New Patient Form

Name: _____

Date of visit: _____

Date of birth: _____

Pain Description

What is the location of your pain?_____

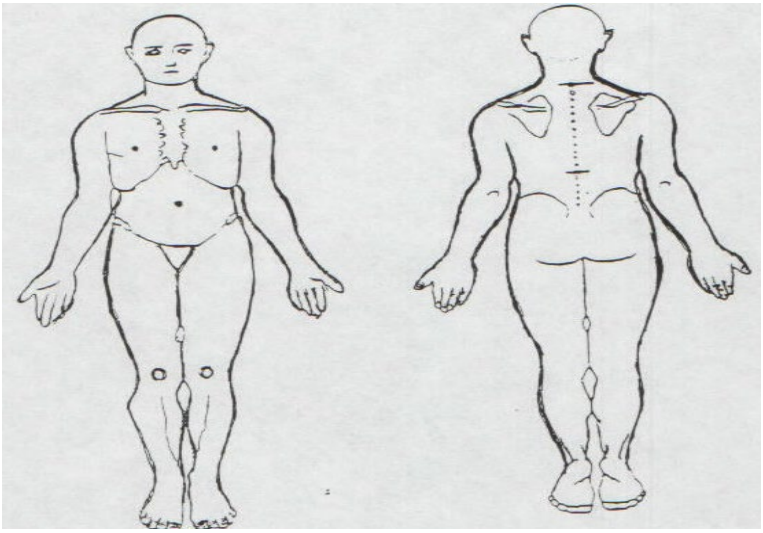
Does the pain radiate? Where? _____

When did your current pain begin? _____

How did it happen? _____

Rate your pain from 1-10:

Currently: ____ Worst: _____ Least Level: ____



Mark the location of pain, numbness, or tingling on the diagram. Mark with a X.

How would you describe your pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Shooting ☐ Stabbing ☐Throbbing Other:_____

Duration of pain? ☐ Constant ☐ Intermittent

How often do you have flare-ups of pain? ☐ Daily ☐ every 2-3 days ☐ every 4-5 days

What makes your pain worse? _____

What makes your pain better? _____

Do you have numbness/tingling sensations in your: ☐ Arms ☐ Hands ☐ Legs ☐ Feet

Associated Symptoms: ☐ Arms weakness ☐ Leg weakness

Does your pain interfere with your: ☐ Walking ☐ Work ☐ Activity of Daily Living ☐ Hobbies ☐ Sleep ☐Exercise

Treatment History

Check all treatments you have received for this problem:

☐Pain Medications Please list and please note if it helped or did not help with pain:

_____

_____

☐ Physical therapy (Please circle) Help with pain Did not help with pain

☐ Injection

What type of injection: _____

When: _____ (Please circle) Help with pain Did not help with pain

☐ Radiofrequency Ablation Where_____ When:_____

☐ Spinal cord stimulator Where _____ When:_____

☐ Chiropractor (Please circle) Help with pain Did not help with pain

☐ Other things tried: _____

List all previous pain doctors:_____

Diagnostic imaging that you have done for your problem:

X-Ray of (what body parts)_____ Date: _____ Facility:_____

CT scan_____ Date:_____ Facility:_____

MRI_____ Date:_____ Facility:_____

EMG _____ Date:_____ Facility:_____

Other Test:_____ Date:_____ Facility:_____

Medications That You Are Currently Taking:

Drug Name	Dose	How Often

Currently prescribed a blood thinner? ☐ Yes ☐ No Medication: _____Prescriber:_____

Allergies and side effects: ☐ No known allergies ☐ Latex ☐Iodine ☐ Medications (list all)

_____

_____

Medical History

Do you have any history of: (Check all that apply)

☐Hypertension ☐Diabetes (circle) Type 1 / 2 ☐Heart Disease ☐High Cholesterol ☐Neuropathy
☐Kidney Disease ☐ On Dialysis ☐GERD ☐Hepatitis A/B/C ☐Asthma ☐COPD
☐Cancer _____ ☐Stroke ☐Seizure ☐Lupus ☐Blood clot(s) ☐Thyroid problem
☐HIV/AIDS ☐ Substance abuse ☐Depression ☐Anxiety ☐Bipolar ☐ADHD
Other health problems not mentioned above: _____

