

NEW PATIENT QUESTIONNAIRE

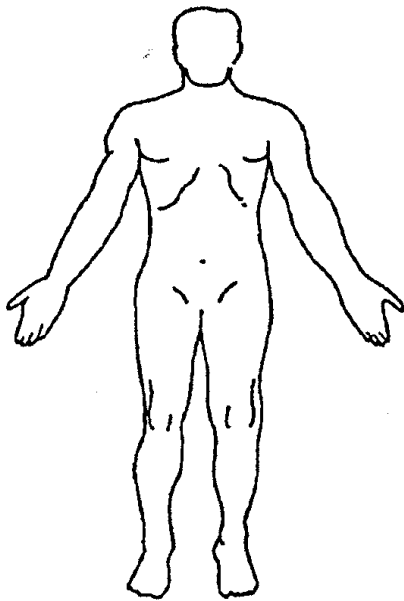
Date _____

Name _____ DOB _____ Age _____

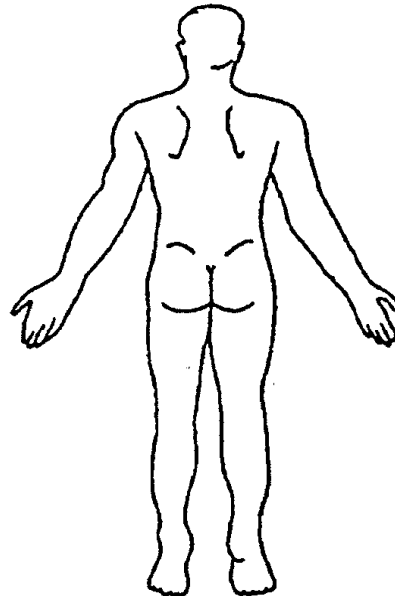
Referring Physician _____ Height _____ Weight _____

PAIN HISTORY

On the drawings below, shade in the areas in which you are having pain. Indicate the worst area with an X.



Front



Back

When did the pain start and how long has the pain been present in this area?

Did an accident or other event precipitate your pain? If yes, please describe:

Describe the pain. Circle all that apply:

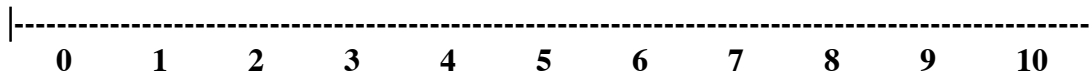
Burning Sharp Shooting Throbbing Aching Pins/Needles
Numbness Cutting Cramps Gripping Electrical Dull

How frequently do you have your pain? Circle one:

Continuously Intermittently

How do you rate the severity of your pain?

On the line below, please mark with an **X**, how much pain you are having right now.



NO PAIN

WORST PAIN

What makes your pain better? _____

What makes your pain worse? _____

Were you injured on the job? Yes No If yes, date of injury _____

Are you currently involved in litigation? Yes No

Are you currently working? Yes No If no, when did you stop? _____

PAST HISTORY

Please list ALL current medications

Medication	Dosage & Frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

List all medical problems:

List all surgeries:

Please List Allergies

Allergies to Medications	Reaction
1.	
2.	
3.	
4.	

Could you be pregnant? Yes No N/A

Do you smoke? Yes No Packs per day _____ Years _____

Do you drink alcohol? Yes No How much: _____ How often: _____

Do you use illicit (street drugs)? Yes No Name of Drug(s) _____ Last used _____
