HSHS St. Elizabeth's Hospital

NEW PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Today's Date: _____

Name of the physician you are seeing today: _____

Primary care physician's name: _____ Phone Number: _____

Have you ever been seen at another pain clinic? ☐ No ☐ Yes If Yes, when _____

By whom? _____ Treatment: _____

Allergies to medicines: _____

_____

Current medications:

Drug	Dose/Frequency	Drug	Dose/Frequency

Are you taking any blood thinners?

☐ Coumadin® ☐ Aspirin If so, how much? _____
☐ Plavix® ☐ Lovenox® ☐ Other: _____

HISTORY OF PRESENT ILLNESS

Chief Complaint (describe your pain problem): _____

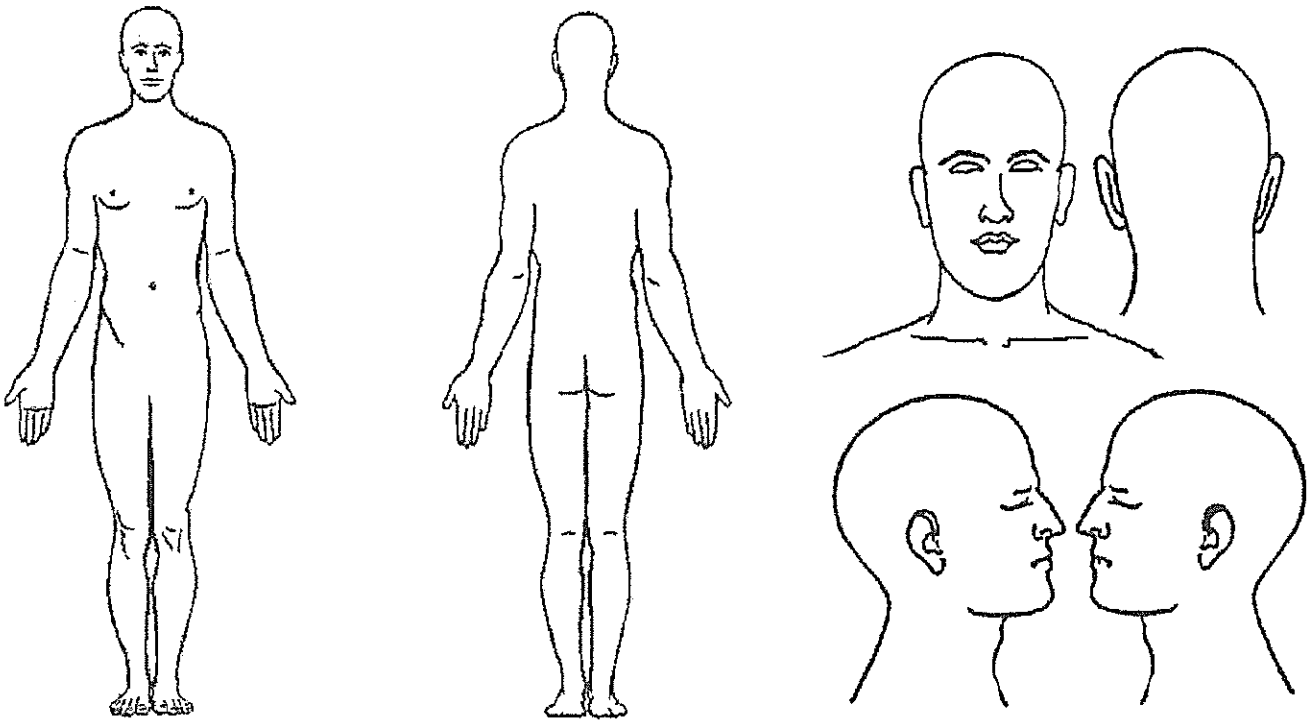
_____

_____

1. When did the pain first begin? _____ Year _____ Month _____ Weeks ago
2. What caused the pain? _____
3. How did the pain come on at first? ☐ Gradually ☐ Suddenly ☐ Explosively
4. Where on your body does the pain start? _____
5. Where does the pain seem to travel? _____

LOCATION OF YOUR PAIN:

Please use the figures below to shade in the area where you have pain. If your pain moves around, put an X where it starts and draw an arrow where it spreads.



