



NEW PATIENT QUESTIONNAIRE

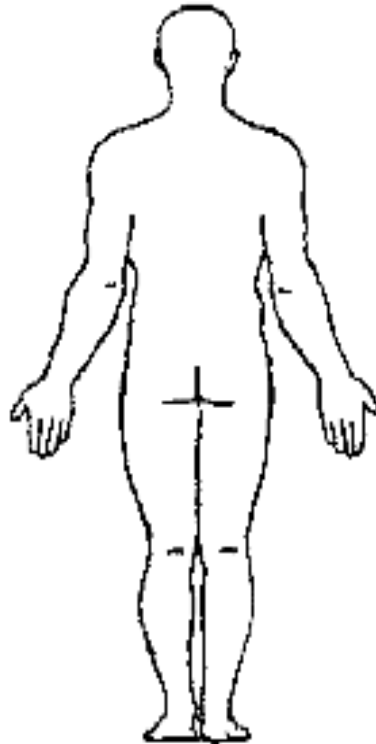
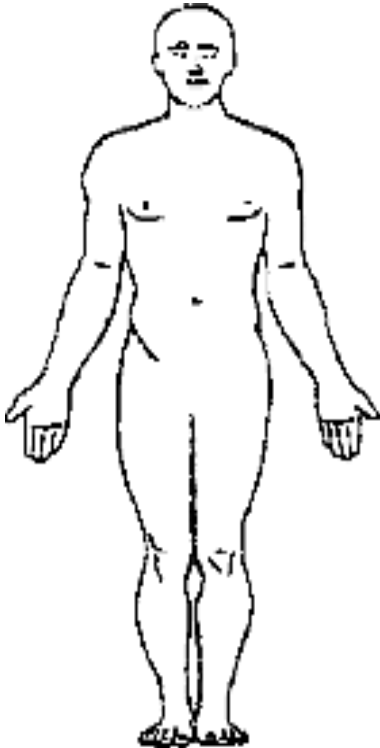
PATIENT NAME: _____

DATE: _____

PRIMARY
DOCTOR: _____

REFERRING
DOCTOR: _____

Please show the location of your pain by drawing on the figures below:



12. WHAT MAKES THE PAIN BETTER? Standing Walking Bending Lifting Sitting
 Medications Ice Heat Lying Down

Other:

13. IN ADDITION TO THE PAIN, DO YOU HAVE? Numbness Weakness
 In the Right Leg In the Left Leg In Both Legs
 In the Right Arm In the Left Arm In Both Arms
 New Bladder New Bowel None of These
 Incontinence Incontinence

14. IS YOUR PAIN Getting Better Getting Worse Staying About the Same

15. WHAT MEDICATIONS HAVE YOU TRIED FOR YOUR PAIN? (Check all that apply)

Anti-Inflammatory: Ibuprofen (Advil, Motrin) Naproxen Celebrex Aspirin
 Relafen Meloxicam (Mobic) Indomethicin

Narcotic: Morphine Avinza MSIR MS Contin
 Kadian Dilaudid Oxycodone Oxycontin
 Darvocet Darvon Hydrocodone Vicodin
 Lortab Lorcet Norco Fentanyl
 Duragesic Actiq Fentora Codeine
 Tramadol Ultram Stadol Percocet
 Percodan

Antidepressants Duloxetine (Cymbalta) Fluoxetine (Prozac) Escitalopram (Lexapro) Trazodone (Deseryl)
 Venflaxine (Effexor) Sertraline (Zoloft) Amitriptyline (Elavil) Nortriptyline (Pamelor)
 Desipramine(Norpramine) Bupropion (Wellbutrin) Citalopram (Celexa) Paroxetine (Paxil)
 Nefazodone (Serzone)

Anti-Seizure: Gabapentin (Neurontin) Pregabalin (Lyrica) Zonisamide (Zonegram) Carbamazepine (Tegretol)
 Lamotrigine (Lamictal) Oxycarbazepine (Trileptal) Tiagabine (Gabatril) Topiramate (Topamax)

Muscle Relaxants/
Anti-Anxiety: Baclofen (Lioresal) Tizanidine (Zanaflex) Metaxolone (Skelaxin) Cyclobenzaprine (Flexeril)
 Methocarbamol (Robaxin) Carisoprodol (Soma) Diazepam (Valium) Clonazepam (Klonopin)
 Alprazolam (Xanax)

Sleeping Aids: Zolpidem (Ambien) Eszopiclone (Lunesta) Zalepion (Sonata) Trazodone (Deseryl)
 Amitriptyline (Elavil) Temazepam (Restoril) Tylenol – PM

OTHER SYMPTOMS (Please indicate other symptoms you may have)

CONSTITUTIONAL

Fever **0 Yes 0 No**
 Fatigue **0 Yes 0 No**
 Insomnia **0 Yes 0 No**
 Weight Loss **0 Yes 0 No**
 Weight Gain **0 Yes 0 No**
 Loss of Appetite **0 Yes 0 No**

GI

Blood in stool **0 Yes 0 No**
 Diarrhea **0 Yes 0 No**
 Vomiting **0 Yes 0 No**
 Constipation **0 Yes 0 No**
 Nausea **0 Yes 0 No**
 Difficulty Swallowing **0 Yes 0 No**
 Abdominal Pain **0 Yes 0 No**
Heartburn 0 Yes 0 No

CARDIOVASCULAR

Dizziness **0 Yes 0 No**
 Chest Pain **0 Yes 0 No**
 Palpitations **0 Yes 0 No**
 Leg Swelling **0 Yes 0 No**
 Shortness of Breath **0 Yes 0 No**

ENT

Cough **0 Yes 0 No**

OTHER CONCERNS:

HEMATOLOGY

Abnormal Bruising **0 Yes 0 No**
 Abnormal Bleeding **0 Yes 0 No**

NEUROLOGY

Seizures **0 Yes 0 No**
 Headache **0 Yes 0 No**
 Memory Loss **0 Yes 0 No**
 Numbness **0 Yes 0 No**
 Where?

URINARY

Urinary Retention **0 Yes 0 No**
 Incontinence **0 Yes 0 No**

RESPIRATORY

Wheezing **0 Yes 0 No**

MUSCULOSKELETAL

Joint Pain **0 Yes 0 No**
 Joint Stiffness **0 Yes 0 No**
 Back Pain **0 Yes 0 No**
 Muscle Weakness **0 Yes 0 No**

PSYCH

Depression **0 Yes 0 No**
 Sleep Disturbances **0 Yes 0 No**
 Suicidal Ideation **0 Yes 0 No**
 Anxiety **0 Yes 0 No**

CURRENT MEDICATIONS (Include dosage and # of tablets per day)

Have you had any surgeries? _____

Are you taking any blood thinners, such as Coumadin or Plavix? 0 Yes 0 No

If so, what: _____

Do you have any allergies we should know about, such as to latex or iodine 0 Yes 0 No

If so, what: _____

Do you have any allergies to Medications? 0 Yes 0 No

If so, what: _____

What are your goals for your pain treatment? _____

Are there any specific treatments you feel would help your pain?

Medications: _____

Physical Therapy: _____

Exercise: _____

Injections: _____

Psychologist Referral: _____

Surgical Referral: _____

Platelet Rich Plasma or Other New Therapies _____

Other Pain Therapies: _____

Do you have a driver with you today? 0 Yes 0 No

THIS IS THE END OF THE QUESTIONNAIRE. THANK YOU!