

Please note which department or physician you are requesting to see: \_\_\_\_\_  
Neurosurgery                      Neurology                      Pain Management                      Physiatry/Rehab Medicine

**NEW PATIENT QUESTIONNAIRE**

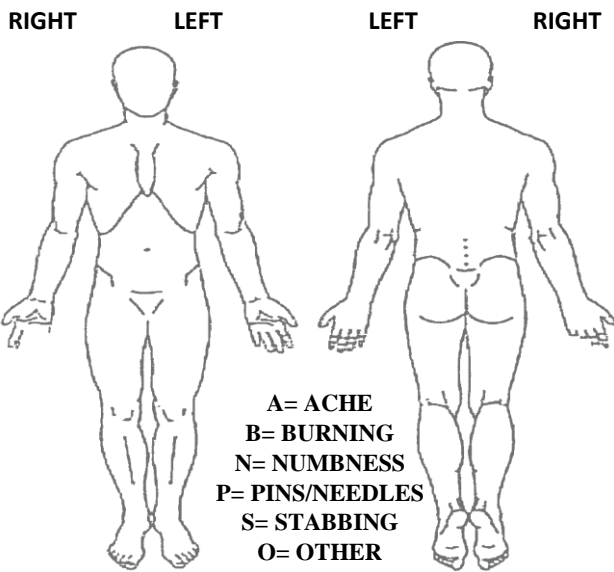
DATE: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M or F  
Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_  
Referred by \_\_\_\_\_ Insurance Carrier/ ID or Policy # \_\_\_\_\_  
Reason for Visit: \_\_\_\_\_

Have you had a history of accident or injury? If yes, please explain and answer the next three questions:

- Was the accident at work? Yes or No
- Are you using Workman’s Compensation? Yes or No
- Are you currently involved in litigation? Yes or No

On the diagram below, please mark where you are feeling your symptoms with the appropriate letters.



Please note if other: \_\_\_\_\_

On a scale of 0 to 10, please circle your level of pain or discomfort  
**0 being none and 10 being unbearable** for the following areas:

- |                            |   |   |   |   |   |   |   |   |   |   |    |
|----------------------------|---|---|---|---|---|---|---|---|---|---|----|
| 1. Neck Pain:              | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. Left Shoulder Pain:     | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. Right Shoulder Pain:    | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4. Left Arm Pain:          | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 5. Right Arm Pain:         | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 6. Back Pain:              | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 7. Left Hip/Buttock Pain:  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 8. Right Hip/Buttock Pain: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 9. Left Leg Pain:          | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 10. Right Leg Pain:        | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11. Left Foot Pain:        | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 12. Right Foot Pain:       | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

If you are not experiencing pain as a symptom, please skip Questions 1-7.

1. When did the pain begin? \_\_\_\_\_

Duration of Pain: \_\_\_\_\_

Overall the pain is:

Improved                      Worse                      Stable

2. Quality of Pain (check all that applies)?

- |                                   |                                    |                                    |
|-----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Sore     | <input type="checkbox"/> Aching    | <input type="checkbox"/> Burning   |
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Dull      | <input type="checkbox"/> Tender    |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tingling  | <input type="checkbox"/> Cramping  |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Pulling   | <input type="checkbox"/> Radiating |
| <input type="checkbox"/> Unsure   | <input type="checkbox"/> Throbbing |                                    |

3. What makes the pain better (check all that applies)?

- |                                    |  |  |
|------------------------------------|--|--|
| <input type="checkbox"/> Heat      | <input type="checkbox"/> Cold              | <input type="checkbox"/> Bend Forward      |
| <input type="checkbox"/> Bend Back | <input type="checkbox"/> Change Position   | <input type="checkbox"/> Sitting           |
| <input type="checkbox"/> Standing  | <input type="checkbox"/> Walking           | <input type="checkbox"/> Twisting          |
| <input type="checkbox"/> Movement  | <input type="checkbox"/> Change in weather | <input type="checkbox"/> Lying Supine      |
| <input type="checkbox"/> Rest      | <input type="checkbox"/> Valsalva          | <input type="checkbox"/> Coughing/Sneezing |
| <input type="checkbox"/> Nothing   | <input type="checkbox"/> Sex               | <input type="checkbox"/> N/A               |

