# New Patient Health History and Pain Management Questionnaire

**Name:** _____ **Date:** _____
First Middle Last

**Date of Birth:** _____ **Age:** _____ **Gender:** □ Male □ Female **Marital Status:** □ S □ M □ D □ W

**Ethnicity:** □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ Some Other Race □ Unspecified □ White

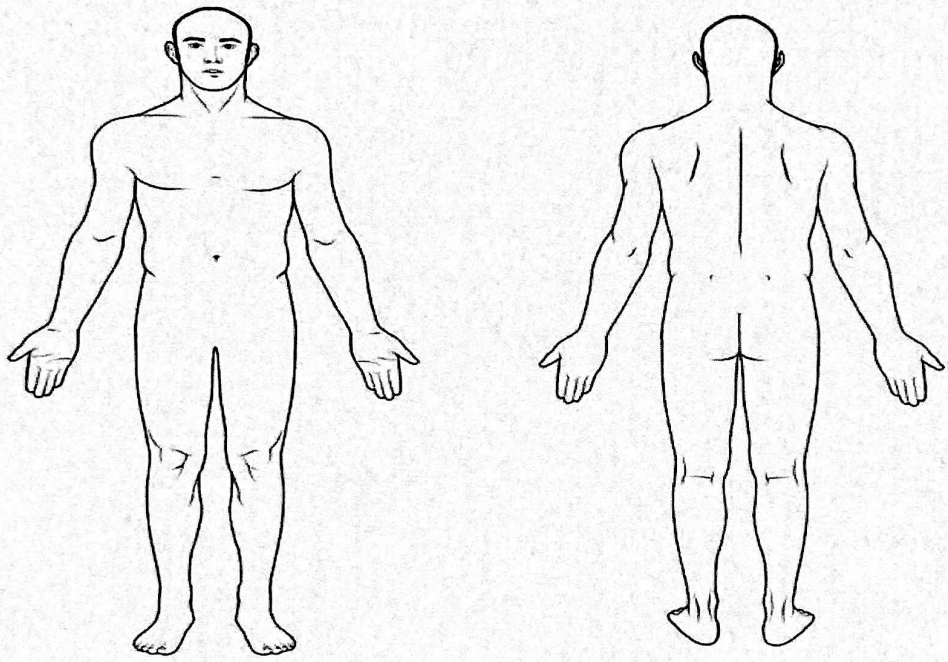
**Referring Physician:** _____ **Primary Care Physician** (Required): _____

**Pharmacy Preference:** _____ **Phone #:** _____

**Date of first episode of pain:** _____ **Date of Diagnosis:** _____

**Under what circumstances did the pain begin?**
□ Work Accident □ Home Accident □ Auto Accident □ Surgery □ Fall □ Other _____

**Where is your pain? Please indicate below:**



**PLEASE INDICATE YOUR PAIN BY CIRCLING:**

YOUR PAIN AT THE PRESENT TIME: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

YOUR PAIN AT ITS WORST: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

**SINCE YOUR PAIN BEGAN IT HAS:** **INCREASED** **DECREASED** **STAYED THE SAME**

**Describe your pain briefly (include location of your pain):**

_____

□ Aching □ Burning □ Penetrating □ Sharp □ Shooting □ Stabbing □ Throbbing

**Is your pain:** □ Constant □ Off and on

**Do you have any of the following?**
□ Numbness □ Tingling (Pins & Needles) □ Weakness □ Coldness □ Muscle Spasm □ Tightness

**Does pain interfere with your sleep?**
□ Occasionally □ Frequently □ Does not Affect

**Aggravating factors?** □ Sitting □ Standing □ Walking □ Coughing □ Bending over □ Exercise □ Lifting

□ Deep Breathing □ Lying on your back □ Other: _____

**What makes the pain better?** _____

Name: _____ DOB: _____

**Do you take pain medication?** ☐ YES ☐ NO **If yes, describe the effect:** _____
**How long does the pain relief last?** _____
**How many times a day do you take pain medication?** _____
**In the past 2 weeks, have you taken more, the same or less pain medication?** _____
**Has the pain caused depression or other emotional problems?** ☐ YES ☐ NO
**If yes, have you sought medical care?** _____
**Has the pain affected your ability to work?** ☐ YES ☐ NO **For how long?** _____
**What diagnostic test(s) or treatment(s) have you had? Please indicate when and where they were done.**

| | Date | Location |
|---|---|---|
| X-ray | | |
| MRI/CT Scan | | |
| EMG | | |
| Epidural Steroid Injection | | |
| Physical Therapy | | |
| Chiropractor/Acupuncture | | |
| Braces/TENS unit | | |
| Psychologist | | |
| Comprehensive Pain Clinic | | |
| Other_____ | | |