Surgical History

Do you have previous surgeries? (Check all that apply and specify type)

☐Heart surgery ☐Defibrillator ☐Pacemaker ☐Kidney surgery
☐Neck surgery ☐Back surgery ☐Joint surgery. If yes, which joint: _____
☐Gallbladder surgery ☐ Appendectomy ☐Tonsillectomy
Other Surgeries or types of surgeries mentioned above:

_____

_____

If yes to any surgery above, List date of surgery: _____

Family History

Check all that apply to your Family History

☐Hypertension Relatives:_____ ☐Diabetes Relatives:_____ ☐Heart Problems Relatives:_____
☐Cholesterol Relatives:_____ ☐Cancer Type:_____ Relatives:_____
☐Arthritis Relatives:_____ ☐Neck Pain Relatives:_____ ☐Back pain Relatives:_____
☐ Substance abuse. Relatives:_____☐Depression: Relatives:_____
Other Health Problems not mentioned above: _____

Social History

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Who do you live with? ☐Alone☐spouse ☐Significant other ☐Children ☐Parents ☐Other
Employment status Circle one: ☐Full Time ☐Part Time ☐Retired ☐Unemployed
Smoking: ☐ Never a smoker ☐ Former Smoker ☐ Current Smoker: Frequency _____
How many years of smoking:_____ When do you stop smoking:_____
Alcohol use: ☐ Never drinks ☐ Socially (Drinks/wk)_____ ☐ History of Alcoholism
☐ Current Alcoholism
Illegal Drug Use : ☐ Yes ☐ No ☐ Formerly Used Illegal drugs.
If yes, please elaborate_____
Have you ever abused prescription medications: ☐ Yes ☐ No If yes, please elaborate _____

Review of Systems (Please Check All That Apply)

General

- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Tiredness/Fatigue
- ☐ Fever ☐ Chills

Allergy/Immunology

- ☐ Rash
- ☐ Seasonal allergy
- ☐ Nasal Congestion

HEENT

- ☐ Decrease Hearing
- ☐ Dry Mouth ☐ Ear Pain

Endocrine

- ☐ Cold/Heat Intolerance
- ☐ Excessive Sweating

Respiratory

- ☐ Difficulty Breathing
- ☐ Wheezing
- ☐ Shortness of Breath

Cardiovascular

- ☐ Palpitation
- ☐ Chest Pain
- ☐ Swelling of Hands/Feet

Gastrointestinal

- ☐ Nausea ☐ Vomiting
- ☐ Diarrhea ☐ Constipation
- ☐ Abdominal Pain
- ☐ Incontinence of Stool

Genitourinary

- ☐ Pelvic Pain
- ☐ Incontinence of Urine
- ☐ Difficulty with Urination
- ☐ Painful Urination

Musculoskeletal

- ☐ Neck Pain
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Swollen Joint

Neurological

- ☐ Headaches ☐ Dizziness
- ☐ Arm Weakness
- ☐ Leg Weakness
- ☐ Arm/Leg Numbness/Tingling
- ☐ Balance Difficulty

Psychiatric

- ☐ Depression
- ☐ Suicidal Ideation
- ☐ Anxiety
- ☐ Insomnia

Hematology

- ☐ Abnormal bleeding
- ☐ Bruise easily

Peripheral Vascular

- ☐ Blood clots
- ☐ Cold Extremities

Pharmacy Information

Pharmacy Name: _____ Phone Number: _____

Address: _____

Office Use Only:

Risk level: Low Mod High SOAPP-R score: _____

Ht: _____ Wt: _____ Temp _____

O2: _____ BP: _____ / _____ Pulse: _____

Drug Screen: UDS POC/Oral Swab: Not required Done

Patient last took opioid medication:_____

Previous UDS: ☐ Consistent ☐ Inconsistent_____

BZO BAR COC THC MET OPI/MOP MTD TCA OXY PCP AMP BUP NEGATIVE