

Patient: _____

Date: _____

NEW PATIENT FORM

Referred by _____

What is / are your main pain area(s) ? _____

When did the pain start? _____

Did an accident or trauma precede the beginning of the pain? Yes ___ No ___ Describe _____

Do you have any numbness in your arms, hands, legs or feet? Yes ___ No ___ If Yes, where? _____

Do you have any weakness in your arms, hands, legs or feet? Yes ___ No ___ If Yes, where? _____

Do you lose control of your bowel or bladder? Yes ___ No ___ If Yes, which? _____

Draw a vertical line on each line below to indicate the **level** or **intensity** of your pain:
(0 = no pain 10 = "worst pain I've ever had")

Usually _____
0 1 2 3 4 5 6 7 8 9 10

Right now: _____
0 1 2 3 4 5 6 7 8 9 10

List any specific activities or things that **INCREASE** your pain:

List any specific activities or things that **DECREASE** your pain:

Does your pain interfere with your ability to sleep? Yes ___ No ___

What activities does your pain prevent you from doing? _____

Please circle each of the following words that apply to your pain:

Throbbing Shooting Stabbing Sharp Cramping Gnawing Hot-burning Aching Heavy

Tender Splitting Tiring-exhausting Sickening Fearful Punishing-cruel

Have you seen any other healthcare provider(s) for your pain?

Name	Type Provider	Treatment	Date(s)	Helpful?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What medications or therapies (such as heat, TENS unit, Biofeedback, Ultrasound, etc.) have you tried for your pain?

Medication/Therapy	? Helpful	Side effects if any

Have you had any of the following done concerning your pain area?

X-rays Yes _____ No _____ if Yes, When _____ Where _____

CT-scan Yes _____ No _____ if Yes, When _____ Where _____

MRI scan Yes _____ No _____ if Yes, When _____ Where _____

Discography Yes _____ No _____ if Yes, When _____ Where _____

PAST MEDICAL HISTORY

Please list current medical problems (diabetes, high blood pressure, etc):

Medical Problem	Details

Please list previous surgeries:

Surgery	Date	Details

What medications are you taking regularly?

Medication	Dose	How often

Do you have allergies to any medications? YES _____ NO _____ If Yes, please write below

Medication	Type of reaction

FAMILY HISTORY

Are there any pain problems that run in your family? _____

SOCIAL HISTORY

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Children : Ages _____ Living at home with you? Yes _____ No _____

Use of alcohol Never _____ Rarely _____ Moderate: _____ Daily: _____

Use of tobacco: Never: _____ Previously, but quit: _____ Current packs per day: _____

Have you ever had a problem with dependency or abuse of prescription or non-prescription drugs? Yes _____ No _____

Occupation _____ Hours per day _____

Retired: Yes _____ No _____ Disabled: Yes _____ No _____ If yes, since when? _____

Are you involved in any litigation, workers compensation claim or disability claim? Yes _____ No _____

REVIEW OF SYSTEMS:**CONSTITUTIONAL SYMPTOMS**

Good general health lately Yes _____ No _____
Recent weight change Yes _____ No _____
Fever Yes _____ No _____
Fatigue Yes _____ No _____

EYES

Eye disease or injury Yes _____ No _____
Wear glasses/contact lenses Yes _____ No _____
Blurred vision Yes _____ No _____
Glaucoma Yes _____ No _____

EAR/NOSE/MOUTH/THROAT

Hearing loss or ringing Yes _____ No _____
Earaches or drainage Yes _____ No _____
Chronic sinus problem or rhinitis Yes _____ No _____
Nose bleeds Yes _____ No _____
Mouth sores Yes _____ No _____
Bleeding gums Yes _____ No _____
Sore throat or voice change Yes _____ No _____

CARDIOVASCULAR

Heart trouble Yes _____ No _____
Chest pain or angina pectoris Yes _____ No _____
Palpitations Yes _____ No _____
Exposure to TB? Yes _____ No _____
Swelling of feet, ankles or hands Yes _____ No _____
Murmurs Yes _____ No _____

RESPIRATORY

Chronic or frequent coughs Yes _____ No _____
Spitting up blood Yes _____ No _____
Shortness of breath Yes _____ No _____
Asthma or Wheezing Yes _____ No _____

GASTROINTESTINAL

Loss of appetite Yes _____ No _____
Nausea or vomiting Yes _____ No _____
Frequent diarrhea Yes _____ No _____
Painful bowel movements or constipation Yes _____ No _____
Rectal bleeding or blood in stool Yes _____ No _____
Abdominal pain Yes _____ No _____
Peptic ulcer(stomach or duodenal) Yes _____ No _____
Hepatitis Yes _____ No _____
Pancreatitis Yes _____ No _____

GENITOURINARY

Frequent urination Yes _____ No _____
Burning or painful urination Yes _____ No _____
Blood in urine Yes _____ No _____
Incontinence or dribbling Yes _____ No _____
Kidney stones Yes _____ No _____
Sexual difficulty Yes _____ No _____
Male – testicle pain Yes _____ No _____
Female – pain with periods Yes _____ No _____
irregular periods Yes _____ No _____
Do you experience pain with intercourse? Yes _____ No _____
Could you be pregnant now? Yes _____ No _____

MUSCULOSKELETAL

Joint pain Yes _____ No _____
Joint stiffness or swelling Yes _____ No _____
Weakness of muscles or joints Yes _____ No _____
Muscle pain or cramps Yes _____ No _____
Back pain Yes _____ No _____
Difficulty in walking Yes _____ No _____

INTEGUMENTARY (skin,breast)

Rash or itching Yes _____ No _____
Change in skin color Yes _____ No _____
Change in hair or nails Yes _____ No _____
Change in temperature of extremities Yes _____ No _____
Varicose veins Yes _____ No _____
Breast pain Yes _____ No _____

NEUROLOGICAL

Frequent or recurring headaches Yes _____ No _____
Light headed or dizzy Yes _____ No _____
Convulsions or seizures Yes _____ No _____
Numbness or tingling sensations Yes _____ No _____
Tremors Yes _____ No _____
Paralysis Yes _____ No _____
Stroke Yes _____ No _____
Head injury Yes _____ No _____

PSYCHIATRIC

Memory loss or confusion Yes___ No___
 Anxiety Yes___ No___
 Depression Yes___ No___
 Insomnia Yes___ No___

ENDOCRINE

Glandular or hormone problem Yes___ No___
 Thyroid disease Yes___ No___
 Diabetes (insulin or Non insulin – circle one) Yes___ No___
 Excessive thirst or urination Yes___ No___
 Heat or cold intolerance Yes___ No___
 Skin becoming dryer Yes___ No___
 Change in hat or glove size Yes___ No___

HEMATOLOGIC/LYMPHATIC

Bleeding or bruising tendency Yes___ No___
 Anemia Yes___ No___
 Phlebitis Yes___ No___
 Past transfusion Yes___ No___
 Enlarged glands Yes___ No___

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
 Penicillin or other antibiotics Yes___ No___
 Morphine, Demerol or other narcotics Yes___ No___
 Novocain or other anesthetics Yes___ No___
 Aspirin or other pain remedies Yes___ No___
 Tetanus antitoxin or other serums Yes___ No___
 Iodine or other antiseptic Yes___ No___

PHYSICAL EXAMINATION:**GENERAL****SKIN****HEENT****LUNGS****HEART****ABDOMEN****EXTREMITIES****SPINE****NEUROLOGICAL****CLINICAL IMPRESSION:****PLAN:**