and *WORST POSSIBLE PAIN* and then circle the appropriate number on the second scale.

NO PAIN — WORST POSSIBLE PAIN

Circle one of the following words that best describes your current pain:

0 No Pain
1 Mild
2 Discomforting
3 Distressing
4 Excruciating

(4) Do you feel numbness? Y N

(5) Do you feel pins & needles? Y N

(6) Do you feel electricity? Y N

TIMING

(7) How often is your pain present (please check one)?

- ☐ Constant (100% of the time)
- ☐ Frequent (75% of the time)
- ☐ Intermittent (50% of the time)
- ☐ Occasional (25% of the time)

(8) Circle your current pain level ("0" is no pain and "10" is the worst pain you could ever imagine):

0 1 2 3 4 5 6 7 8 9 10

(9) Circle your average pain over the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

(10) Circle your best pain score over the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

*Patient Name*_____

Initial Visit Pain Questionnaire cont.

(11) Circle your worst pain score over the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

RELIEVING AND AGGRAVATING FACTORS

Of the activities listed below, please check the box indicating whether it makes your pain better, worse or the same:

	Decrease (12)	Increase (13)	No Effect (14)
Lying Down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Going up hill/stairs	☐	☐	☐
Going down hill/stairs	☐	☐	☐
Leaning forward	☐	☐	☐
Leaning backward	☐	☐	☐
Hunching forward on cart/walker	☐	☐	☐
Exercise	☐	☐	☐
Medication	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel Movements	☐	☐	☐
Eating/Chewing	☐	☐	☐
Swallowing	☐	☐	☐

PREVIOUS DIAGNOSTIC STUDIES

Please indicate the approximate date of the relevant tests listed below, if any, and the results:

(15) MRI: _____

(16) CT: _____

*Patient Name*_____

Initial Visit Pain Questionnaire cont.

(17) Xray: _____

(18) EMG: _____

PREVIOUS PAIN TREATMENT(S)

What has been done so far for you pain and how well has it worked?

Please provide the date for all of the treatments you have tried prior to today and then check the appropriate box for how well it worked:

	Date (19)	Excellent Relief (20)	Moderate Relief (21)	No Relief (22)
Physical Therapy	_____	☐	☐	☐
Chiropractic	_____	☐	☐	☐
Trigger Point Inj	_____	☐	☐	☐
Epidural/Nerve Block	_____	☐	☐	☐
Massage Therapy	_____	☐	☐	☐
TENS Therapy	_____	☐	☐	☐
Acupuncture	_____	☐	☐	☐
Surgery	_____	☐	☐	☐
Biofeedback	_____	☐	☐	☐
Psychotherapy	_____	☐	☐	☐
Other:_____	_____	☐	☐	☐

FUNCTIONAL LIMITATIONS

(23) How man blocks can you walk before having to stop from pain? _____

(24) How long can can you stand before you have to sit down?

_____ hours _____ minutes

(25) How long can you sit before having to get up and/or change positions?

_____ hours _____ minutes