New Patient Information

The following questionnaire is a very important tool for our office to help assess your current condition and to help us determine the best course of treatment for you.

Please read and fill out all items in this form. Failure to completely fill this out and bring it with you to your appointment will result in a delay in your appointment.

Thank you very much for your cooperation and we look forward to working with you.

Name: _____Age: _____

Daytime Phone Number:_____

Email Address: _____

Primary Care Physician:_____

Address:_____

_____

Phone Number:_____ Fax Number:_____

Pharmacy:_____

Address:_____

_____

Phone Number:_____ Fax Number:_____

Cardiologist_____
Address_____
Phone_____
Fax_____

Pain Management Specialist _____
Address_____
Phone_____
Fax_____

Other Doctors that you would like us to send a copy of your report to:

Full Name_____
Address_____
Phone_____
Fax_____

Full Name_____
Address_____
Phone_____
Fax_____

What is the reason for your visit today? _____
If you have pain, then please describe your pain problem. Please include the location of your pain and if it spreads to other locations.

_____

_____

Is one side worse than the other side? (Please circle) Left Right Both are equal

Which areas bother you? *May choose more than one*

☐ Neck ☐ Right Shoulder or Arm ☐ Left Shoulder or Arm ☐ Upper Back

☐ Buttock ☐ Right Hip or Leg ☐ Left Hip or Leg

Which area currently bothers you most?

☐ Neck ☐ Right Shoulder or Arm ☐ Left Shoulder or Arm ☐ Upper Back

☐ Buttock ☐ Right Hip or Leg ☐ Left Hip or Leg

How would you describe your symptoms? *You may choose more than one*

	Numbness	Weakness	Pain	Burning	Stabbing	Tingling	Deep Ache
Neck	☐	☐	☐	☐	☐	☐	☐
Right Shoulder or Arm	☐	☐	☐	☐	☐	☐	☐
Left Shoulder or Arm	☐	☐	☐	☐	☐	☐	☐
Lower Back	☐	☐	☐	☐	☐	☐	☐
Right Hip, Buttock, or Leg	☐	☐	☐	☐	☐	☐	☐
Left Hip, Buttock, or Leg	☐	☐	☐	☐	☐	☐	☐

For how long has your current problem been bothering you?_____

When did your symptoms begin? _____

Is your injury due to an accident/work related? _____

Is there litigation pending? _____

What does your pain feel like? _____

How does your pain affect your lifestyle? (Which activities or hobbies would you like to do that you can no longer do?_____

_____

_____

What causes your symptoms to come on? *May choose more than one*

	Nothing- There all the time	Nothing- But not there All the time	Activity	Rest	Lying Down	Lifting	Pushing/ Pulling	Climbing Stairs	Walking	Standing
Neck	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Right Arm or Shoulder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Left Arm or Shoulder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Right Hip, Buttock or Leg	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Left Hip, Buttock or Leg	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Which <u>Treatments</u> have you tried? May choose more than one

	Was this helpful?	Comments about this treatment?
☐ Over-the-counter Medications	☐ Yes ☐ No	_____
☐ Narcotic Medications	☐ Yes ☐ No	_____
☐ Physical Therapy	☐ Yes ☐ No	_____
☐ Chiropractic Therapy	☐ Yes ☐ No	_____
☐ Traction	☐ Yes ☐ No	_____
☐ Braces	☐ Yes ☐ No	_____
☐ Relaxation Training	☐ Yes ☐ No	_____
☐ Hypnosis	☐ Yes ☐ No	_____
☐ Biofeedback	☐ Yes ☐ No	_____
☐ Ice/Heat	☐ Yes ☐ No	_____
☐ Religious Counseling	☐ Yes ☐ No	_____
☐ Psychological Counseling	☐ Yes ☐ No	_____
☐ Surgery	☐ Yes ☐ No	_____
☐ Massage	☐ Yes ☐ No	_____
☐ Acupuncture	☐ Yes ☐ No	_____
☐ Epidural Injections	☐ Yes ☐ No	_____
☐ Facet Injections	☐ Yes ☐ No	_____
☐ Peripheral Nerve Blocks	☐ Yes ☐ No	_____
☐ Sympathetic Block	☐ Yes ☐ No	_____
☐ Stellate Block	☐ Yes ☐ No	_____
☐ Trigger Point Injections	☐ Yes ☐ No	_____
☐ Muscle Relaxants	☐ Yes ☐ No	_____
☐ TENS unit	☐ Yes ☐ No	_____

☐ Other treatments: _____

Which Diagnostic Studies have been done to evaluate your current problem?

