NEW PATIENT HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS TO PROVIDE US WITH YOUR HISTORY

Today's Date_____

Name_____ DOB_____ Age_____ Sex M____ F____

Are you referred from another physician? Yes____ No____ Doctor's Name_____

Is your condition the result of an accident? Yes____ No____

If Yes, When_____ Where_____ How_____

How long ago did your symptoms begin?_____
Are they getting better, worse, or staying the same?_____

Your CHIEF complaint (or write it in):

Neck Pain Yes____ No____

Arm Pain Yes____ No____ If Yes, Right____ Left____ Both____

Low Back Pain Yes____ No____

Leg Pain Yes____ No____ If Yes, Right____ Left____ Both____

My pain is:	I also have	YES	NO
Constant____	Numbness	_____	_____
Dull_____	Tingling	_____	_____
Achy_____	Weakness	_____	_____
Sharp_____			
Stabbing____			

What makes your pain BETTER?_____

What makes your pain WORSE?_____

On a good day, my pain score is: _____ out of 10 (with 10 being worst pain imaginable)

On a bad day, my pain score is: _____ out of 10 (with 10 being worst pain imaginable)

Have you had any recent change in Bowel or Bladder function (incontinence)? YES____ NO____

If Yes, Describe_____

NEW PATIENT HISTORY

Have you had any of the following treatments for your condition:

	YES	NO	Did it help?
Medication	_____	_____	_____
Physical Therapy	_____	_____	_____
Chiropractor	_____	_____	_____
Epidural Injections	_____	_____	_____
Facet Injections	_____	_____	_____

Have you had previous Spine Surgery? Yes____ No____

If yes, when_____ Where_____

What was the surgery (laminectomy, decompression, fusion, discectomy)?_____

Are you Depressed? Yes____ No____

If yes, are you being seen by a psychologist/psychiatrist or on any medication for depression?

Explain_____

Do you have any history of substance abuse (including prescription drugs, alcohol, illegal drugs)?

Explain_____

What is your functional level?

How many flights of stairs can you go up before significant pain? _____

How many blocks can you walk before significant pain? _____

How long can you stand before significant pain?_____

Do you have trouble sleeping because of pain?_____

NEW PATIENT HISTORY

REVIEW OF CURRENT SYMPTOMS

Please review the following and check any that currently apply.

General Health:
____ Night sweats
____ Fever/Chills
____ Fatigue

Eyes:
____ Blurry vision

Ears/Nose/Mouth/Throat:
____ Ringing in ears
____ Sore Throat

Cardiovascular:
____ Chest Pain
____ Swelling
____ Recent fractures

Respiratory:
____ Cough
____ Shortness of Breath/Dyspnea

GI:
____ Abdominal Pain
____ Nausea
____ Constipation
____ Diarrhea

Genitourinary:
____ Losing control of urine
____ Difficulty controlling bladder
____ Bowel incontinence

Skin:
____ Rashes

Neurologic:
____ Headache
____ Numbness/Tingling
____ Numbness in Groin Area/Saddle Anesthesia

Endocrine:
____ Excessive appetite
____ Excessive sweating
____ Excessive thirst
____ Excessive urination

Hematological:
____ Easy Bruising/Bleeding

Allergic:
____ Latex Allergy

Musculoskeletal:
____ Painful or Swollen Joints
____ Muscle twitching

Psychiatric:
____ Depression
____ Thoughts Hurting Self
____ Thoughts of Hurting Others

NEW PATIENT HISTORY

PAST MEDICAL HISTORY: Do you suffer from any of the following?

	YES	NO		YES	NO
Chronic Headaches	___	___	Urine/Stool Leakage (incontinence)	___	___
High Blood Pressure	___	___	Seizures	___	___
Heart Rhythm Disorders	___	___	Strokes	___	___
Heart Attacks	___	___	Muscular Dystrophy	___	___
Other Heart Disease	___	___	Recent Infections	___	___
Diabetes	___	___	Reactions to Anesthesia	___	___
Thyroid Problems	___	___	Sickle Cell Anemia	___	___
Asthma	___	___	Hemophilia/Easy Bleeding	___	___
Emphysema/COPD	___	___	Recent Weight Loss	___	___
Other Lung Disease	___	___	Depression	___	___
Heartburn or Ulcers	___	___	Suicidal Thoughts	___	___
Hepatitis	___	___	Cancer	___	___
Pancreatitis	___	___	Type:_____		
Kidney Stones	___	___	OTHER_____		

PAST SURGICAL HISTORY

Spine (Neck or Back)	___	___	Tubal Ligation	___	___
Tonsillectomy	___	___	Bladder/Kidney	___	___
Appendectomy	___	___	Bowel/Colon/Ulcer	___	___
Gallbladder	___	___	Shoulder/Knee/Hip/Joint	___	___
Lung	___	___	Spine/Back/Neck	___	___
Heart	___	___	OTHER_____		
Hysterectomy	___	___	_____		

FAMILY HISTORY: Do your parents, brothers, sisters, etc…suffer from any of the following?

Heart Diease	___	___	Migraines	___	___
Hemophilia/Bleeding Disorder	___	___	Anesthetic Reactions	___	___
Sickle Cell Anemia	___	___	Muscular Disorders	___	___
Cancer	___	___	OTHER_____		

SOCIAL HISTORY: Do you, or have you ever used the following?

Smoking Tobacco	___	___	Cocaine	___	___
Alcohol	___	___	Other Street Drugs_____		
Marijuana	___	___	OTHER_____		

Work: ___Employed ___Unemployed ___Retired ___Homemaker ___Disabled

Marital Status: ___Married ___Separated ___Divorced ___Single ___Widowed

Lawsuits Pending: ___Yes ___No ___Settled

NEW PATIENT HISTORY

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

NEW PATIENT HISTORY

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in the home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o

NEW PATIENT HISTORY

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	o	o	o	o	o
14. How often have others told you that you had a bad temper?	o	o	o	o	o
15. How often have you felt consumed by the need to get pain medication?	o	o	o	o	o
16. How often have you run out of pain medication early?	o	o	o	o	o
17. How often have others kept you from getting what you deserve?	o	o	o	o	o
18. How often, in your lifetime, have you had legal problems or been arrested?	o	o	o	o	o
19. How often have you attended an AA or NA meeting?	o	o	o	o	o
20. How often have you been in an argument that was so out of control that someone got hurt?	o	o	o	o	o
21. How often have you been sexually abused?	o	o	o	o	o
22. How often have others suggested that you have a drug or alcohol problem?	o	o	o	o	o
23. How often have you had to borrow pain medications from your family or friends?	o	o	o	o	o
24. How often have you been treated for an alcohol or drug problem?	o	o	o	o	o

Please include any additional information you wish about the above answers.
Thank you.

_____
_____
_____
_____