# New Patient Form

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

**Date of birth:** _____

## Pain Description

**Where is your pain?**_____

**When did your current pain problem begin?** _____

**How did it happen?** _____

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

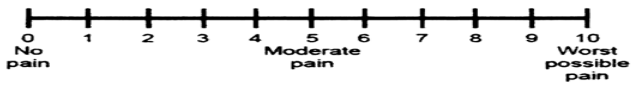
**How would you describe your pain?** ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Shooting ☐ Stabbing ☐Throbbing ☐ Numb ☐ Tingling ☐ Crampy Other:_____

**Duration of pain**? ☐ Constant ☐ Intermittent

Frequency of pain: ☐ Daily ☐ every 2-3 days/wk ☐ every 4-5 days/wk

**Over the last month, rate your pain**:

Currently: ____ Worst: _____ Least Level: ____




**Does the pain radiate? Where?** _____

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

**Associate Symptoms:** ☐ R/L Arms weakness ☐ R/L Leg weakness

**What makes your pain worse?** _____

**What makes your pain better?** _____

**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

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

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

_____

_____

**Office Use Only:**

Risk level: Low Mod High

Ht: _____ Wt: _____ Temp _____ SOAPP-R:_____

O2: _____ BP: _____ / _____ Pulse: _____ PHQ-9:_____

Drug Screen: UDS POC Oral Swab: Not required Done

(Circle all apply)

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