New Patient Information Sheet

PLEASE COMPLETE THIS ENTIRE FORM

The form may seem lengthy but it is very important to help us understand your pain complaints. This will help us provide you with the highest level of care.

Name: _____ **Date of Appointment**: ____/____/_____

Tell us why you are here today:

☐ Lower Back Pain ☐ Neck Pain

☐ Mid Back pain ☐ Shoulder/Arm Pain

☐ Hip and Leg Pain ☐ Other: _____

For lower back pain, does it travel down into the leg? ☐ Yes ☐ No
If yes, which side? ☐ Right ☐ Left ☐ Both

For neck pain, does it travel down into the arm? ☐ Yes ☐No If yes, which side? ☐ Right ☐ Left ☐ Both

When did your pain begin: _____Week(s) Ago _____ Month(s) Ago _____Year (s) Ago

Date of Onset (if known) _____

How long have you had this pain (enter a number)? ____ Days ___ Weeks ___ Months ___ years

How did your pain first start:

☐ Unknown ☐ Lifting ☐ Athletic Activity (Describe) _____ ☐ Lifting ☐ A Fall

☐ Auto Accident: date ____/____/____ ☐ Other Trauma _____

Is your pain?

☐ Aching ☐ Shooting ☐ Stabbing ☐ Sharp ☐ Dull ☐ Burning ☐ Numbness ☐ Tingling

☐ Other (Describe) _____

Is your pain? ☐ Constant ☐ Intermittent

Is your injury/condition work related? ☐ Yes W/C case number: _____ ☐ No

Have you had any falls in the last 12 months? ☐ Yes ☐ No

If yes, how many and was there any injury? ☐ 1 ☐ 2 or more ☐ without injury ☐ with injury

What activities increase and decrease your pain:

ACTIVITY	INCREASES PAIN	DECREASES PAIN
Sitting		
Standing		
Walking		
Other:		

Please indicate if you have received any of the following treatments for your pain condition, when the treatment occurred, and whether the outcome was positive (+) or negative (-)

Treatment	Approximate Month & Year	Treatment Outcome
Surgery		
Physical Therapy		
Chiropractic Treatment		
Trigger Point Injections		
Injections using X-Ray ❑ Epidural Steroid Injection ❑ Facet Joint Injection ❑ Sacroiliac (SI) Joint Injection ❑ Hip Joint Injection ❑ Other:		

Have you had any diagnostic imaging (MRI, CT, x-rays, bone scan) within the past 6 months? ☐ Yes ☐ No

If yes, what kind? (ex. MRI of low back) _____

at what facility? _____

Date of the study (if exact date unknown, what month/year)? _____

Phone number of the facility (if known)? _____

Fax number of the facility (if known)? _____

What Medications are you <u>CURRENTLY</u> taking? (attach a separate piece of paper if needed)

Medication Name	Dose (#mg)	Times Taken Per Day

What Medications did you <u>PREVIOUSLY</u> take for your pain?

Medication Name	Dose (#mg)	Times Taken Per Day

Medical History - Check (√) any of the following conditions or problems that you have faced at <u>any time in your life.</u>

o AIDS	o Emphysema	o Mononucleosis	o Tuberculosis
o Alcoholism	o Glaucoma	o Multiple Sclerosis	o Typhoid Fever
o Anorexia/Bulimia	o Heart Disease	o Mumps	o Vascular Disease
o Arthritis	o Hepatitis	o Pacemaker Implant	o Other (list)
o Asthma/COPD	Type: _____	o Pneumonia	_____
o Bleeding Disorder	o Hernia	o Polio	_____
o Cataracts	o HIV Positive	o Prostate Problems	_____
o Cancer	o Hypertension	o Psychiatric Conditions	_____
Type: _____	o Kidney Disease	o Rheumatic Fever	
o Chicken pox	o Liver Disease	o Stomach Ulcer	
o Diabetes	o Measles	o Stroke	
Type: ☐ 1 ☐ 2	o Migraine Headaches	o Thyroid Condition	
o Drug Dependency			

Surgical History – Please list any previous surgeries and their respective dates

Date	Surgery

Are you allergic to any of the following? (Describe type of reaction)

a. Shellfish ☐ Yes ☐ No _____

b. Contrast Dye ☐ Yes ☐ No _____

c. Local anesthetic ☐ Yes ☐ No _____

d. Latex ☐ Yes ☐ No _____

e. Medications ☐ Yes ☐ No _____

If 'Yes,' list medications & reaction: _____

Family History – Please (√) any conditions experienced by your parents, children, or siblings:

