New Patient Form

Name: _____ **Date of visit:** _____

Date of birth: _____

Pain Description

Where is your pain?_____

Does the pain radiate? Where? _____

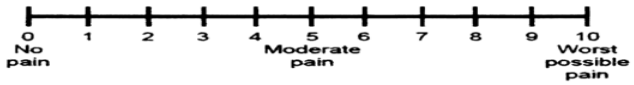
When did your current pain problem begin? _____

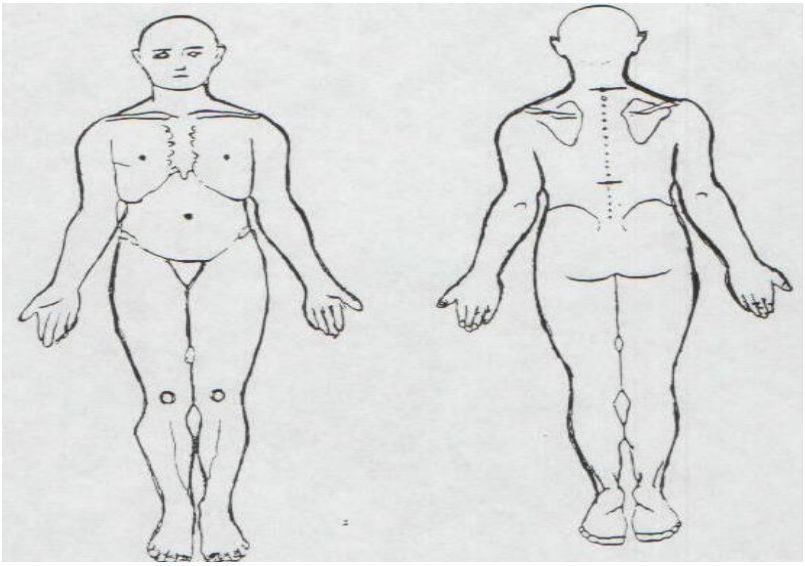
How did it happen? _____

Are your symptoms getting better, worse or the same? _____

Over the last month, rate your pain:

Currently: ____ Worst: _____ Least Level: ____





Mark pain/numbness/tingling on diagram. Mark worst spot with an X

How would you describe your pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Shooting ☐ Stabbing ☐Throbbing ☐ Numb ☐ Tingling ☐ Pressure ☐ Nagging ☐ Crampy Other:_____

Frequency of pain? ☐ Constant ☐ Intermittent

What makes your pain worse? _____

What makes your pain better? _____

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

Associate Symptoms: ☐ Arms weakness ☐ Leg weakness ☐ Loss of Bowel control ☐ loss of Bladder control

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

Treatment History

Check all treatments you have received for this problem:

☐ Medications. Please list: _____

☐ 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:_____

☐ Surgery. What type of surgery: _____ When: _____

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

☐ Other things tried: _____

Who has treated this pain before: _____

Diagnostic Tests that you have done for your problem:

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

CT(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: ☐ No known allergies ☐ Latex ☐Iodine ☐ Medications (list all)

_____

Medical History

Do You Have any History of (Check All That Apply)

☐Hypertension ☐Diabetes ☐Heart Disease ☐High Cholesterol ☐Thyroid problem
☐Kidney Disease ☐ On Dialysis ☐GERD ☐Hepatitis A/B/C ☐Asthma ☐COPD
☐Cancer _____ ☐Stroke ☐Seizure ☐Lupus ☐Rheumatoid Arthritis ☐DVT
☐HIV/AIDS ☐ Substance abuse ☐Depression ☐Anxiety ☐Bipolar ☐ADHD
Other Health Problems not mentioned above: _____

Surgical History

Do You Have Previous Surgery (Check All That Apply)

☐Heart surgery ☐Defibrillator ☐Pacemaker ☐Kidney surgery ☐Bladder surgery
☐Neck surgery ☐Back surgery ☐Joint surgery. If yes, which joint: _____
☐Gallbladder surgery ☐ Appendectomy ☐Tonsillectomy
Other Surgeries not mentioned above: _____
If yes to any surgery above, List date of surgery: _____

Family History

Please Check All That Apply to your Family History

☐Hypertension. Relatives:_____ ☐Diabetes. Relatives:_____ ☐Heart Problem. 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
Smoking: ☐ Never a smoker ☐ Former Smoker ☐ Current Smoker: Frequency _____
How many years of 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: _____
Patient signature: _____
Date: _____

Office Use Only:
Risk level: Low Mod High
Ht: _____ Wt: _____ Pulse: _____
O2: _____ Temp _____ BP: _____ / _____
Opiate Treatment Agreement Signed. Date _____
UA POC/Oral Swab: Not required Done
(Circle all apply)
BZO BAR COC THC MET OPI MTD TCA OXY PCP AMP