



Welcome to the office of
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BP ____ P ____
HT ____ WT ____
Resp ____

NEW PATIENT QUESTIONNAIRE

DATE: _____

NAME: _____ AGE: _____ MALE FEMALE

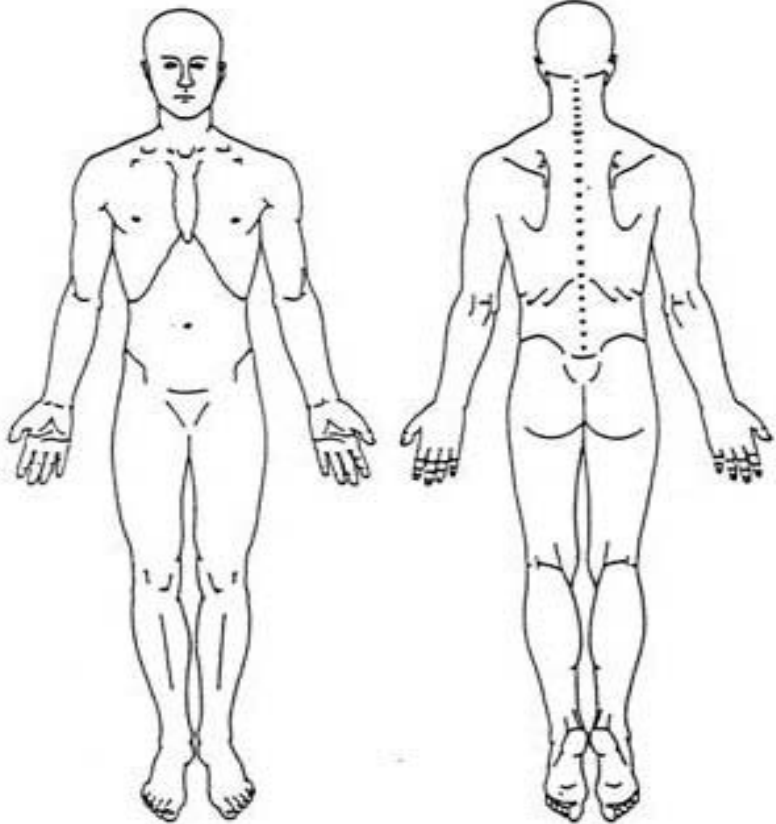
REFERRED BY: _____ IF MD, PHONE #: _____

CHIEF COMPLAINT: _____

DURATION OF SYMPTOMS: _____ HOW DID IT BEGIN? _____

PLEASE COMPLETE THE PAIN DRAWING

WHERE IS YOUR PAIN? Please mark on the drawing where you feel pain right now and use the key below the figures.



RATE YOUR PAIN

0 = no pain 10 = extreme pain

1. Right Now: 0 1 2 3 4 5 6 7 8 9 10

2. At Best: 0 1 2 3 4 5 6 7 8 9 10

3. At Worst: 0 1 2 3 4 5 6 7 8 9 10

4. What makes it better?

5. What makes it worse?

6. Any NUMBNESS/TINGLING?
NO **YES**

7. Any WEAKNESS?
NO **YES**

Pins & Needles – OOOO
Sharp/Stabbing - XXXX

Burning – ~ ~ ~ ~
Dull/Deep Ache – ZZZZ

CONTINUED →

HAVE YOU HAD ANY OF THE FOLLOWING TESTS OR TREATMENTS FOR THIS PROBLEM?

<u>TESTS</u>	<u>NO</u>	<u>YES</u>	<u>DATE(S)</u>	<u>TREATMENTS</u>	<u>NO</u>	<u>YES</u>	<u>DATE(S)</u>
X-RAYS	<input type="checkbox"/>	<input type="checkbox"/>	_____	MEDICATIONS	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT SCAN	<input type="checkbox"/>	<input type="checkbox"/>	_____	List name(s) of medications: _____			
MRI SCAN	<input type="checkbox"/>	<input type="checkbox"/>	_____	INJECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMG (Nerve Test)	<input type="checkbox"/>	<input type="checkbox"/>	_____	SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	_____
BONE SCAN	<input type="checkbox"/>	<input type="checkbox"/>	_____	PHYSICAL THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	_____

OTHER TESTS OR TREATMENTS: _____

MEDICAL HISTORY:

LIST MEDICAL PROBLEMS: _____

LIST SURGERIES & DATES: _____

LIST CURRENT MEDICATIONS: _____

LIST ANY MEDICATION ALLERGIES: _____

ANY ALLEGIES TO: Shellfish Iodine Contrast/IV Dye Latex

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? Weight Change Night Pain

Fever/Chills Heart Problems Breathing Problems Stomach Problems

Joint pain/swelling Morning Stiffness Skin Problems Easy Bleeding/Bruising

Bowel/Bladder Changes Depression/Anxiety

Other: _____

DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING PROBLEMS?

Heart Disease Diabetes High Blood Pressure Cancer Nerve Problem

Other: _____

SOCIAL HISTORY: Single Domestic Partner Married Divorced Widow/Widower

Tobacco Use: Nonsmoker Previous smoker/quit date: _____ Smoker _____ packs per day

Alcohol Consumption: Never Occasionally Frequent

CURRENT EMPLOYMENT STATUS: Working As: _____

Full Time Part Time Retired Student

Unemployed On Disability Workers' Compensation Working Homemaker

I prefer to receive any test results: By Mail By Phone By E-mail: _____