

Initial Visit Questionnaire

All **New Patients** and Established Patients, who have not been seen in 6 months or longer are to complete this questionnaire in full.

Pt. Name: _____ Age: _____ Referring MD: _____ Date: _____

1. Where is your pain located?
2. Does the pain radiate or travel to any part of your body?
3. How long have you had this pain?
4. Can the onset of pain be traced to a specific event or circumstance (i.e. injury, etc)? Please Specify:
5. Do you have a history of this type of pain before the above specified event? No Yes, please explain _____
6. How would you describe your pain?
 Burning Stabbing Sharp Dull Toothache-like Other: _____
7. Is your pain constant or intermittent?
8. Place an X on the scale that best indicates the severity of your pain.
 Today: No Pain ----- Worst Possible Pain
 A "Good Day": No Pain----- Worst Possible Pain
 A "Bad Day": No Pain----- Worst Possible Pain
9. Does anything (position, exercise, medications, etc.) improve your pain? Please specify:
10. Does anything (position, exercise, medication, etc.) worsen your pain? Please specify:
- 11(a).Does your pain keep you awake? Y N 11(b). Are there any rashes or blisters over the painful area? Y N
12. Does the affected area exhibit any difference in:
 Sensitivity Temperature Color Hair Distribution Sweating
13. What pain treatments have you attempted in the past?
 Physical Therapy Surgery Biofeedback TENS Unit Nerve Blocks
 Hypnosis Acupuncture Chiropractor Massage Therapy
14. Please list all your current medications:

15. Are you on any blood thinners (i.e. Coumadin, Plavix etc) _____
16. Do you take aspirin, Aleve, naproxen or any products containing aspirin? _____
17. Please list any allergies to medications and **list the reaction to the medications please:**
18. Are you allergic to Latex? Yes No
19. Have you had a hysterectomy? Yes No NA
20. Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	Y N Heart Surg/Pacemaker	Y N Heart Murmur	Y N Joint Pain
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves	Y N GERD
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N Thyroid Conditions
Y N HIV+/Aids	Y N Shingles	Y N Cancer	Y N Liver Conditions
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia	Y N Kidney Conditions
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Arthritis
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis	Y N Asthma
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Lower Back Problems	Y N Chemotherapy
Y N Diabetes/Tuberculosis	Y N Difficulty Breathing	Y N Artificial Bones/Joints	Y N MRSA/VRE/ESBL

Other: _____

21. Please list any surgery and approximate date:

22. Do you have a pacemaker or ICD: Yes No

23. Is there a chance that you are pregnant: Yes No

24. Is there a history or current use of illegal substances? (Marijuana, Cocaine, narcotics, amphetamines, etc.) Yes No
If yes what? _____

25. Is there a history in your family of?

High Blood Pressure Heart Disease Diabetes Arthritis Cancer Type of Cancer: _____

26. Do you use alcohol or tobacco regularly: Yes No Specify Quantity: _____

27. Have you ever seen a psychiatrist for your pain? Yes No

28. Have you ever attempted suicide because of your pain? Yes No

29. Are you currently working? Yes No What is your occupation? _____

30. Are you receiving Workers' Compensation? Yes No

31. Are you currently, or have you previously, been involved in lawsuit regarding your pain? Yes No

32. Do you have an AHD (Advanced Health Directive)? Yes No If yes, please bring with you.

33. Review of Systems: Please note pertinent problems:

Constitution:	Fever:	No	Yes	Comment:
	Weight loss:	No	Yes	Comment:
Eyes:	Vision Problems:	No	Yes	Comment:
Ears/Nose/Throat/Mouth:	Problems:	No	Yes	Comment:
Cardiovascular:	Chest Pain:	No	Yes	Comment:
	Shortness of Breath	No	Yes	Comment:
	Palpitations:	No	Yes	Comment:
	Foot Swelling:	No	Yes	Comment:
Respiratory:	Cough:	No	Yes	Comment:
	Wheeze:	No	Yes	Comment:
Gastrointestinal:	Constipation:	No	Yes	Comment:
	Diarrhea:	No	Yes	Comment:
	Abdominal Pain:	No	Yes	Comment:
	Nausea:	No	Yes	Comment:
Genitourinary:	Problems:	No	Yes	Comment:
Musculoskeletal:	Problems:	No	Yes	Comment:
Skin:	Changes/Problems:	No	Yes	Comment:
Neurological:	Fainting:	No	Yes	Comment:
	Dizziness:	No	Yes	Comment:
Psychiatric:	Depression:	No	Yes	Comment:
Hormonal:	Problems:	No	Yes	Comment:
Hematology/Lymphatic:	Problems:	No	Yes	Comment:
Endocrine:	Diabetes:	No	Yes	Comment:
	Thyroid:	No	Yes	Comment:

34. What is your current weight and height? Weight _____ Height _____

35. Have you had testing for osteoporosis, such as bone density? YES NO
(this applies to *both* men and women)

36. Do you have a living will also known as a health care directive? YES NO if you answered yes, please supply us with a copy.

Initial Visit Questionnaire

Patient Name: _____

DOB: _____

Date: _____

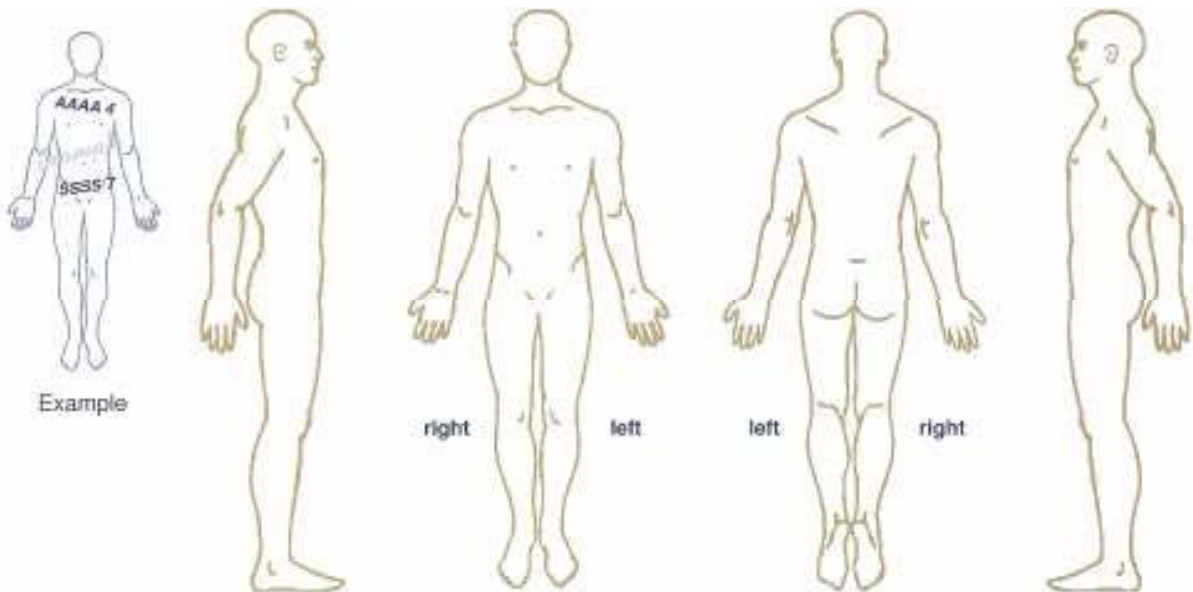
SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
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Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS
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○ Circle any area of pain not represented by a symbol



I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____

Adult Patient

Parent/Guardian

Spouse

Date: _____