

NEW PATIENT PAIN QUESTIONNAIRE PACKET

(PLEASE FILL OUT THIS PACKET AND BRING IT WITH YOU TO YOUR FIRST APPOINTMENT)

Date: _____

Name: _____

Date of Birth: _____

Age: _____

Height: _____

Weight: _____

Referring Physician: _____

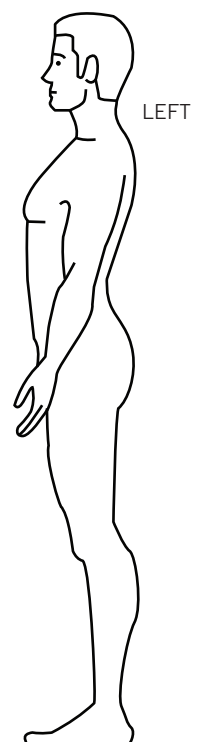
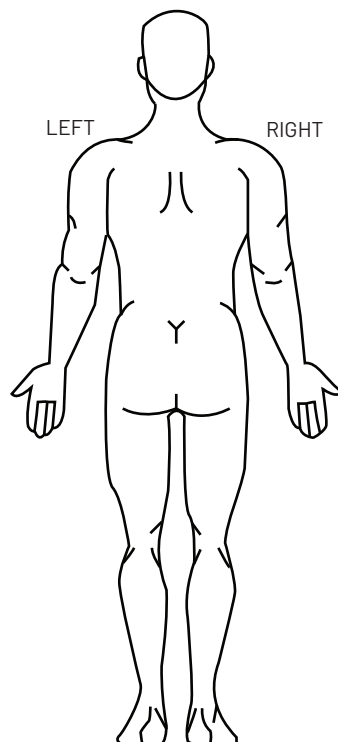
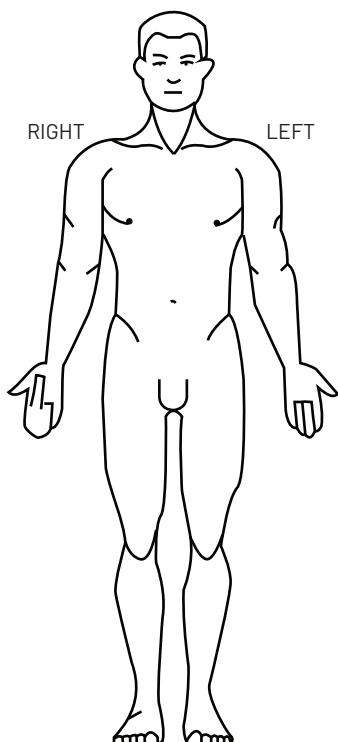
Primary Care Physician: _____

Chief Complaint (What pain brings you here today) _____

Please describe your pain and what you think may have caused this pain. _____

When did you first notice your pain? _____ (month) _____ (year)

Please shade in the area of your pain that you described above:



Wisconsin Spine and Pain

Circle the words that best describe your pain:

Sharp Comes and goes Continuous Burning Throbbing Deep Cramping Aching

What makes your pain worse? _____

What makes your pain better? _____

Do you have any related symptoms?

Numbness ☐ No ☐ Yes, where? _____
Weakness ☐ No ☐ Yes, where? _____
Tingling ☐ No ☐ Yes, where? _____
Pins and needles ☐ No ☐ Yes, where? _____

Has pain affected your :

Sleep ☐ No ☐ Yes How many hours do you sleep in a 24 hour period? _____
Daily activities ☐ No ☐ Yes Name _____
Work duties ☐ No ☐ Yes Explain _____

Pain Intensity

On a scale 0-10 (with 0 representing no pain and 10 with the most severe pain), rate your pain

Least pain on average day _____

Worst pain on average day _____

Previous Treatments:

1. Physical Therapy ☐ No ☐ Yes where/when _____
2. Chiropractor ☐ No ☐ Yes where/when _____
3. Injections ☐ No ☐ Yes where/when _____
4. Tens Unit ☐ No ☐ Yes where/when _____

MRI Where/when _____

CT Scan Where/when _____

Xrays Where/when _____

EMG Where/when _____

Wisconsin Spine and Pain

Medical History:

Allergies: _____

Past medical history (Diagnosis): _____

Past Surgical history (Procedures): _____

Family Medical History (relation and diagnosis): Please circle: Chronic Pain, Arthritis, Cancer, Osteoporosis, Alcohol/Drug Abuse, stroke, depression, other _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are you Currently Working: ☐ Yes ☐ No IF no? ☐ Unemployed ☐ Disabled ☐ Other _____

Do you smoke: ☐ No ☐ Yes If yes how much per day _____ How many years _____

Do you drink alcohol? ☐ No ☐ Yes If yes, How many drinks per week _____

Have you ever had problems with alcohol? If yes, please explain _____

Do you currently use illicit drugs? ☐ No ☐ Yes If yes, please explain _____

Any past history of illicit drugs use? ☐ No ☐ Yes If yes, please explain _____

Any current or past history of prescription medication abuse? ☐ No ☐ Yes

Have you ever had treatment for drug abuse? ☐ No ☐ Yes If yes, when and where _____

Have you ever been treated for depression or emotional / behavioral disorder? ☐ No ☐ Yes

Have you ever attempted suicide? ☐ No ☐ Yes

Are you under the care of a psychiatrist or mental health professional ☐ No ☐ Yes

Name of the treating physician: _____

Wisconsin Spine and Pain

Review of Systems: (circle the words that best describe your history):

General: fever, fatigue, weight loss, loss of appetite, weakness, sedation, HIV / AIDS

Eyes: Decreased vision, use of corrective glasses / contact lens, dryness, other _____

ENT: Decreased hearing, difficulty swallowing, hoarseness, sinus problems, ringing in the ears

Cardiovascular: High blood pressure, Chest pain, palpitations, shortness of breath, pace maker, Poor circulation,
easy bleeding / bruising, usage of blood thinner, other _____

Respiratory: Asthma, COPD, bronchitis, cough other _____

Gastrointestinal: Nausea, vomiting, constipation, IBS, Crohn's disease, abdominal pain Diarrhea, change in bowel habits,
other _____

Musculoskeletal: neck pain, low back pain, joint pain _____

Skin: Rashes, lumps _____ other skin condition _____

Neurologic: Anxiety disorder, mental disturbance, seizures/epilepsy, weakness, paralysis, Memory loss, fainting spells,
dizziness, panic attacks, loss of bowel / bladder control

Genitourinary system: Pregnant, Incontinence, urgency, hematuria, decrease in libido

Endocrine: Diabetes Mellitus, under / over functioning thyroid, intolerance to heat / cold

Psyche: Attention deficit disorder, bipolar, Schizophrenia, Obsessive compulsive disorder.

Wisconsin Spine and Pain

Pharmacy Information:

Pharmacy Name: _____

Location: _____

Phone number: _____

Fax number: _____

What medications have you taken in the past that were not helpful?

Drug	Dosage	Reason for discontinuance?

What medications are you currently taking?

Drug	Dosage	Reason for discontinuance?