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QUESTIONNAIRE TO BE FILLED IN BY ALL NEW PATIENTS

NAME: ________________________ **DATE:** ________________________

Age:__________ **Sex:** ❒ **Male** ❒ **Female**
Marital Status: ❒ **Single** ❒ **Married** ❒ **Divorced** ❒ **Widowed**
Employment Status: ❒ **Full Time** ❒ **Part Time** ❒ **Unable to Work** ❒ **Retired**
Disabled/Reason for Disability:________________________
Occupation: ________________________

Nature of your Problem: ________________________

How do you describe your pain (i.e. stabbing, pins and needles, etc.)? ________________________

To the best of your understanding, what is the cause of your pain? ________________________
Is your pain related to an injury ❒ Yes ❒ No (If yes, please describe.)________________________

How long have you had this problem? ________________________

What physician(s), Surgeon(s) have you seen for treatment of your pain? ________________________

What other treatment options have you tried? (Physical therapy, alternative therapy, blocks, etc.) ________________________
________________________. Which were effective? ________________________

What medication(s) do you currently take for pain? Are they effective?________________________

What medication(s) have you tried that were not effective or may have caused side effects? ________________________

What things do you do (or can do) to bring on the pain? ________________________

What things do you do (or can do) to lessen the pain? ________________________

Do you engage in physical activity daily/weekly? If so, explain: ________________________

Do you have numbness of your skin? ❐ Yes ❐ No If yes, where? ______________________________

____

Do you have weakness of your muscles? ❐ Yes ❐ No If yes, where? ______________________________

____

How many times have you been to an ER or urgent care clinic in the past 6 months for the treatment of pain?

____

What are your expectations of how we can help you? ______________________________

____

Circle the corresponding number (1-10) to show how far from normal toward the worst possible situation your pain has caused you to be. The left side of each line is the "best" or "normal" situation and the right side of the line is the "worst" it could be.

Severity of your pain (average):

None 1 2 3 4 5 6 7 8 9 10 severe/worst

To what extent do you need to use pain medications?

Never 1 2 3 4 5 6 7 8 9 10 More than recommended/Prescribed

What is the effect of the pain on your work (please take into account absence from work or interfering with work abilities, etc.)?

None 1 2 3 4 5 6 7 8 9 10 Unable to work

How does the pain affect your need for help with daily activities (household chores and personal care?)

None 1 2 3 4 5 6 7 8 9 10 Need total assistance

Effect of your pain on your mood (depression/anxiety):

None 1 2 3 4 5 6 7 8 9 10 Severe

How much does the pain interfere with your sleep?

None 1 2 3 4 5 6 7 8 9 10 Cannot sleep at all

Effect of pain on your lifestyle (i.e. social, sports, hobbies, etc.):

None 1 2 3 4 5 6 7 8 9 10 Severe

How much do you feel your pain has changed your relationships with others?

No change 1 2 3 4 5 6 7 8 9 10 Drastic Change

Do you have allergies to medications? ❐ Yes ❐ No If yes, please list______________________________