	Alive/Deceased	Diabetes	High Blood Pressure	Heart Disease	Stroke	Cancer Type:	Other:
Mother							
Father							
Son(s)							
Daughter(s)							
Brother(s)							
Sister(s)							

Social / Vocational / Work History

Do you smoke cigarettes? ☐ Yes ☐ No

If 'No,' did you ever smoke? ☐ Yes ☐ No

If 'Yes,' indicate how much you smoke/smoked <u>per day</u> by checking one of the following:

☐ Less than ¼ pack per day ☐ About ¾ pack per day (15 cigarettes)

☐ About ¼ pack per day (5 cigarettes) ☐ About 1 pack per day (20 cigarettes)

☐ About ½ pack per day (10 cigarettes) ☐ More than 1 pack per day

Do you use any illegal drugs? ☐ Yes ☐ No
If yes, what? _____

Do you drink alcohol? ☐ Yes ☐ No If 'yes', how often? _____/day _____/week _____/month _____/year

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Employment Status ☐ Unemployed ☐ Employed ___ Full Time ___ Part Time

If unemployed right now, indicate the last date worked: _____/_____/_____

If out of work, what was your reason for leaving? ☐ Due to pain problem ☐ N<u>ot</u> due to pain

Please check any of the following symptoms or problems that you have experienced during the last six (6) months

CONSTITUTIONAL: ☐ Weight gain ☐ Weight loss ☐ Marked fatigue ☐ Fever ☐ Chills/Sweats

EYES: ☐ Blurred vision ☐ Double vision ☐ Eye pain

EARS, NOSE & THROAT: ☐ Loss of hearing ☐ Ringing in ears ☐ Sinus problems

ENDOCRINE: ☐ Excessive thirst ☐ Cold intolerance ☐ Heat intolerance

RESPIRATORY: ☐ Persistent cough ☐ Coughing up blood ☐ Wheezing

CARDIOVASCULAR: ☐ Chest pain/ pressure/ tightness ☐ Heart Palpitations ☐ Rapid of Irregular heart rate ☐ Low blood pressure ☐ High blood pressure ☐ Shortness of breath ☐ Poor circulation

GASTROINTESTINAL: ☐ Persistent/recurring stomach pain ☐ Diarrhea ☐ Constipation ☐ Blood in stool ☐ Heartburn or indigestion ☐ Nausea/vomiting ☐ Yellowing of skin/jaundice

HEMATOLOGY: ☐ Easy or frequent bruising ☐ Prolonged bleeding

GENITOURINARY: ☐ Blood in urine ☐ Painful urination ☐ Urgency to urinate ☐ Frequent urination ☐ Difficulty urinating ☐ Loss of control of bladder ☐ Loss of control of bowel

MUSCULOSKELETAL: ☐ Joint pain ☐ Joint stiffness ☐ Joint redness or swelling ☐ Leg cramps

SKIN: ☐ Rash ☐ Nail or hair changes ☐ Hives ☐ Sores that don't heal

NEUROLOGICAL: ☐ Headaches ☐ Blackouts/Fainting ☐ Dizziness or Vertigo ☐ Seizures ☐ Weakness ☐ Memory loss

PSYCHIATRIC: ☐ Depression or depressed mood ☐ Anxiety ☐ Difficulty sleeping

Please answer the following questions:

In the last 2 weeks have you been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