	Who ordered the test?	When?	Where were they done?
☐ X-Rays	_____	_____	_____
☐ MRI Scans	_____	_____	_____
☐ CT Scans	_____	_____	_____
☐ EMG / Nerve Conduction Studies	_____	_____	_____
☐ Other: _____	_____	_____	_____

Please let us know something about your previous spine surgery/surgeries:

Fill in as much as you can

	What type of surgery was performed? (ALIF, PLIF, Lumbar Fusion, Scoliosis Surgery, Tumor Surgery, Laminectomy, Discectomy, ACDF, etc,)	Which Levels were Operated upon? (L45, L5S1, C6, C34, etc)	What was the date of the surgery?	Who was the Operating Physician?	Was a Fusion performed?	Were there any complications?
#1						
#2						
#3						
#4						

Other spine surgeries:

_____

_____

_____

Have you ever had a problem with anesthesia? _____ If yes, please explain._____

Have you ever had a blood transfusion? _____ If yes, please explain._____

PAST MEDICAL HISTORY (Check All that Apply)

What other medical problems do you have or have you had with your Heart or Blood?

	Sickle Cell Anemia		Stroke		Heart Disease
	Anemia				
	OTHER				
	Blood Clots		Congestive Heart Failure		Arrhythmia
	Coronary Artery Disease		High blood pressure		High cholesterol

What other medical problems do you have or have you had with your Lungs?

	Asthma		COPD		Pneumonia
	OTHER				

What other medical problems do you have or have you had with your Stomach or Intestines?

	GERD		IBS – Irritable Bowel Syndrome		Ulcers
	OTHER				

What other medical problems do you have or have you had with your Nervous System or Mental Health?

	Depression		Anxiety
	OTHER		

What other medical problems do you have or have you had?

	Diabetes Mellitus		Stroke		Osteoarthritis
	Lung Cancer		Gout		Prostate Cancer
	Lupus		Sleep Apnea		Rheumatoid Arthritis
	Breast Cancer		Hepatitis		Seizures
	Colon Cancer		HIV/AIDS		Hypothyroid
	Alcohol Abuse		Kidney Disease		Fibromyalgia
	OTHER				

Please write any additional medical problems not mentioned previously:

_____

_____

_____

_____

SURGICAL HISTORY (Check All That Apply)

What **surgeries** have you had on your Heart or Blood Vessels?

	Heart Surgery		Coronary Artery Bypass Graft		Heart Valve Replacement or Repair
	Aneurysm Repair		Abdominal Aortic Aneurysm Repair		Pacemaker / Defibrillator
	OTHER				

What **surgeries** have you had on your Lungs, Chest, or Breasts?

	Chest surgery		Removal of lung		Breast surgery
	OTHER				

What **surgeries** have you had on your Stomach, Abdomen, or Pelvis?

	Appendectomy		Cholecystectomy – Gallbladder surgery		C-section
	Hernia Repair		Hysterectomy		Tubal Ligation
	Vasectomy		Liver surgery		Small bowel obstruction
	Bladder repair		Colon surgery		Spleen removed – Splenectomy
	OTHER				

What **surgeries** have you had on your Head, Face, Neck, or Brain?

	Neurosurgery		Spine tumor surgery		VP shunt
	Tonsillectomy – tonsils removed		Tracheostomy		Brain tumor surgery
	Sinus or nose surgery		Vocal cord surgery		
	OTHER				

Please list any surgeries not mentioned previously

_____

_____

_____

Do you experience any of these symptoms? *(Please check ALL that apply)*

Heart Symptoms

- ☐ Palpitations
- ☐ Chest Pain
- ☐ Excessive Sweating

Breathing Problems

- ☐ Difficulty Breathing while lying flat
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Night Sweats
- ☐ Pneumonias

Blood Problems

- ☐ Anemia
- ☐ Easy Bleeding
- ☐ Frequent Infections

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Being seen by a Psychiatrist

