

Clearwater Pain Management Associates
New Patient Questionnaire

Name _____ Age _____ Date _____
Referring Physician _____ Primary Care Physician _____
Occupation _____

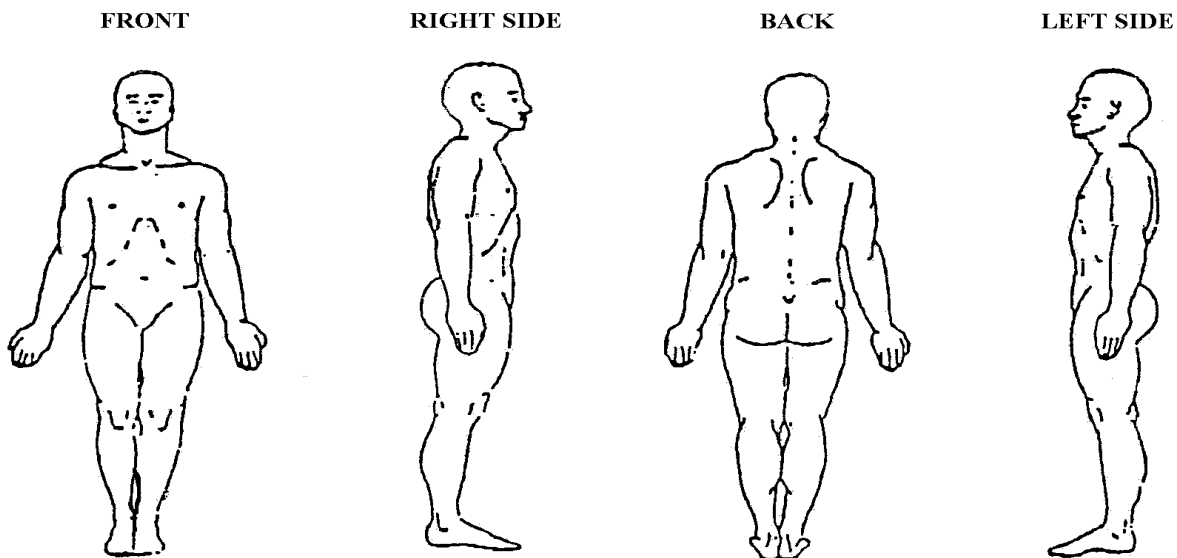
I. Chief Complaint:

1) Where is your pain located? _____

2) When and how did it begin? _____

3) Does your pain radiate anywhere? _____

4) Please mark the area(s) in the diagrams below where you are having pain:



5) On a scale from 0-10, with 0 being no pain and 10 being the worst pain imaginable, what number describes your pain:

At it's best: _____ At it's worst _____ Right at this moment: _____

6) How often does the pain occur: __ Continuously __ Several times a day __ Intermittent
__ Occasionally __ Less than daily

7) When is your pain worse?

__ Morning __ Afternoon __ Evening __ No Usual Pattern __ All the time

8) How has the pain intensity changed since it began?

__ Better __ Worse __ No change

9) Select one or more items below to describe your pain:

Aching Burning Cramping Dull Electric Shock Sharp Shooting
 Stabbing Throbbing Other _____

10) What makes the pain worse?

Standing Sitting Walking Movement Lying Down Bending Forward
 Arching Backward Coughing/Sneezing Using Bathroom
 Other _____

11) What makes the pain better?

Standing Sitting Walking Movement Lying Down Bending Forward
 Arching Backward Coughing/Sneezing Using Bathroom
 Other _____

12) What tests have been done and when?

Test: X-ray MRI CT Myelogram EMG Bone Scan Other

Date: _____

13) Do you have any of the following symptoms associated with your pain?

Numbness/Tingling If yes, where? _____

Weakness If yes, where? _____

Bowel/Bladder Incontinence When did it start? _____

14) List the names of other doctors or specialists you have seen for your pain or who have treated your pain: _____

15) Please check all procedures or modalities you have tried to manage or treat your pain:

	Did it help?		Did it help?
<input type="checkbox"/> Acupuncture	_____	<input type="checkbox"/> Massage	_____
<input type="checkbox"/> Biofeedback	_____	<input type="checkbox"/> Meditation	_____
<input type="checkbox"/> Chiropractor	_____	<input type="checkbox"/> Nerve Blocks	_____
<input type="checkbox"/> Epidural	_____	<input type="checkbox"/> Physical Therapy	_____
<input type="checkbox"/> Facet Block	_____	<input type="checkbox"/> Psychotherapy	_____
<input type="checkbox"/> Ice/Heat	_____	<input type="checkbox"/> Surgery	_____
<input type="checkbox"/> Medications	_____	<input type="checkbox"/> TENS	_____
<input type="checkbox"/> Other	_____		

16) Are you involved in any litigation or lawsuit regarding your pain? Yes___ No___

17) Are you seeking Worker's Compensation as a result of your pain? Yes___ No___

II. Medical Illnesses (check all that apply):

- Thyroid
- Liver (Hepatitis, cirrhosis)
- Psychiatric (depression, anxiety, suicide)
- High Blood Pressure
- High Cholesterol
- Diabetes (diet, medication, insulin)
- Cancer (Type _____)

- Lung (asthma, emphysema, COPD)
- Heart (angina, heart attack, irregular heart beat, pacemaker, heart failure)
- Stomach (ulcer, GERD/reflux)
- Kidney (stones, failure, dialysis)
- Neurologic (stroke, seizure, neuropathy)
- Arthritis (rheumatoid, fibromyalgia)

III. Prior Surgeries:

Type: _____ **Date:** _____

Type: _____ **Date:** _____

IV. Medications

Allergies: _____

Current Non-pain Medications:

Do you take any of the following?

- Aspirin Coumadin
- Plavix Heparin
- Aggrenox Pletal
- Lovenox Ticlid

Current Pain Medicatons:

Previous Pain Medications:

V. Social History (check all that apply):

- Use tobacco? Amount _____
- Use alcohol? Amount _____

- Use illegal drugs? Type _____
- Been treated for alcohol or drug addiction?

VI. Family History (check all that apply):

- Cancer ___ Who? _____
- Diabetes ___ Who? _____
- Heart Disease ___ Who? _____

- Hypertension ___ Who? _____
- Stroke ___ Who? _____
- Alcohol/Drug abuse ___ Who? _____

VII. Review of Systems (circle all that apply):

- GEN: Weight changes, fatigue
- SKIN: Bruising, rashes
- HEAD/EYES: Headache, blurry vision
- ENT: Ears ringing, sinusitis, soar throat
- RES: Chronic cough, shortness of breath
- CV: Chest pain, palpitations
- HEM: Anemia, easy bruising/bleeding

- GI: Heartburn, nausea, constipation
- GU: Blood in urine, painful urination
- M.S. Joint pain, arthritis
- NEURO: Stroke, seizures, weakness
- PS: Depression, anxiety, sleep problems
- END: Thyroid problems, diabetes
- VASC: Leg cramps, aneurysms

Other

Form Completed By: (circle one) Patient