6. Rate your pain intensity: On a scale of 0 to 10, with "0" representing no pain, "1" representing a nuisance which would not interfere with daily activities (i.e., toothache) while "10" would be the most severe pain imaginable. (suicidal pain, having a baby, or pain of a kidney stone, which number would best describe your pain?

a.	What is your pain like today?	0	1	2	3	4	5	6	7	8 9 10
b.	What is your least pain?	0	1	2	3	4	5	6	7	8 9 10
c.	What is your worst pain?	0	1	2	3	4	5	6	7	8 9 10
d.	Overall average pain?	0	1	2	3	4	5	6	7	8 9 10

7. Which words best describe your pain? (*check all of the following that apply*):

☐ shooting ☐ dull ☐ sharp ☐ burning

☐ throbbing ☐ aching ☐ electric shock

8. Which of the following best describes the pain? (*check the one that applies*): ☐ severe ☐ moderate ☐ mild

9. Which words best describe the timing of the pain? (*check all that applies*):

☐ constant ☐ mostly in the morning ☐ mostly in the Evening

☐ intermittent ☐ mostly in the afternoon ☐ very Variable

10. As time goes on, is the pain getting? ☐ Worse ☐ about the same? ☐ better?

11. Which of the following symptoms is associated with the pain? (*check all that applies*):

☐ Numbness ☐ weakness ☐ nausea/vomiting

☐ Tingling ☐ headache ☐ bowel/bladder dysfunction

12. Which of the following makes the pain worse? (*check all that apply*):

☐ coughing	☐ sexual activity	☐ touch	☐ sneezing	☐ weather changes
☐ rolling in bed	☐ exercise	☐ bright lights	☐ moving from sitting to standing	☐ walking
☐ noise	☐ taking stairs	☐ sitting	☐ cold	☐ stress/fatigue
☐ standing	☐ driving	☐ menstrual cycle	☐ lying down	☐ other

13. What factors seem to relieve the pain? (*check all that apply*):

☐ sitting	☐ sexual activity	☐ walking	☐ standing	☐ heat	☐ ice	
☐ lying down	☐ massage	☐ relaxation	☐ alcoholic drinks	☐ medicines	☐ other _____	

14. Which of the following previous treatments have you tried? (*check all that apply*):

☐ physical Therapy	☐ cold therapy	☐ relaxation training	☐ chiropractic care	☐ bedrest
☐ occupational therapy	☐ acupuncture	☐ surgery	☐ cortisone injection	☐ biofeedback
☐ traction	☐ heat	☐ psychologist	☐ nerve blocks	☐ TENS unit
☐ epidural steroid injection		☐ trigger point injections		☐ Other: _____

15. Have you ever had any previous Physical Therapy? If so, when _____ where _____

16. List all the past medications you have taken for your pain below:

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

17. In your past, have you ever had any of the following health problems? (*check all that apply*):

Cardiovascular: ☐ None ☐ Congestive heart failure ☐ Heart attack
☐ High blood pressure ☐ Angina
☐ Other: _____

Endocrine: ☐ None ☐ Diabetes ☐ Thyroid disease
☐ Other: _____

Cancers: ☐ None ☐ Prostate ☐ Breast ☐ Skin
☐ Other: _____

Hematological: ☐ None ☐ Sickle Cell ☐ Anemia
☐ Other: _____

Autoimmune: ☐ None ☐ Lupus ☐ TMJ
☐ Osteoarthritis ☐ Fibromyalgia ☐ Rheumatoid arthritis
☐ Other: _____

Renal: ☐ None ☐ Kidney infections ☐ Kidney stones
☐ Other: _____

Genitourinary: ☐ None ☐ Urinary Incontinence
☐ Prostate problems ☐ Bladder infections
☐ Other: _____

Central Nervous system: ☐ None ☐ Stroke ☐ Headaches
☐ Headaches ☐ Nerve damage ☐ Migraines
☐ Other: _____

