Restorative Pain Management New Patient Questionnaire

Name: _____ Date: _____

Address: _____

_____

Telephone # _____ Cell Phone # _____ Gender: Male Female

Date of Birth: _____ Age: _____ Email: _____

Race: Caucasian African-American Hispanic Asian Other Right or Left-Handed?

Primary Care Physician: _____ Telephone # _____

When did your pain start? (Approximate Date): _____

How did your pain start? _____

Have you been treated by another pain doctor in the past? Yes No

If yes, please list who and when: _____

Is there pending litigation associated with the pain? Workers Comp Personal Injury Car Accident

Are you receiving disability payments? Yes No Are you currently working? Yes No

Which best describes your pain? (Circle as many as apply):

Sharp Dull Burning Shooting Stabbing Tingling Throbbing Sore Aching

What activity brings on the pain or makes it worse? _____

What eases or eliminates the pain? _____

Is your pain getting better, worse or staying about the same? (Circle one)

Does your pain disrupt your sleep? Yes No How many hours do you sleep on average? _____

Past Medical Treatments for Pain (Circle all that apply): Bed Rest Physical Therapy TENS

Chiropractic Acupuncture Anti-Inflammatories Pain Pills Muscle Relaxants Steroid Injections

Past Surgical Treatments for Pain: _____

Current Pain Medications and Dose (Attach list if needed): _____

_____

Allergies to medications? _____

Please bring an up to date list of **ALL** of your medications to your initial visit

Past Medical History (Circle as many as apply): High Blood Pressure Diabetes Stroke Heart Disease Kidney Disease Liver Disease Hepatitis HIV/AIDS Bleeding/Bruising Stomach Ulcers/Reflux Thyroid Gout Arthritis Anxiety Depression Bipolar Schizophrenia Breathing Problems Head Aches Autoimmune Disease Epilepsy Sexual Difficulties Cancer, Location?_____

Review of Symptoms (Circle all that apply) Change in Vision Fevers/Chills Fatigue Depression Chest Pain Trouble Breathing Unusual Bleeding Impotence Tingling (pins & needles) Insomnia

Past Surgical Procedures for Your Medical Conditions (Please include approximate date):

_____

Social History: Current occupation? _____ Full or Part-Time?

If you are retired or disabled what type of work did you previously do? _____

When did you last work? _____

Marital Status? (Circle): Single Married Widowed Divorced/Separated Living with Sig. Other

Number of Children: _____ Do you have a support system at home? _____

Do you smoke? Yes No If yes, how many packs per day? _____ How long? _____

Do you drink alcohol? Yes No If yes, how much in an average day, week or month? _____

Do you have a history of alcohol or drug abuse? Yes No If yes, how long sober? _____

If yes, what substance was abused? _____

Do you manage your pain with illicit drugs or alcohol? Yes No What type? _____

Have you ever felt the need to cut down on your drinking or drug use? Yes No

Have people annoyed you by criticizing your drinking or drug use? Yes No

Have you ever felt bad or guilty about your drinking or drug use? Yes No

Have you ever needed an eye opener first thing in the morning to steady your nerves? Yes No

Do you exercise? Yes No How often? _____

Females: Last menstrual period: _____ Could you be pregnant? Yes No

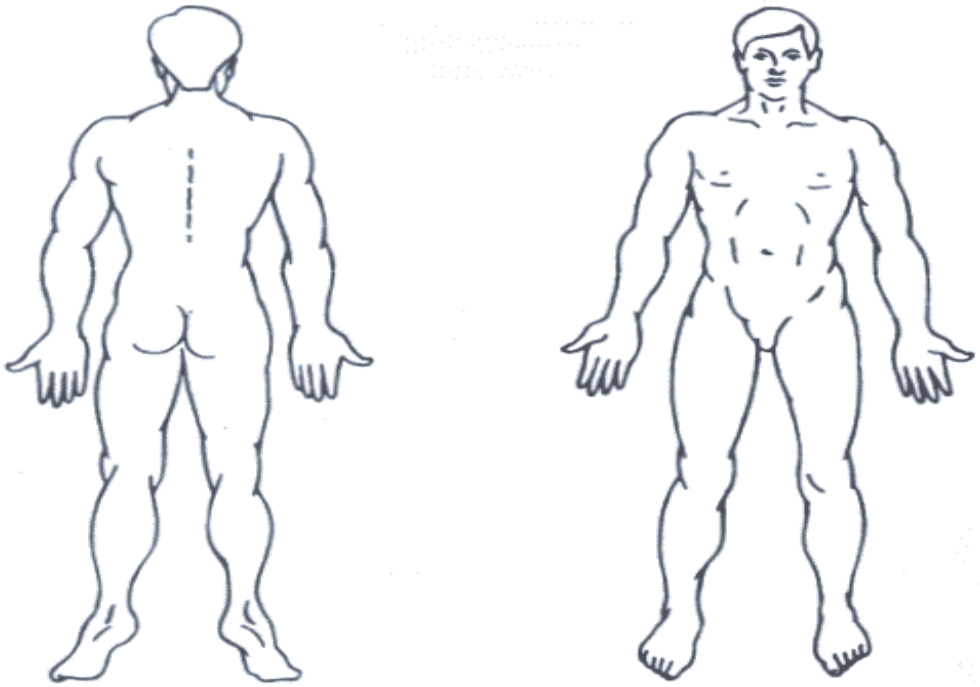
Describe your pain: _____

_____

_____

Rate your overall pain: No Pain 0----1----2----3----4----5----6----7----8----9----10 Worst Pain Ever

Please mark the location of your pain with an "**X**" and draw areas of radiation where your pain travels with an arrow " ⬇ "



_____ _____

Patient Signature Date