**List ALL your medications: (including over the counter) OR provide a current list of ALL your medications.**

| Medication Name | Dose | How often do you take it? ( 3 x day, 2 x day) |
|---|---|---|
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**ALLERGIES:** List medications to which you are allergic: ☐ NO KNOWN DRUG ALLERGIES

| **Medication** | **Type of Reaction** (rash, itching, swelling, etc.) |
|---|---|
| | |
| | |
| | |

**Do you have an allergy to latex?** ☐ Yes ☐ No Reaction _____
**Do you have an allergy to iodine?** ☐ Yes ☐ No Reaction _____
**Are you currently taking anti-coagulants or blood thinners?** ☐ Yes ☐ No ***(Please check all that apply)***
☐ Coumadin ☐ Aspirin ☐ Plavix ☐ Anti-inflammatories or any others?
**Who is prescribing this for you?** Doctor: _____ Tel #: _____

Name: _____ DOB: _____

**Past Medical History:**
□ High blood pressure □ Sleep Apnea □ Hepatitis □ Depression □ Bi-polar disorder □ Anxiety □ Diabetes □ COPD
□ Others _____

**List any spine surgeries with dates:**

_____ Date: _____

_____ Date: _____

_____ Date: _____

**List any other past Surgeries and Hospitalizations – List ALL surgeries and hospitalizations with date:**

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

**Past Family History – List all medical conditions a family member has, had or died from:**
Is your mother still living? □ Yes □ No Is your father still living? □ Yes □ No

_____

_____

_____

**Social History:**

**Work Status:** □ Employed □ Full Time □ Part Time □ Retired □ Disability □ Permanent □ Temporary
**Do you drink alcohol?** □ Yes □ No How many drinks per week? _____ Month? _____
**Tobacco use?** □ Yes □ No **Number per day of:** Cigarettes _____ Cigars_____ Chewing tobacco ____ E-cig _____
What year did you start? _____ What year did you quit? _____
**Do you use recreational drugs?** □ Yes □ No If yes, what type and when was your last use?_____
**Have you ever been treated for alcohol dependence or addiction?** □ Yes □ No
**Have you ever been treated for drug dependence or addiction?** □ Yes □ No

**Systems Review:** Check any of the following which you have had in the **last 3 months or currently** have:
**Cardiac:**
□ Chest pain □ Varicose veins □ Irregular pulse □ Swollen ankles □ High blood pressure □ Pacemaker
**Respiratory:** □ Cough □ Shortness of Breath □ Asthma/wheezing □ Sleep Apnea
**Gastrointestinal:** □ Abdominal pain □ Constipation □ Heartburn □ Nausea □ Vomiting □ Bloody or tarry stools
□ Urinary: Blood in urine □ Kidney stones □ Kidney failure
**Musculoskeletal:** □ Back pain □ Neck pain □ Aching joints □ Weakness □ Bone fracture □ Muscle pain
**Neurologic:** □ Headache □ Weakness □ Numbness □ Tingling □ Seizures □ Tremor □ Loss of control of stool
□ Loss of urinary control
**Psychiatric:** □ Depression □ Bi-polar disorder □ ADHD/ADD □ Memory Loss □ Anxiety □ Sleeping difficulty
**Endocrine:** □ Heat intolerance □ Cold intolerance □ Frequent thirst □ Frequent urination
**General:** □ Fatigue □ Fever or chills_____
**Nutritional:** □ Unexplained weight loss

***Immunizations:***
***Have you had the flu vaccine?*** □ Yes □ No When? _____
***Have you had the pneumonia vaccine?*** □ Yes □ No When? _____
***Are your vaccines up to date?*** □ Yes □ No