Head or Neurologic

- ☐ Headaches
- ☐ Dizziness
- ☐ Blackouts
- ☐ Paralysis
- ☐ Seizures

Kidney, Bladder & Sexual

- ☐ Burning on Urination
- ☐ Frequent Urination
- ☐ Nighttime Urination
- ☐ Difficulty Starting Urination
- ☐ Blood in Your Urine
- ☐ Sexual Difficulties

Overall Health

- ☐ Heart Attacks
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Swelling in the Legs – Edema
- ☐ Legs cramp when walking
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss
- ☐ Weakness

Abdomen and Stomach

- ☐ Heartburn
- ☐ Indigestion
- ☐ Difficulty Swallowing
- ☐ Ulcers
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Rectal Bleeding
- ☐ Change in Bowel Habits
- ☐ Jaundice

Bone and Joints

- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Pain

Do you Drink? If so, how much?

- ☐ None
- ☐ 1-4 drinks per week
- ☐ About a drink per day
- ☐ Several drinks per day

Do you Smoke? If so, how much?

- ☐ None
- ☐ Less than 1 pack per week
- ☐ 1-3 packs per week
- ☐ About a pack per day
- ☐ More than a pack per day
- ☐ Not Currently, but I did smoke a pack or more in the past

Do you do any drugs not listed in the medications? If so, how much?

- ☐ None
- ☐ Marijuana
- ☐ Cocaine
- ☐ Injectable Drugs

Do you work? If so, please write in your job title: _____

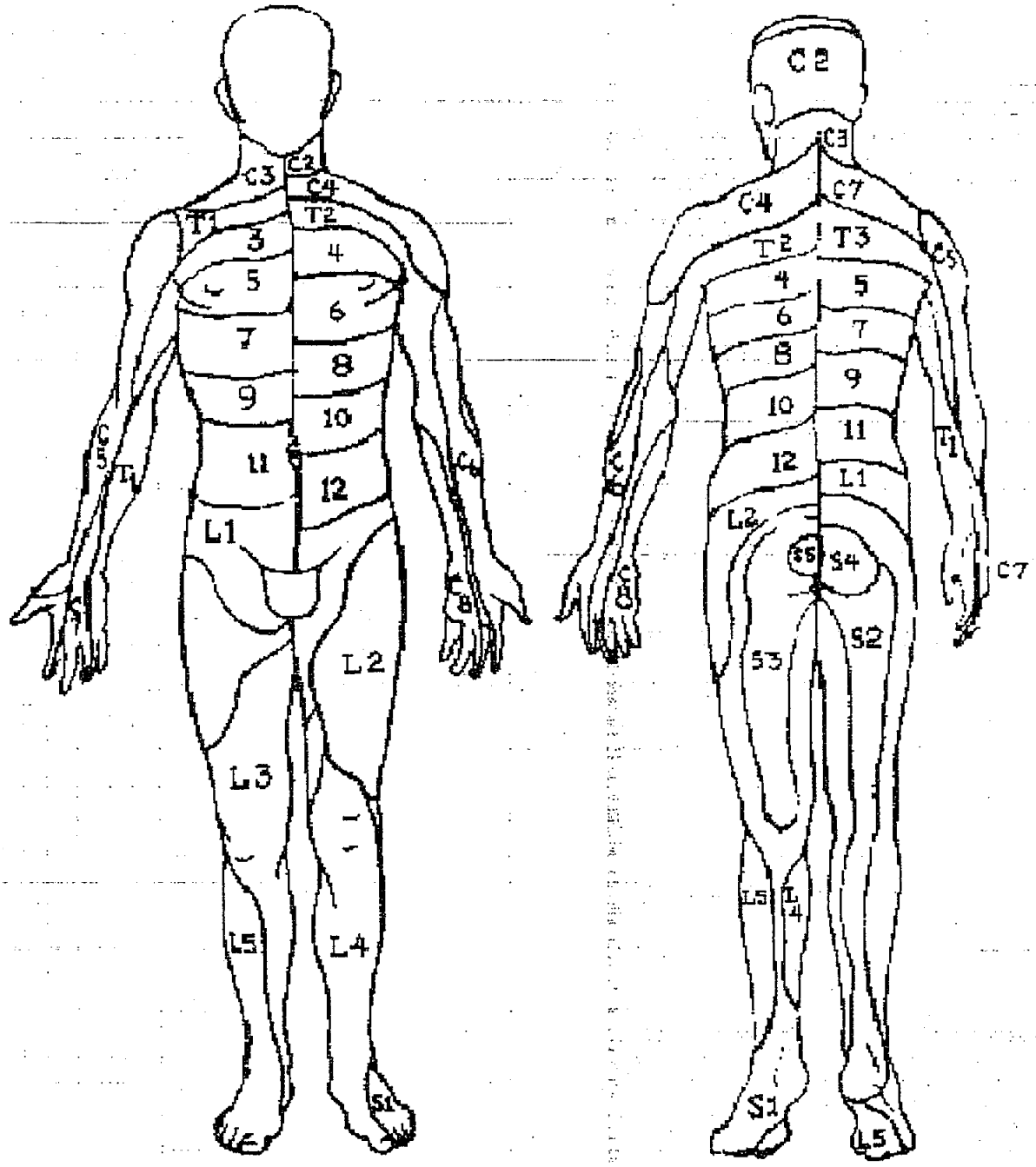
If not, then please explain your current situation:_____

