Clearwater Pain Management Associates

New Patient Questionnaire

Name:_____DOB:_____Sex: M / F Date:_____

Referring Physician:_____PCP:_____

Your occupation:_____retired/unemployed/student

I.Chief Complaint:

1.) Where is your pain located?_____

_____

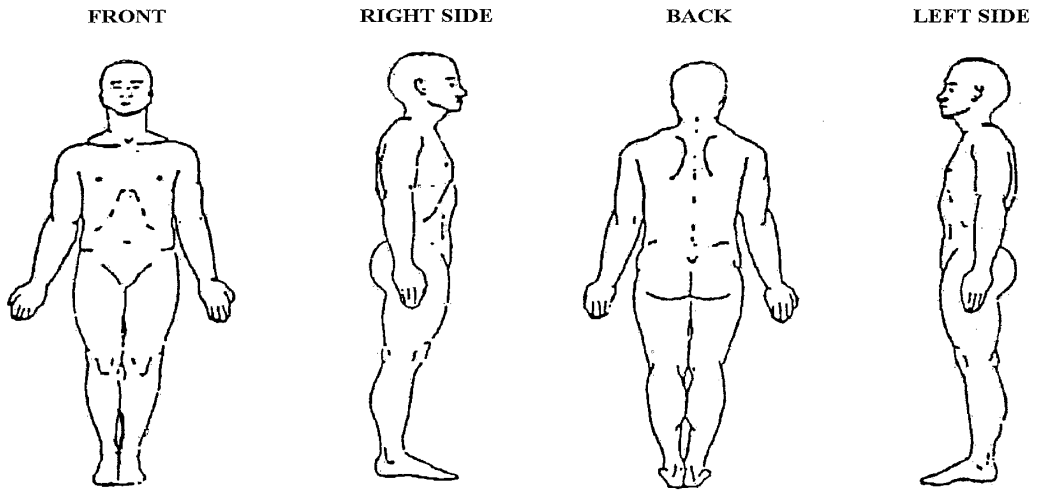
2.) Have you been involved in any Motor Vehicle Accident(s) within the past 12 months?_____

_____

3.) When and how did your pain begin?_____

4.) Does your pain radiate anywhere?_____

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



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

At its best: _____ At its worst_____Right at this moment: _____

7.) How often does the pain occur: ____Constant_____Several times a day_____Intermittent_____

_____Occasionally _____Less than daily

8.) When is your pain worse?

____Morning_____Afternoon_____Evening_____No usual pattern_____All the time

9.) How has the pain intensity changed since it began?_____Better_____Worse_____No change

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10.) Select one or more items below to describe your pain:_____Aching_____Burning_____Cramping

_____Dull_____ Electric Shock_____Sharp_____Shooting_____Stabbing_____Throbbing_____Other

_____

11.) What makes the pain **worse**?_____Standing _____Sitting_____Walking____ _____Lying down

_____Bending forward_____Arching Backward_____Coughing/Sneezing_____Using bathroom

_____Movement_____Other_____

12.) What makes the pain **better**?_____Standing_____Sitting_____Walking _____Lying Down_____

Bending Forward_____Arching Backward_____Movement _____Other_____

13.) What test have been done and when?

_____X-Ray_____MRI_____CT_____Myelogram_____EMG_____Bone Scan_____Other

Date: _____ _____ _____ _____ _____ _____ _____

14.) 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? _____

15.) List the names of other doctors or specialists you have seen for your pain or who have treated your pain_____

_____

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

	Did it help?		Did it help?
_____Acupuncture	_____	_____Massage	_____
_____Biofeedback	_____	_____Meditation	_____
_____Chiropractor	_____	_____ Nerve Blocks	_____
_____Epidural	_____	_____ Physical Therapy	_____
_____Facet Block	_____	_____Psychotherapy	_____
_____Ice/Heat	_____	_____Surgery	_____
_____Medications	_____	_____TENS Unit	_____

_____Other _____

17.) Are you involved in any litigation or lawsuit regarding your pain? Yes_____ No____

If so please give contact information:_____

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18.) Are you seeking Worker's Compensation as a result of your pain? Yes_____ No_____

If so please give contact information:_____

II.) Medical Illnesses (Check all that apply):

____Thyroid

_____Liver (Hepatitis A, B, C, cirrhosis)

_____Psychiatric (depression,anxiety,suicide)

_____High Blood Pressure

_____High Cholesterol

_____Diabetes(diet,medication, insulin)

_____Cancer(type_____)

_____Arthritis(rheumatoid,fibromyalgia, lupus)

_____Back / Neck Pain

_____Lung (asthma, emphysema,COPD)

_____Heart(angina,heart attack,irregular heart beat,pacemaker,heart failure, difibrillator)

_____Stomach (ulcer, GERD/reflux)

_____ Kidney(stones,failure,dialysis)

_____Neurologic(stroke,seizure,neuropathy , MS, migraine)

III). Prior Surgeries:

Type:	Date:	Type:	Date:
_____		_____	
_____		_____	
_____		_____	

IV.) Medications

Medication Allergies:_____

Current **NON-PAIN** Medications:

_____

_____

_____

_____

Do you take any of the following:

_____Aspirin _____Coumadin_____Effient_____Pradaxa

_____Plavix _____Persantine_____Brilinta_____Xarelto

_____Aggrenox_____Pletal_____Eliquis

_____Lovenox_____Ticlid_____Jantoven

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Current Pain Medications: Previous Pain Medications:

_____

_____

_____

_____

_____

V.) Social History (check all that apply):

_____Use tobacco Never /former /current_____pack/day

_____Use Alcohol Never / former /current_____drinks/day

_____Been treated for alcohol or drug addiction_____yes / no Date:_____

_____Use Illegal drugs Never / former /current Type: marijuana /cocaine /PCP / other

VI.) Family Hisiory (check all that apply):

Cancer_____Who?_____ Hypertension_____Who?_____

Diabetes_____Who?_____ Stroke_____Who?_____

Heart Disease_____Who?_____ Alcohol /Drug abuse_____Who?_____

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

GEN.: Weight gain / loss , fatigue GI: Heartburn,nausea, constipation

SKIN:Bruising, rashes GU: Blood in urine, painful urination

HEAD /EYES: Headache, blurry vision M.S: Joint pain, arthritis, back pain, neck pain

ENT: Ears, ringing, sinusitis, sore throat NEURO: Stroke,seizures, weakness

RES: chronic cough,shortness of breath PS: Depression,anxiety,insomnia

CV: Chest pain,palpitations END:Thyroid problems, diabetes

HEM:Anemia,easy bruising/bleeding VASC:Leg cramps,aneurysms

Form Completed by: (circle one) Patient Other

Patient Signature:_____Date:_____

Other (relationship to patient):_____Date:_____