Hillside Pain Management
New Patient Questionnaire

Please complete all questions.

Chief Complaint:
Where is your pain located?
When did your pain begin?
How did it start: Suddenly___ Gradually___
Was this associated with an injury?
Please rate your pain using the following scale: 0 being no pain up to 10 being the worst pain you can imagine:
Your highest pain: ____ Your lowest: _____ Your pain right now: _____
Please check the words that describe your pain:
__achy __deep __numbing __stinging __unbearable
__band-like __dull __pinching __throbbing
__burning __heavy __sharp __tight
__crampy __knifelike __shooting __tender
What other words would you use to describe your pain?

How frequently do you have pain? Rarely_____ Comes & goes_____
Most of the time_____Always_____
How long does your pain last: _____
What time of day is your pain worst? __Morning __Afternoon _Evening __Nighttime
Which of the following decreases your pain? ___Cold ___Heat ___Acupuncture ___Chiropractor ___Distraction ___Massage ___Medications ___Relaxation ___ TENS unit
Which of the following increases your pain? ___Sitting ___Bending over ___Twisting ___Vacuuming ___Standing ___Walking
Effects of pain: (Note decreased function, decreased quality of life.)
Accompanying symptoms (e.g., nausea)_____
Sleep: Does pain frequently awaken you? ___Yes ___No
How many times a night?
When awakened, do you ___Empty bladder ___Take medicine ___Sit up awhile
Do you return to sleep easily? ___Yes ___No
Appetite_____
Physical activity_____
Relationship with others (e.g., irritability) _____
Emotions (e.g., anger, suicidal, crying) _____

Please **circle** any daily activity listed that you are having difficulty with due to pain:

Eating Bathing Using the toilet Dressing Getting up from bed or chair

Past Treatment of Your Pain

Have you ever had surgery for your current pain problem?
Have you ever had injections or nerve blocks for your pain problem?
What kind?
How many and when?
Did any injection relieve your pain?
Have you had physical therapy for your current pain problem?
When
Where
What did the treatment consist of?
Did it help?
Have you had chiropractic manipulation for your current pain problem?
Did it help?
Have you had acupuncture for your current pain problem?
Did it help?
Do you use any of the following, due to your current pain problem?

Walker	___Sometimes	___Always
Cane	___Sometimes	___Always
Crutch	___Sometimes	___Always
Wheelchair	___Sometimes	___Always
Brace	___Sometimes	___Always
Neck Collar	___Sometimes	___Always

List all medications that have tried for this pain_____
_____
_____

Diagnostic Studies

If you have had any of the following studies, please list the year and place performed:
MRI
Bonescan
Plain or regular X-rays
EMG/NCS (nerve conduction studies)
CT scans
Lab tests relating to pain
Other studies or tests

Social History

Marital Status __Single __Married __Widowed __Divorced __Separated __Remarried
Number of Children: Ages:
Who shares your home?
Highest year of school ____
Occupation_____
Work status __full time __part time __disabled __self- retired __unemployed __student
If disabled, date last worked

If working less than full-time, is pain the reason?	___Yes	___No
If you had NO pain, would you go back to work?	___Yes	___No
Do you think you can work at your regular job?	___Yes	___No
Any current work limitations? For how long?	___Yes	___No

Personal Habits

Tobacco User Now? (type, amount per day)
Previous smoker? ___Yes ___No
When did you quit?
Alcohol (amount per day or week)
Have you had a problem with alcohol? ___Yes ___No
Drug use: marijuana (pot), heroin, cocaine, speed, ecstasy, PCP? ___Yes ___No
Coffee, tea and cola beverages (cups/glasses per day)
Have you had the Pneumonia Vaccine? ____Did you receive the flu vaccine this season? ____
Please mark the box that applies:

1. Family history of substance **abuse**
   Alcohol ( )
   Illegal drugs ( )
   Prescription drugs ( )
2. Personal history of substance **abuse**
   Alcohol ( )
   Illegal drugs ( )
   Prescription drugs ( )
3. Age (mark box if 16-45) ( )
4. History of preadolescent sexual abuse ( )
5. Psychological disease
   Attention deficit disorder, ( )
   Obsessive-compulsive disorder, bipolar, schizophrenia ( )
   Depression ( )

General Medical History

Are you currently taking blood thinning medication (examples: Plavix [clopidogrel] or Coumadin [warfarin], Aggrenox [aspirin/dipyridamole])?
Have you ever had a MRSA (methicillin resistant staph aureus) infection?
Have you had any of these medical problems?

___Asthma	___ High cholesterol
___Anxiety attacks	___ Irritable Bowel Syndrome
___Arthritis	___ Osteoporosis
___Bleeding disorder	___Phlebitis
___Cancer	___Pneumonia
___Depression	___Polio
___Diabetes	___Skin Infection
___Drug resistant infection	___Seizure Disorder
___Fibromyalgia	___Stroke
___High blood pressure	___TB/lung Disease
___Head injury	___Ulcer
___ Heart attack/Heart disease	___Other _____
___ Heart murmur	_____
___ Hepatitis/liver disease	_____

Past Surgical History List all surgeries with Year and Operation: _____
_____
_____

Family History

Is there a history of any of the following in a blood relative?

___Alcoholism ___Disability
___Cancer ___Heart attack
___Depression ___High blood pressure
___Diabetes ___Psychiatric illness
___Chronic Pain ___Stroke
___Other_____

Please list any medicine, food or other <u>Allergies</u>: _____
_____
_____

Please list your current medications, including over the counter medicines, herbs and supplements, with dosage:

_____
_____
_____
_____
_____
_____

Review of Symptoms:

Do you have any of the following problems?

General: ___fevers ___chills ___sweats ___loss of appetite ___fatigue ___weight loss
Eyes: ___blurring ___vision loss ___trouble with bright light ___wears glasses
Ears/Nose/Throat: ___ringing ___decreased hearing ___wears hearing aids ___nasal congestion ___sore throat ___hoarseness ___trouble swallowing
Cardiovascular: ___chest pains ___palpitations ___shortness of breath on exertion ___swelling in legs
Respiratory: ___cough ___shortness of breath ___wheezing
Gastrointestinal: ___nausea ___vomiting ___diarrhea ___constipation ___ abdominal pain
Genitourinary: ___trouble with urination ___need to urinate at night ___incontinence ____Increased frequency
Musculoskeletal: ___back pain ___neck pain ___joint pain ___joint swelling ___muscle cramps ___muscle weakness ___stiffness ___arthritis
Skin: ___rash ___itching ___dryness ___suspicious lesions
Neurologic: ___temporary paralysis ___weakness ___seizures ___syncope or passing out
Psychiatric: ___depression ___anxiety ___memory loss
Endocrine: ___cold intolerance ___heat intolerance ___frequent urination ___weight change
Heme/lymphatic: ___abnormal bruising ___bleeding ___enlarged lymph nodes
Allergic/Immunologic: ___hay fever ___persistent infections ___HIV exposure

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