New Patient Questionnaire

What is your main reason for seeing us?

What is your diagnosis?

Previous Diagnosis:

Have you received a diagnosis from a previous pain specialist?

Did he/ she explain the cause or reason for the pain you're feeling?

What do you think causes the pain?

When did your symptoms of pain begin?

Was your Injury on the job/ auto accident/ fall/ spontaneous occurance/ sports injury/ other:

Date of injury:

Is the pain constant/ intermittent/ sporadic/ worse at night/ worse in the morning/ other:

Your best position is: lying on back/ lying on stomach/ lying on side/ sitting/ standing/ reclining/ none/ other:

Your worst position is: lying on back/ lying on stomach/ lying on side/ sitting/ standing/ reclining/ other:

Modifying Factors:

Is the pain worsened by: lifting/ bending/ sitting/ playing with children/ walking/ driving/ sports activities/ socializing/ all activities/ other:

The Pain is relieved by: rest/ changing positions/ medications/ heat/ ice/ exercise/ distraction/ relaxation strategies/ reclining/ nothing/ other:

Motor Vehicle Accident Details: **(Complete only if in motor vehicle accident)**

Auto Accident: Type of accident/ head on/ t-boned/ rear ended/ sandwiched/ roll over/ other:

Were you a driver or a passenger?

If passenger, were you in the front seat/ back seat/ right/ left/ or middle seat

Were you wearing a seat-belt? Yes/ No

Did air bags deploy? Yes/ No

Did you/ and/ or the other driver receive a ticket?

Amount of dollar damage done?

Immediate Care: **(Complete for Worker's Comp, Motor Vehicle Accident or other injury)**

Required no immediate care.

Taken by ambulance to emergency room.

Was treated at urgent care.

Was cared for onsite by paramedic.

You went to your primary care physican _____ days later.

Where did you feel pain immediately?

Did you experience pain in a different area after the accident? If so, where and how many days, weeks or months after the accident?

Functional Limitations:

Are you having difficulty with any of the following activities: playing with children/ walking/ sitting/ bending/ lifting/ working/ driving/ sports activities/ socializing/ standing/ household chores/ other:

Are you having any bowel problems such as: uncontrollable bowel/ constipation/ irritable bowel syndrome/ other:

Are you having any problems with your bladder such as: urinary frequency/ urinary incontinence/ inability to urinate/ other:

Sexual Dysfunction:

Males: Are you having erectile dysfunction: difficulty achieving erection/ difficulty maintaining erection/ difficulty ejaculating/ other:

Females: Difficulty achieving orgasm/ painful intercourse/ other:

Treatments Tried to Date:

Physical therapy: Yes/ No Provided relief/ provided no relief/ made pain worse.

Chiropractic Manipulation: Yes/ No Provided relief/ provided no relief/ made pain worse.

Acupuncture: Yes/ No Provided relief/ provided no relief/ made pain worse.

Massage therapy: Yes/ No Provided relief/ provided no relief/ made pain worse.

Injections: Yes/ No Location: Back/ Neck/ Joint, If tendon, which one?

If injections have been received which of these have you had: Facet blocks/ epidural injection/ SNRB/ TFE/ SI joint/ trigger point injection/ bursal injection/ joint injection/ tendon injection/ unknown type/ other:

Provided relief / Provided no relief / Made pain worse *(Please circle)*

Exercise: Yes/ No Type of Exercise:

x per week For min/hour How far?

Is this beneficial: Yes/ No

Medications Tried:

Narcotic Analgesics: Actiq/ Avinza/ Butrans/ Demerol/ Dilaudid/ Duragesic Patch/ Exalgo/ Hydrocodone/APAP/ Oxycodone/ Hydromorphone/ APAP/ Kadian/ Methadone/ MS Contin/ MSIR (Morphine Sulfate Immediate Release)/ MSER (Morphine Sulfate Extended Release)/ Opana IR/ Opana ER/ Oxycodone/ Oxymorphone /APAP/ OxyContin/ Oxyfast /Tylenol 3/ Ultram (tramadol)/ Suboxone other: None

Anti-Inflammatories: Celebrex/ DayPro/ Etodolac/ Ibuprofen/ Mobic/ Naprosyn/ Prednisone/ Relafen/ other: None

Muscle Relaxants: Amrix/ Baclofen/ Flexeril/ Zanaflex (tizanidine)/ Norflex/ Robaxin (methocarbamol) / Skelaxin/ Soma (carisoprodol)/ other: None

Benzodiazepines: Clonazepam/ Lorazepam/ Valium/ Xanax-Alprazolam/ other: None

Antidepressants: Amitriptyline/ Buspirone/ Cymbalta/ Desipramine/ Effexor/ Lexapro/ Nortriptyline/ Paxil/ Pristique/ Trazodone/ Viibryd/ Zoloft/ other: None

Anti-Seizure Medications: Keppra/ Neurontin/ Topomax/ Trileptil/ Valproic Acid/ Zonegran/ Lamictal/ Lyrica/ other: None

Sleep Medications: Ambien (zolpidem)/ Lunesta/ Amitriptyline/ Melatonin/ Trazodone/ other: None

Diagnostics: Please bring the following studies with you to your New Patient Evaluation

Lab Tests: (blood draw) Lab where done? SED (Quest) TriCore Other_____ None

X-rays: Body part _____Date: _____ (month/year) where was this done? None

(example) Presbyterian Radiology/ Lovelace Radiology/ RAA/ XRANM/ Dr. Office: Name: _____

Other: None

MRI: Spine/ Neck/ Back/ Arm/ Leg/ Brain/ Abdomen/ Pelvis Date: _____(month/year) where was this done?