____

Please list all medications you currently take: ______________________________

____

Prior surgeries (& year): ______________________________

____

Anesthesia Complications/Problems: ______________________________

____

Family Medical and Drug Abuse History: ______________________________

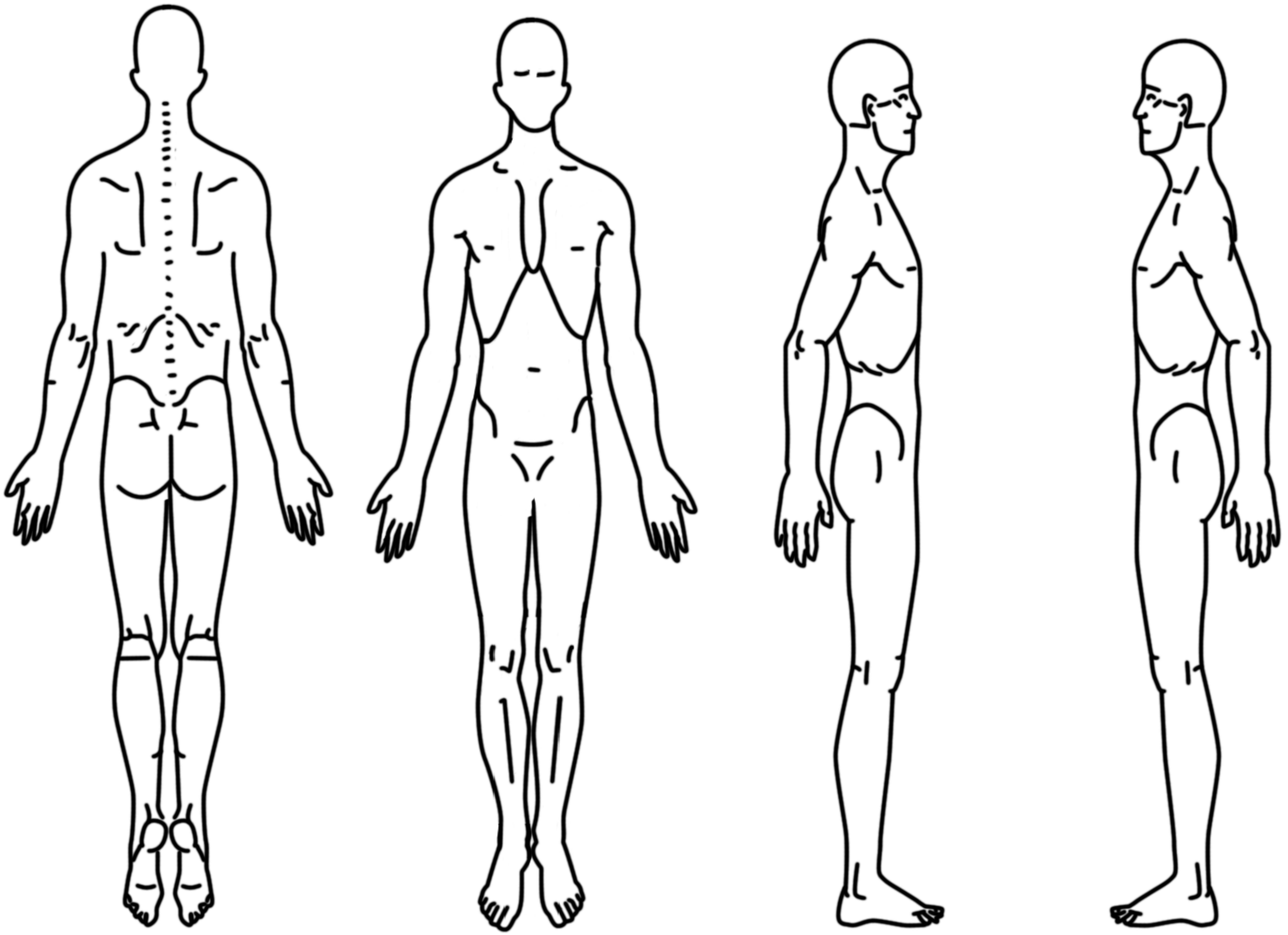
____

REVIEW OF SYSTEMS & MEDICAL ILLNESSES

Please check either Yes or No to the following:

Constitutional Symptoms:	**Hematological**
❐ Yes ❐ No **Weight Changes**	❐ Yes ❐ No **Anemia**
❐ Yes ❐ No **Fever or Chills**	❐ Yes ❐ No **Easy bleeding**
❐ Yes ❐ No **Cancer or tumors**	
	Psychiatric
Genitourinary	❐ Yes ❐ No **Fatigue**
❐ Yes ❐ No **Frequent urine infections**	❐ Yes ❐ No **Loss of appetite**
❐ Yes ❐ No **Kidney disease**	❐ Yes ❐ No **Hallucinations**
❐ Yes ❐ No **Loss of urine control**	❐ Yes ❐ No **Anxiety / Nervousness**
How often do you get up at night to void?	❐ Yes ❐ No **Depression**
	❐ Yes ❐ No **Panic attacks**
Eyes, ears, nose, mouth, and throat	❐ Yes ❐ No **Memory changes**
❐ Yes ❐ No **Visual changes**	❐ Yes ❐ No **Difficulty with work**
❐ Yes ❐ No **Hearing loss**	❐ Yes ❐ No **Attention Deficit Disorder**
❐ Yes ❐ No **Hypertension**	❐ Yes ❐ No **Obsessive Compulsive Disorder**
❐ Yes ❐ No **Rheumatic fever**	❐ Yes ❐ No **Schitzophrenia**
❐ Yes ❐ No **Chest pain (Angina)**	
❐ Yes ❐ No **Heart attack**	**Endocrine**
❐ Yes ❐ No **Irregular heart beat**	❐ Yes ❐ No **Thyroid disease**
❐ Yes ❐ No **Heart murmur**	❐ Yes ❐ No **Diabetes**
❐ Yes ❐ No **Leg swelling**	
❐ Yes ❐ No **Blood clots in legs**	**Female**
	❐ Yes ❐ No **Pregnant**
Respiratory	**When was your last menstrual period:** _______________
❐ Yes ❐ No **Pneumonia**	
❐ Yes ❐ No **Emphysema**	**Musculoskeletal**
❐ Yes ❐ No **Tuberculosis**	❐ Yes ❐ No **Joint pain**
❐ Yes ❐ No **Chronic obstructive disease**	❐ Yes ❐ No **Joint swelling**
❐ Yes ❐ No **Asthma**	❐ Yes ❐ No **Muscle wasting**
❐ Yes ❐ No **Shortness of breath**	❐ Yes ❐ No **Osteoporosis**
	❐ Yes ❐ No **Arthritis**
Gastrointestinal	❐ Yes ❐ No **Skin lesions/rash**
❐ Yes ❐ No **Frequent heart burn/reflux**	❐ Yes ❐ No **Hair and/or nail changes**
❐ Yes ❐ No **Nausea and vomiting**	
❐ Yes ❐ No **Hepatitis or cirrhosis**	**Neurological**
❐ Yes ❐ No **Constipation**	❐ Yes ❐ No **Seizures**
❐ Yes ❐ No **Ulcers**	❐ Yes ❐ No **Loss of consciousness**
❐ Yes ❐ No **Change in bowel movements**	❐ Yes ❐ No **Paralysis**
❐ Yes ❐ No **Bloody bowel movements**	❐ Yes ❐ No **Tremors**
	❐ Yes ❐ No **Gait disturbances**
	❐ Yes ❐ No **Headache**
	❐ Yes ❐ No **Stroke**

Other Illnesses	
❐ Yes ❐ No **Do you Smoke cigarettes? If yes, how many packs per day?** ____________________	❐ Yes ❐ No **Do you consume alcoholic beverages? If yes, how many per day**____________________
❐ Yes ❐ No **Do you use illicit drugs? If yes, what type?** ________________________	❐ Yes ❐ No **Have you abused narcotic drugs? If yes, what type?** ________________________



Using the figures above, mark the locations of your pain.

Indicate an **X** for Stabbing or Burning Pain; Use a **Z** to indicate Tingling; and Use an **N** for Numbness

Also indicate if the pain radiates to any other part of your body, by placing arrows from where the pain originates to where it goes.

Patient Signature

Date