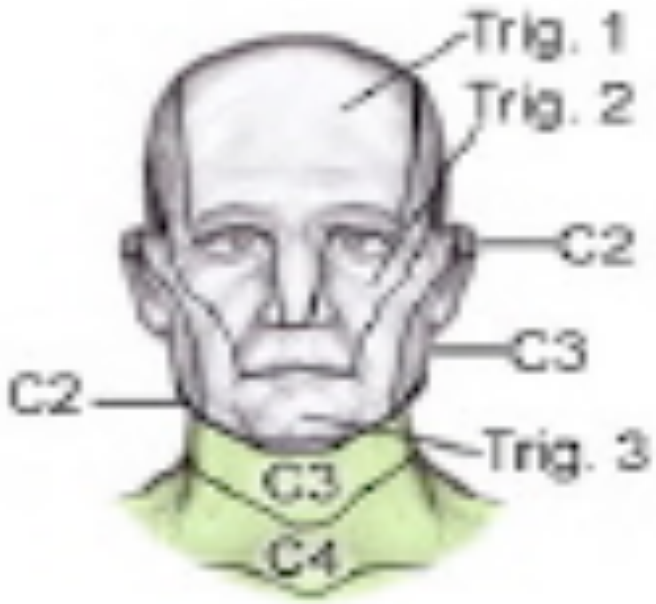
Please tell us what medical problems your family members have or had? *May choose more than one*

	Living	Deceased	No Medical Problems	Heart Disease	Lung Disease	Cancer	Stroke	Stroke	Diabetes	Bleeding Problems	Other
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling #1 Brother/Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling #2 Brother/Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling #3 Brother/Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child #1 Son/Daughter	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other things that run in the family	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please list any allergies you have to medicines:

SHADE AREAS WHERE YOU HAVE PAIN

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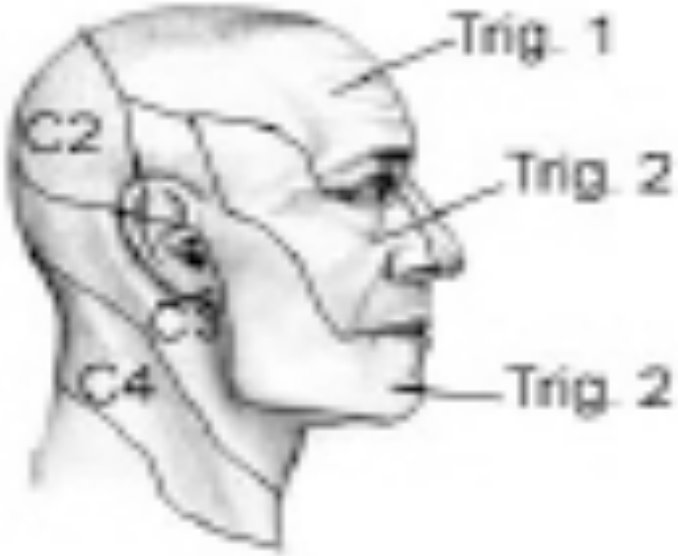
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