Albuquerque Imaging Center/ Presbyterian/ Lovelace/ Stand Up MRI/ Northwest Imaging/ Santa Fe Imaging/ RAA

XRANM/ Mobile Imaging

Other: None

CT Scan: Spine/ Neck/ Back/ Arm/ Leg/ Brain/ Abdomen/ Pelvis Date: _____(month/year) where was this done?

Albuquerque Imaging Center/ Presbyterian/ Lovelace/ Stand Up MRI/ Northwest Imaging/ Santa Fe Imaging/ RAA

XRANM/ Mobile Imaging, Other: None

Ultrasound: Pelvis/ abdomen/ blood vessels/ carotid arteries

Presbyterian/ Lovelace/ Duke City Vascular Lab/ Dr. Reddy/ Other Date: _____ (month/year) None

Bone Scan: Date: Lovelace/ Presbyterian/ RAA/ XRANM

Other: None

Osteoporosis Screen: Date: (month/year)

Lovelace Radiology/ Presbyterian Radiology/ RAA/ High Resolution

Other: None

EMG/Nerve Conduction Studies: (study where your arm or leg was shocked and several muscles were

poked by needles).

Date: Facility/ Doctor Presbyterian Neurology/ Lovelace Neurology

Southwest Medical Group/ New Mexico Neurology/ New Mexico Orthopaedics/

Dr. Barrett/ Dr. Shibuya/ Dr. Gurule/ Dr. Berger/ Dr. Owensby /Dr. Harris/ Dr. Ross

Other: None

Goals of Treatment:

What are your goals of treatment: return to work/ care for family/ play with children/ travel comfortably/ sleep/

increase up time/ relieve pain/ resume physical therapy/ medication management/ have no goals/ other: None

If you are only in need of medication management then we are not a good fit for you. Please contact your primary

care provider.

Psychiatric History:

Have you received psychiatric care or medications for depression or other mental illness Yes/ No

Have you ever attempted suicide? Yes/ No

Have you ever harmed yourself? Yes/ No

Have you ever harmed someone else? Yes/ No

Have you ever been diagnosed with: Depression/ post traumatic stress disorder/ bipolar disorder/ schizophrenia/

anxiety/ ADD/ ADHD/ other:

Are you currently on medications for a psychiatric problem? Yes/ No If not, were your medications discontinued by

your provider or yourself? Do you feel you are stable with current treatment? Yes/ No

Review of Systems:

Do you have any of the following symptoms: Headache/ fever/ chills/ sweats/ fatigue/ dizziness/ nausea/ vomiting/ diarrhea/ constipation/ blood in stool/ vomiting blood/ blood in urine/ painful urination/ weight loss/ weight gain/ trouble seeing/ blurred vision/ ringing in ears/ trouble hearing/ chest pain/ swollen ankles or feet/ fainting irregular heart beat/ cold or blue feet/ persistent rash/ hair loss/ problems swallowing/ problems speaking/ numbness tingling/ tremor/ memory loss/ anxiety/ bleeding gums/ swollen lymph nodes/ other: None

Past Medical History:

Have you ever been diagnosed with or suffered from any of the following?

Arthritis: Osteoarthritis/ rheumatoid arthritis/ lupus/ ankylosing spondylitis/ psoriatic arthritis/ osteoporosis/ scoliosis leg length discrepancy/ other: None

Cancer: Type: Breast cancer/ Bladder cancer/ Cervical cancer/ Colon cancer/ Esophageal cancer/ Leukemia/ Lymphoma/ Multiple myeloma/ Ovarian cancer/ Prostate cancer/ Pancreatic cancer/ Brain cancer/ Renal cancer Skin cancer/ Stomach cancer/ Testicular cancer/ Thyroid cancer/ Uterine cancer/ Unknown type/ other: None

Treatment for cancer: Are you currently being treated: Yes/ No Surgery/ Chemotherapy/ Radiation Therapy

Muscular diseases: Muscular dystrophy/ polymyositis/ fibromyalgia/ other: None

Nerve diseases: Multiple sclerosis/ Seizures/ Parkinson's disease/ Post Herpetic Neuralgia/ Poly Neuropathy/ Carpal Tunnel Diseases/ Ulnar Neuropathy/ Tasal Tunnel Syndrome/ Brachial Plexopathy/ Pudendal Neuropathy/ Charcot-Marie Tooth-NSMN/ Headache/ other: None

