

New patient questionnaire

IF YOU WANT DR. BROWN TO PRESCRIBE PAIN MEDICATION BRING ALL YOUR MOST RECENT MEDICINE BOTTLES TO THIS APPOINTMENT AND BE PREPARED TO PROVIDE A URINE SAMPLE.

Patient Name: _____

Date: _____

1. Where is your pain located? _____

2. How long have you had pain? Less than 6 months 6-12 months
 More than a year More than 2 years – how long? _____

3. How did your pain start?

- After a work related injury. Date: _____
- After an auto accident. Date: _____
- After an injury. Date: _____
- Developed slowly over time
- Other: _____

4. Check the one(s) that describe your pain:

- constant pain always present
- periodic pain not present all the time
- pain that occurs with standing or sitting only
- a sharp “knife like” pain
- pain that occurs only with activity
- other: _____

5. Does anything make your pain worse? _____

6. Does anything make your pain better? _____

7. Please rate your pain according to the following::

Mild----- Moderate ----- -Severe
1 2 3 4 5 6 7 8 9 10

This is how my pain felt during the past week:

8. What tests have been done to try to diagnose your pain?

- X-rays MRI scan CT scan Myelogram
- Bone Scan Blood work Ultrasound Other: _____

Findings (if known): _____

Patient Name: _____

Date: _____

9. What other treatments have you tried to help this pain?

- Physical therapy
- TENS unit
- Home exercises
- Injections or nerve blocks
- Stress management
- Pain programs
- Biofeedback
- Hypnosis
- Acupuncture
- Chiropractor
- Other _____

Medications you have taken for pain (please list any medications you can remember trying for this pain)

Did any of these treatments or medications seem to help your pain?

- No
 - Yes. If so, which ones? _____
- _____

10. Please check the box if your mother, father, brothers or sisters have any of the following illnesses:

- Blood Clots _____
- Bleeding problems _____
- Cancer _____
- High Blood Pressure _____
- Diabetes _____
- Heart problems _____
- Kidney problems _____
- Liver problems _____
- Breathing problems _____
- Drug /alcohol problems _____
- Thyroid problems _____
- Stroke _____
- Ulcers _____
- GI bleeding _____
- Other: _____

11. Mother Alive Deceased Father Alive Deceased

12. Please check either Yes or No to any of these which apply to you:

	Yes	No	
Married?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	How many? _____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	How often and how much? _____
History of alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you seen a psychologist or psychiatrist?	<input type="checkbox"/>	<input type="checkbox"/>	
Currently under high stress?	<input type="checkbox"/>	<input type="checkbox"/>	
Law suit pending?	<input type="checkbox"/>	<input type="checkbox"/>	
Family problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Recent Crisis?	<input type="checkbox"/>	<input type="checkbox"/>	
Current depression?	<input type="checkbox"/>	<input type="checkbox"/>	

Patient Name: _____ Date: _____

13. Please check the “Yes” or “No” box to indicate if you have any of the following symptoms:

	Yes	No		Yes	No
Fatigue	<input type="radio"/>	<input type="radio"/>	Weight loss or weight gain	<input type="radio"/>	<input type="radio"/>
Daytime sleepiness	<input type="radio"/>	<input type="radio"/>	Chills	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>	Confusion	<input type="radio"/>	<input type="radio"/>
Weakness	<input type="radio"/>	<input type="radio"/>	Numbness	<input type="radio"/>	<input type="radio"/>
Tingling	<input type="radio"/>	<input type="radio"/>	Joint aches	<input type="radio"/>	<input type="radio"/>
Muscle aches	<input type="radio"/>	<input type="radio"/>	Easy bruising	<input type="radio"/>	<input type="radio"/>
Swollen glands	<input type="radio"/>	<input type="radio"/>	Bleeding problems	<input type="radio"/>	<input type="radio"/>
Difficulty swallowing	<input type="radio"/>	<input type="radio"/>	Heartburn	<input type="radio"/>	<input type="radio"/>
Abdominal pain	<input type="radio"/>	<input type="radio"/>	Nausea/vomiting	<input type="radio"/>	<input type="radio"/>
Constipation	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>
Rectal bleeding	<input type="radio"/>	<input type="radio"/>	Bowel incontinence	<input type="radio"/>	<input type="radio"/>
Urinary incontinence	<input type="radio"/>	<input type="radio"/>	Blood in the urine	<input type="radio"/>	<input type="radio"/>
Frequent urination	<input type="radio"/>	<input type="radio"/>	Vision changes	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	Problem snoring, sleep apnea	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>	Coughing blood	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>	Wheezing	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>	Abnormal heart beats	<input type="radio"/>	<input type="radio"/>
Ankle swelling	<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>
Anxiety/panic	<input type="radio"/>	<input type="radio"/>	Insomnia	<input type="radio"/>	<input type="radio"/>
Irritability	<input type="radio"/>	<input type="radio"/>	Poor concentration	<input type="radio"/>	<input type="radio"/>
Rash	<input type="radio"/>	<input type="radio"/>	Hives	<input type="radio"/>	<input type="radio"/>
Itching	<input type="radio"/>	<input type="radio"/>	Skin or hair changes	<input type="radio"/>	<input type="radio"/>
Feel warmer than others	<input type="radio"/>	<input type="radio"/>	Feel colder than others	<input type="radio"/>	<input type="radio"/>

