PARADIGM
PAIN & SPINE CONSULTANTS

New Patient Questionnaire

Room:________

Name: _____________________________________ **DOB: __________________________**

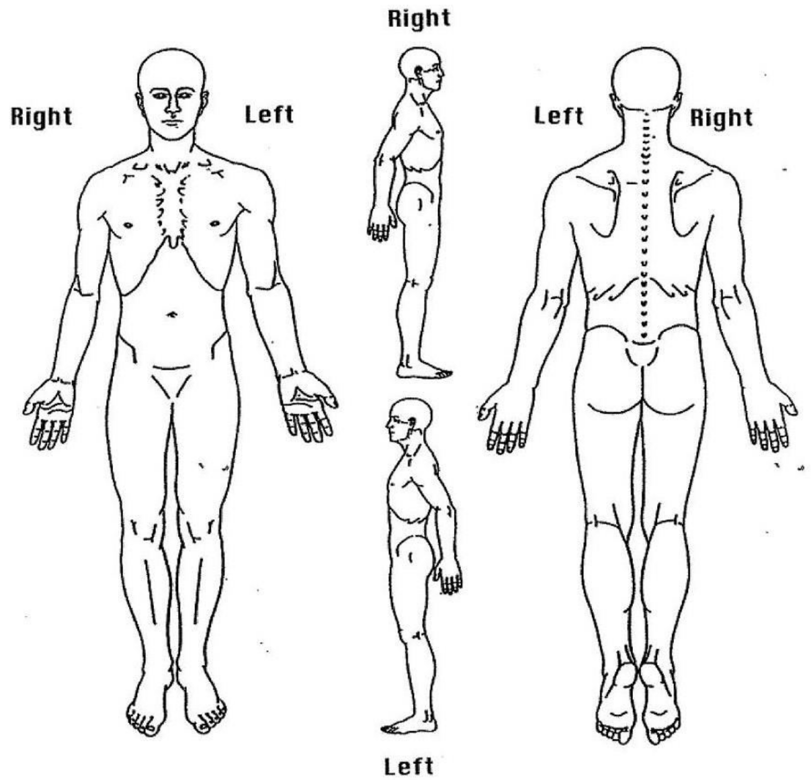
Date: ____________________________ **Insurance:__________________________**

Vitals:
B/P
HR:
02:
Ht: Wt:

SHADE AREAS OF PAIN CIRCLE AREAS OF NUMBNESS

UDS Today (office use only):

YES NO



A:
P:

Flu/PNA:

Falls:

New Patient Questionnaire

Smoker:

Next Appointment Preference:

Name: ____ Date: ______________________

Patient information:

Last Name: ____________________________ First: ___________________________ MI: ______

Address: ____

City: _____________________________ State: _____________________ Zip: ________________

Home Phone: (______) _______-_________   Cell Phone: (______) _______-_________

Date of Birth: ___________________________ SSN: __________-____________-___________

Gender (circle):   MALE   FEMALE   Email Address: _____________________________________

Medical Insurance Information:

Primary Insurance Company: ____

Subscriber ID or Member ID____

Provider Number (on back of insurance card) ____

Secondary Insurance Company: ____

Subscriber ID or Member ID____

Primary Care Physician:

Name: ______________________________________ Phone number (_____) _______-__________

*Please note: We will ordinarily send a letter to your primary care doctor and referring doctor with a summary of your diagnosis and treatment plan. If there are additional doctors you would like us to send a copy to please let us know.

Referring Physician:

Name: ______________________________________ Phone number (_____) _______-__________

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Why are you here?

____

____

My worst area of pain is____

My second worst area of pain is____

Any additional areas of pain____

Is your pain due to an AUTO ACCIDENT OR WORKERS COMPENSATION injury? ____________________

Do you have a lawyer on this case? _____________

If so, who? ____

Address and phone number:

____

____

When did the pain start? (Gradually or a specific incident):___________________________________

____

What exactly happened to you? ____

____

Did you have pain before the incident? (Yes or No):____

If yes, please explain: ____

____

____

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Work Information

Are you working the same job? ____

Is your pain affecting your ability to work? ____

Are you on light duty or performing a less physically demanding job now? __________________________

Are you off work because of your pain? ____

Dates off work: From: __________________________ To: _____________________________________

Do you want to return to work? (Yes or No): ____

Are you on disability? (Short term, long term, or social security disability): ________________________

New Patient Questionnaire

Put an “X” next to any tests or treatments that have been done to help diagnose or treat your current condition, prior to coming to our facility.