4. What makes the pain worse (check all that applies)?

- |                                    |  |  |
|------------------------------------|--|--|
| <input type="checkbox"/> Heat      | <input type="checkbox"/> Cold              | <input type="checkbox"/> Bend Forward      |
| <input type="checkbox"/> Bend Back | <input type="checkbox"/> Change Position   | <input type="checkbox"/> Sitting           |
| <input type="checkbox"/> Standing  | <input type="checkbox"/> Walking           | <input type="checkbox"/> Twisting          |
| <input type="checkbox"/> Movement  | <input type="checkbox"/> Change in weather | <input type="checkbox"/> Lying Supine      |
| <input type="checkbox"/> Rest      | <input type="checkbox"/> Valsalva          | <input type="checkbox"/> Coughing/Sneezing |
| <input type="checkbox"/> Nothing   | <input type="checkbox"/> Sex               | <input type="checkbox"/> N/A               |

**5. Pain interferes with:**

- Sleep
- Self-Care
- Driving
- Lifting
- Household Chores
- Other \_\_\_\_\_
- Appetite
- Hobbies
- Social Life
- Traveling
- Sex
- Job Performance
- Exercise
- Shopping
- Cooking

**6. When is the pain worst? (Circle one)**

Morning    Afternoon    Evening    Night

**7. If pain limits activity, please full in all that apply:**

- I can't tolerate walking more than \_\_\_\_\_ blocks.
- I can't tolerate sitting more than \_\_\_\_\_ minutes.
- I can't tolerate standing more than \_\_\_\_\_ minutes.
- I can't tolerate lying more than \_\_\_\_\_ minutes.

**8. Do you experience weakness? Yes or No**

If yes, please describe (include location) \_\_\_\_\_

**Have you had any of the following imaging studies? If yes, please include the date.**

*IF SO, PLEASE FORWARD A COPY OF THE REPORT TO THE OFFICE PRIOR TO YOUR APPOINTMENT!*

X-ray \_\_\_\_\_ Bone Scan \_\_\_\_\_ MRI \_\_\_\_\_  
 CT scan \_\_\_\_\_ EMG \_\_\_\_\_

**Below, indicate past treatments for your neck/back condition and include the date of treatment:**

Nerve Block \_\_\_\_\_ Steroid Injections \_\_\_\_\_  
 Physical Therapy \_\_\_\_\_ Psychotherapy \_\_\_\_\_  
 Acupuncture \_\_\_\_\_ Surgery \_\_\_\_\_  
 Chiropractic \_\_\_\_\_ Failed Medications \_\_\_\_\_  
 Other \_\_\_\_\_