In the last 2 weeks have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

Have you had the Influenza (Flu) shot within the past year? ☐ Yes ☐ No

If yes, when (approximate date)? _____

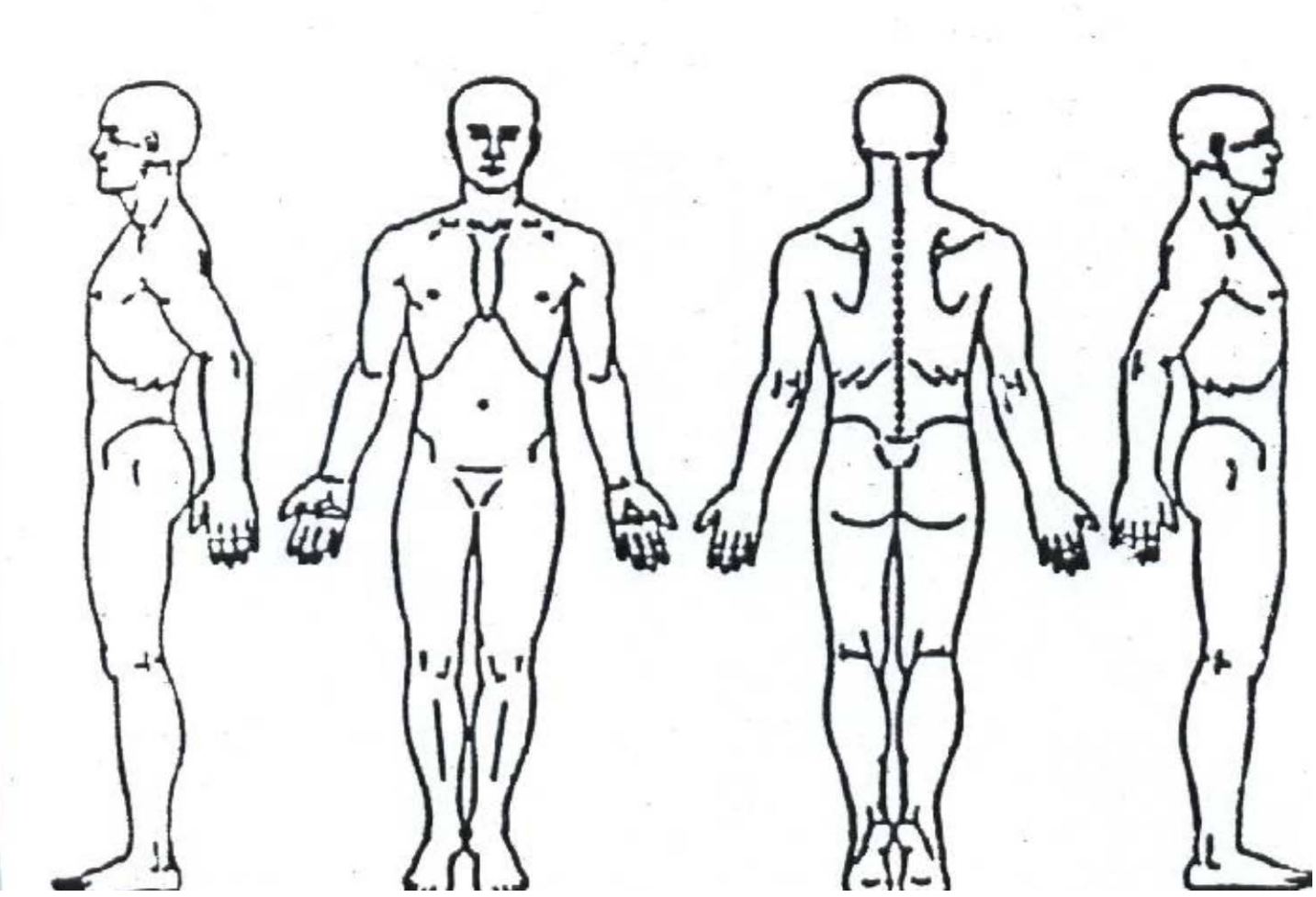
If you are over 65 years of age, have you had a pneumonia shot? ☐ Yes ☐ No

If yes, when (approximate date)? _____

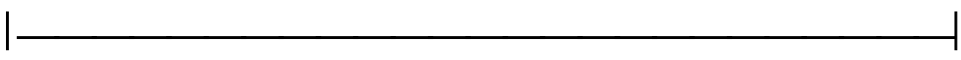
PAIN DIAGRAM

Draw the location of your pain on the body outlines & mark how severe it is on the pain line at the bottom of the page. Use a red pen if available.

Aching	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^	XXXX	000000	*****	/////	……
^^^^	XXXX	000000	*****	/////	……



PAIN LINE Draw a perpendicular line or arrow to indicate your usual level of pain.



Patient Signature: _____ Date: _____

Pain Disability Index

In order to determine how effective your treatment is, we need to know how much pain is interfering in your normal activities. Please select the number on the scale which describes the level of disability you have experienced in each area OVER THE PAST WEEK.

A score of "0" means no disability at all, and a score of "10" indicates that all of the activities which you would normally do have been totally disrupted or prevented by your pain over the past week. Circle "0" if a category does not apply.

FAMILY/HOME RESPONSIBILITIES: This category includes chores or duties performed around the house (e.g., yard work, house cleaning) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

RECREATION: This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

SOCIAL ACTIVITY: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

OCCUPATION: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as housewife or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

SEXUAL BEHAVIOR: This category refers to the frequency and quality of one's sex life.

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

SELF-CARE: This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed).

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

LIFE-SUPPORT ACTIVITY: This category refers to basic life-supporting behaviors such as eating and sleeping.

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

Office Use Scoring: Sum Total: ____/70