Patient Name: _____ Date: _____

Mark the area on your body where you feel the described sensations.

Ache

^^ ^^
^^ ^^
^^ ^^

Numbness

OOOOO
OOOOO
OOOOO

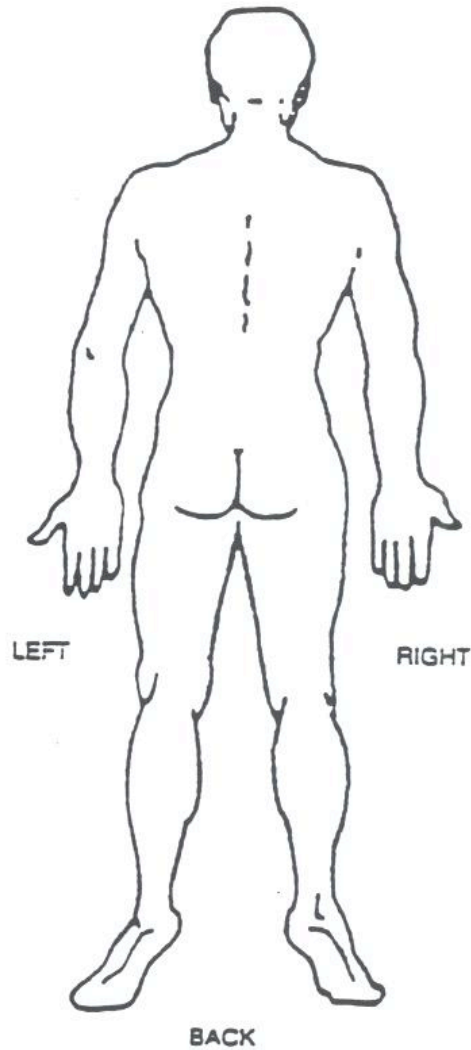
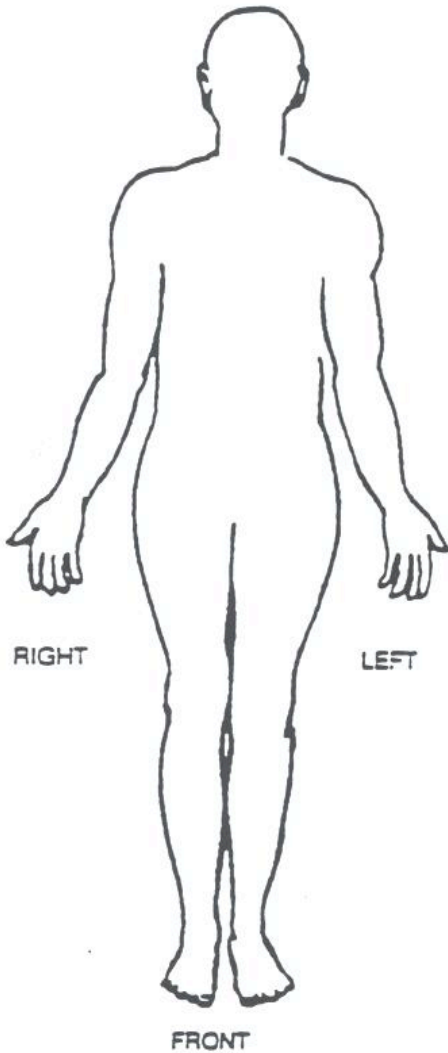
Pins & Needles

Burning

XXXXX
XXXXX
XXXXX

Stabbing

//////
//////
//////



On a scale of 0 to 10 how is your pain now?

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Mild.....Moderate.....Severe