Cardiovascular disease: Heart attack/ CVA (stroke)/ Peripheral Artery Disease/ Deep Venous Thrombosis/ Hypertension/ other: None

Pulmonary disease: COPD/ Asthma/ Emphysema/ Tuberculosis/ other: None

Gastrointestinal disease: Hepatitis A/ B/ C / GERD/ Cirrhosis/ gallbladder disease/ pancreatitis/ other: None

Genitourinary disease: Urinary tract infection/ nephrolithasis/ prostatitis/ other: None

Immunologic/endocrine disorders: HIV/ AIDS/ diabetes mellitus/ gout/ hypocholesterolemia/ hypothyroidism/ hyperthyroidism/ Hashimoto's thyroiditis/ other: None

Skin disorders: Eczema/ psoriasis/ other: None

Trauma/ Fracture: Thoracic spine/ cervical spine/ lumbar spine/ arm/ leg/ pelvis/ ribs/ concussion/ other: None

Past Surgical History:

Circle any surgeries you have had in the past: Bladder Suspension/ Bunionectomy/ Carpal Tunnel/ Cataract/ Cholecystectomy/ Colon Resection/ C-Section/ Exploratory Laproscopic Surgery Hysterectomy/ LASIK/ Lumpectomy/ Mastectomy/ Nephrectomy/ Oophorectomy/ Stomach Banding/ Tonsillectomy/ Transplant/ Tubal Ligation/ Unremarkable/ other: None

Circle any orthopaedic surgeries you have had in the past: Arthroscopic/ Discectomy/ Elbow/ Fracture/ Hip Knee/ Laminectomy/ ORIF/ Spine/ other: None

Family History:

Has any of your family member (i.e. father, mother, or sibling) has ever had any of the following

(Please check and circle below):

□ Alcoholism	(Father / Mother / Sibling)	□ Heart attack	(Father / Mother / Sibling)
□ Bi-Polar disorder	(Father / Mother / Sibling)	□ Hypercholesterolemia	(Father / Mother / Sibling)
□ Cancer	(Father / Mother / Sibling)	□ Hypertension	(Father / Mother / Sibling)
□ CVA-Stroke	(Father / Mother / Sibling)	□ Hypothyroidism	(Father / Mother / Sibling)
□ Deep venous thrombosis	(Father / Mother / Sibling)	□ Lupus	(Father / Mother / Sibling)
□ Depression	(Father / Mother / Sibling)	□ Muscular dystrophy	(Father / Mother / Sibling)
□ Diabetes Mellitus	(Father / Mother / Sibling)	□ Negative	(Father / Mother / Sibling)
□ Drug addiction	(Father / Mother / Sibling)	□ Neuropathy	(Father / Mother / Sibling)
□ Emphysema	(Father / Mother / Sibling)	□ Osteoarthritis	(Father / Mother / Sibling)
□ Fibromyalgia	(Father / Mother / Sibling)	□ Rheumatoid Arthritis	(Father / Mother / Sibling)
□ Gout	(Father / Mother / Sibling)	□ Schizophrenia	(Father / Mother / Sibling)

□ Other:

Social History:

Marital Status: Married/ single/ divorced.

Number of children:____ Age of each child?

How many of these children are currently living at home?

Living Situation: I live alone. I live with spouse/ sister/ brother/ father/ mother/ other:

Occupation: Unemployed/ Unemployed due to pain/ Employed full-time/ Employed part-time/ Homemaker/ Retired/ Self-Employed/ Disabled/ On Social Security/ other:

Smoking History:

Never smoked/ I smoke ___cigarettes per day/ I do not smoke anymore/ other:

Alcohol Use: I do not drink/ Social drinker/ I consume _____drinks ____ days per week. Abstains at times Recovering alcoholic/ other:

Recreational Drug Use: No drugs/ Nicotine/ Methamphetamine/ Cocaine-Crack/ Hallucinogens/ Heroin Marijuana/ Amphetamines/ Opioids/ Benzodiazepines/ other:

Abuse History:

Alcohol: Yes/ No How long_____? Currently using: Yes/ No

Recreational Drugs: Yes/ No How long_____? Currently using: Yes/ No

Prescription Drugs Abuse? Yes/ No How long _____? Currently using: Yes/ No

If abusing either Recreational or Prescription drugs, please list:

Physical Abuse: Yes/ No Were you: Adult/ Child Received therapy: Yes/ No Currently in therapy: Yes/ No

Sexual Abuse: Yes/ No Were you: Adult/ Child Received therapy: Yes/ No Currently in therapy: Yes/ No

Current Medications:

List all medications you are taking and **bring all medication bottles** with you at the time of your visit.

Medications Currently Taking:

Medication:	**Strength:**	**Dosage:**
Ex: Tylenol	*500 mg*	*1 tablet twice daily*

Egg Allergy: Yes/ No

Latex Allergy: Yes/ No

Drug Allergy: Yes/ No If yes, explain below:

Medication:	**Reaction:**
Ex: Penicillin	*(Example: shortness of breath/rash/nausea/headache/dizziness).*

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