**If surgery is recommended, what would be your timeframe available for scheduling? \_\_\_\_\_**

<p><b>REVIEW OF SYSTEMS:</b></p> <p><b>GENERAL</b>                  Fatigue <input type="checkbox"/> NO <input type="checkbox"/> YES                  Weight loss <input type="checkbox"/> NO <input type="checkbox"/> YES                  Weakness <input type="checkbox"/> NO <input type="checkbox"/> YES                  Swollen Lymph nodes <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p><b>HEAD</b>                  Visual problems <input type="checkbox"/> NO <input type="checkbox"/> YES                  Ear pain, decreased hearing <input type="checkbox"/> NO <input type="checkbox"/> YES                  Difficulty swallowing <input type="checkbox"/> NO <input type="checkbox"/> YES                  Other _____</p> <p><b>CHEST, HEART, AND LUNGS</b>                  Shortness of breath <input type="checkbox"/> NO <input type="checkbox"/> YES                  Chest pain or pressure attacks <input type="checkbox"/> NO <input type="checkbox"/> YES                  Frequent cough <input type="checkbox"/> NO <input type="checkbox"/> YES                  Swollen ankles <input type="checkbox"/> NO <input type="checkbox"/> YES                  Valve disorder <input type="checkbox"/> NO <input type="checkbox"/> YES                  Sleep Apnea <input type="checkbox"/> NO <input type="checkbox"/> YES                  DVT <input type="checkbox"/> NO <input type="checkbox"/> YES                  Stents <input type="checkbox"/> NO <input type="checkbox"/> YES                  Other _____</p>	<p><b>ENDOCRINE</b>                  Thyroid condition <input type="checkbox"/> NO <input type="checkbox"/> YES                  Diabetes <input type="checkbox"/> NO <input type="checkbox"/> YES                  Other _____</p> <p><b>KIDNEY</b>                  Difficulty in passing urine <input type="checkbox"/> NO <input type="checkbox"/> YES                  Getting up at night to urinate <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p><b>GASTROINTESTINAL</b>                  Poor appetite <input type="checkbox"/> NO <input type="checkbox"/> YES                  Indigestion or vomiting <input type="checkbox"/> NO <input type="checkbox"/> YES                  Change in bowel habits <input type="checkbox"/> NO <input type="checkbox"/> YES                  Pass blood from rectum <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p><b>MUSCULOSKELETAL</b>                  Decreased Range of Motion <input type="checkbox"/> NO <input type="checkbox"/> YES                  Joint Swelling <input type="checkbox"/> NO <input type="checkbox"/> YES                  Joint Stiffness <input type="checkbox"/> NO <input type="checkbox"/> YES                  Muscle Aches/Pains <input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<p><b>NEUROLOGICAL</b>                  Dizziness/Vertigo <input type="checkbox"/> NO <input type="checkbox"/> YES                  Headaches <input type="checkbox"/> NO <input type="checkbox"/> YES                  Strokes <input type="checkbox"/> NO <input type="checkbox"/> YES                  Seizures <input type="checkbox"/> NO <input type="checkbox"/> YES                  Tremor <input type="checkbox"/> NO <input type="checkbox"/> YES                  Numbness <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p><b>PSYCHOLOGICAL</b>                  Anxiety <input type="checkbox"/> NO <input type="checkbox"/> YES                  Depression <input type="checkbox"/> NO <input type="checkbox"/> YES                  Other _____</p> <p><b>History of Cancer?</b> Yes    No                  If yes, type: _____</p> <p><b>Chemo:</b> Yes    No  <b>Radiation:</b> Yes    No</p> <p><b>Please notify the MD/NP/PA/RN if you are pregnant:</b> Yes    No</p>
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Current Medication:	Dosage:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Any allergies to: Shellfish Iodine Latex Contrast/IV dye

Allergies	Reaction
1.	
2.	
3.	

**Social History:**

1. **Are you a:** Current Smoker / Never Smoker / Former Smoker **Quit Date:** \_\_\_\_\_  
**Type:** \_\_\_\_\_ **Packs/day:** \_\_\_\_\_ **Years:** \_\_\_\_\_
2. **Do you use chewing and/or smokeless tobacco?** Yes or No **Have you quit?** Yes or No  
**When?** \_\_\_\_\_
3. **Do you drink alcohol?** Yes or No **Type(s):** \_\_\_\_\_ **Amount:** \_\_\_\_\_ **How often:** \_\_\_\_\_
4. **Do you use illicit (street) drugs?** Yes or No **Type(s):** \_\_\_\_\_ **Last used:** \_\_\_\_\_
5. **Marital Status:** Single Married Cohabiting Separated Divorced Widowed
6. **Who do you live with?** Alone Spouse Children Parents Other: \_\_\_\_\_
7. **What is your occupation?** \_\_\_\_\_
8. **Are you disabled?** Yes or No **If yes, note disability:** \_\_\_\_\_

**Medical/Personal History:**

**Are you right- or left-handed?** Right Left Ambidextrous

**Past Medical History:**

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**Past Surgical History and Dates:**

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**Family Medical History:**

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**Please share any other information you would like us to know:**

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**Preferred Pharmacy:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**If this form was completed by someone other than the patient, please list the name, relation to the patient and the reason that the patient was unable to complete the form.**

Form Completed by \_\_\_\_\_ Date \_\_\_\_\_