Gastrointestinal: ☐ None ☐ Diverticulitis ☐ Ulcer
☐ Irritable bowel syndrome ☐ Reflux esophagitis
☐ Other: _____

Pulmonary: ☐ None ☐ Asthma ☐ Chronic bronchitis ☐ Pneumonia
☐ Other: _____

Infectious disease: ☐ None ☐ Mononucleosis ☐ Hepatitis
☐ Other: _____

Psychiatric: ☐ None ☐ ECT treatments ☐ Depression
☐ Anxiety ☐ Alcoholism ☐ Drug addiction
☐ Panic attacks ☐ Other _____

PAST SURGICAL HISTORY

18. Have you had any surgeries in the past? Please list (*even if they seem unrelated to your pain problem*).

Date	Procedure	Physician	Facility

FAMILY HISTORY

19. How is the general health of your family? Please report any serious health problems or diseases. Also, please indicate if any of your family has ever had similar pain problems as you.

Mother _____ Brother _____

Father _____ Sister _____

SOCIAL HISTORY: Tell us a little bit about yourself.

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Are you pregnant or do you plan to become pregnant? ☐ Yes ☐ No

Females: Pregnancies # _____ Live births _____

Who do you live with at home? _____

Highest education level _____

Describe your work status:

☐ Employed. What work do you do? _____

☐ Retired. What occupation did you have? _____

☐ Unemployed

☐ Disabled. What is the cause of your disability? _____

☐ If married, describe spouse's occupation _____

Are you being treated under Workmen's Compensation? ☐ Yes ☐ No

Are you currently receiving disability benefits? ☐ Yes ☐ No

Are you involved in legal action related to your pain problem or considering it in the future? ☐ Yes ☐ No

If yes, describe your current state of litigation: _____

_____

HABITS *Please check or write in all that apply:*

Tobacco ☐ No tobacco ☐ Quit smoking for _____ years _____ pack/day Other tobacco use _____

Alcohol ☐ No Alcohol ☐ Social consumption of alcohol _____ beverages/day containing alcohol

Caffeine ☐ No caffeine _____ beverages/day containing caffeine

Exercise ☐ None How many times per week of >20 minutes exercise? _____

Drugs

Do you use or have you ever used recreational drugs? ☐ No ☐ Yes

If yes, which drugs? _____

Have you ever undergone drug or alcohol rehabilitation? ☐ No ☐ Yes

If yes, which drugs? _____

Have you ever misused or abused prescription drugs? ☐ No ☐ Yes

If yes, which drugs? _____

20. Have you had any of the following tests performed within the last 24 months?

Test	Date	Name of Facility	Results
X-ray			
CT Scan			
MRI			
EMG			
Myelogram			

REVIEW OF SYMPTOMS

21. Are you experiencing any of the following symptoms with regularity that is different than what you listed before?

If so, please check.

Hematological
- ☐ Easy bruises
- ☐ Difficulty in clotting the blood

Neurologic
- ☐ Headaches
- ☐ Dizziness
- ☐ Falling
- ☐ Seizures
- ☐ Numbness
- ☐ Tremor

Skin
- ☐ Lacerations
- ☐ Abrasions
- ☐ Pustules
- ☐ Nodules
- ☐ Tumors
- ☐ Breast Changes

Eye
- ☐ Eye infections
- ☐ Blurred vision
- ☐ Double vision
- ☐ Blindness

Psychiatric
- ☐ Depression
- ☐ Mood Swings
- ☐ Anxiety

ENT
- ☐ Hearing loss
- ☐ Dizziness
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Bloody nose
- ☐ Sinusitis

Genitourinary
- ☐ Bladder incontinence
- ☐ Difficulty urinating

Endocrine
- ☐ Hot or cold flashes

Respiratory
- ☐ Cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Difficulty in breathing with exertion

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody stools
- ☐ Nausea/vomiting
- ☐ Bowel incontinence

General
- ☐ Weight gain or loss
- ☐ Appetite changes
- ☐ Fever/chills
- ☐ Disturbed sleeping habits

Cardiac
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Skipped beats

22. Attestment

To the best of my knowledge, the information I recorded in this Patient Questionnaire is accurate and complete.

Patient signature: _____ Date: _____