*****If **YES** to any of the below specify the area of the body treated or imaged and the facility name or Doctor that provided the test/treatment.

TESTS YOU HAVE HAD	TREATMENTS YOU HAVE HAD
CAT Scan	Trigger Point Injections
X-Ray	Nerve Blocks
MRI Scan	TENS Unit
Spinal Tap	Chiropractic Care
EEG (Brain Wave Test)	Physical Therapy
Blood Tests (for this condition)	Massage Therapy
EMG/ NCV (nerve test of arms/legs)	Pain Psychologist
Other (please specify):	Other (please specify):

Over the counter and/or prescribed medications that have been tried or taken in the past to help your alleviate your pain?

1. ___________________________________ 5. __________________________________

2. ___________________________________ 6. __________________________________

3. ___________________________________ 7. __________________________________

4. ___________________________________ 8. __________________________________

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New Patient Questionnaire

Pain Intensity Scale

Circle the area on the scale below that best describes the intensity of the pain that you are experiencing on a daily basis.

0 No Pain	1-2 Annoying	3-4 Uncomfortable	5-6 Moderate Pain	7-8 Severe Pain	9-10 Worst Pain Possible

Please describe your symptoms/ pain: ____

____

Is your pain more (please check one):

_________ aching, gnawing, muscular/ cramping

OR

__________ burning, shooting, sharp, tearing

What makes your pain better? ____

What makes your pain worse? ____

Any positive results? ____

Any temporary results? ____

What other doctors have treated you for this? ____

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New Patient Questionnaire

Current Medications- Please list current medications (including vitamins, birth control pills, and any over the counter medicine such as Tylenol, Advil, or Excedrin).

Medication Name	Dose/ Strength	How many times per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Pain Medication (if applicable):

Prescribing Physician:____________________________________

Please list medication name____________________ and # of pills remaining__________________

Please list medication name____________________ and # of pills remaining__________________

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New Patient Questionnaire

Your Medical History

Place an “X” next to any of the following conditions that you have had, either in the past or currently.

Alcoholism_______________

Seasonal Allergies________________

Anemia______________

Arthritis_______________

Asthma________________

Bleeding Disorder_________________

Cancer/ Tumor______________

Colon Polyps______________

Depression/ Anxiety________________

Diabetes_______________

Drug Abuse_______________

Emphysema/ COPD______________

Epilepsy/ Seizures_____________

Fibromyalgia______________

Glaucoma_________________

Hepatitis________________

High Blood Pressure______________

High Cholesterol_______________

Heart Disease______________

Irritable Bowel______________

Kidney Disease______________

Pancreatitis_______________

Peptic (Stomach) Ulcers____________

Rheumatic Fever____________

Stroke________________

Thyroid Disease_______________

Other: _______________________________

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New Patient Questionnaire

Other Symptoms

We will be discussing your primary reason for being referred to this office in detail. In addition, it is often helpful to understand any additional symptoms you may be currently having. Please place an "X" next to any of the following symptoms you are currently experiencing.

Unexplained fever (not occurring during an illness such as cold or flu)

Excessive weight loss

Excessive weight gain

Insomnia

Rash

Vision loss (other than blurring that is corrected by wearing eyeglasses or contacts)

Hearing loss

Ringing in the ears (Tinnitus)

Excessive cough

Excessive unexplained shortness of breath (Dyspnea)

Chest Pain

Abdominal pain

Nausea/ vomiting

Diarrhea

Constipation

Difficulties with sexual functioning/ intercourse

Depression

Anxiety

For women only:

Irregular menstrual cycles

Extremely painful menstrual cycles

When did your last menstrual cycle begin? ____/____/_____

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New Patient Questionnaire

Drug Allergies

Please list any medication allergies and associated reaction.
1.
2.
3.
4.
5.

*Note: Please bring all of your medication in the original prescription bottles to this appointment and all future appointments unless otherwise directed.

Surgeries: (List all surgeries you have had)

Type: Year:

1.____ ________________________

2.____ ________________________

3.____ ________________________

4.____ ________________________

5.____ ________________________

6.____ ________________________

7.____ ________________________

Hospitalizations: Reason: Year:

1.____ ________________________

2.____ ________________________

3.____ ________________________

4.____ ________________________

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FAMILY HISTORY

- Please check any of the following medical conditions which have occurred in your family
- Column labeled "Status" please circle: Alive, Deceased, or Unknown

	Mother	**Father**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Status	alive deceased unknown	alive deceased unknown	alive deceased unknown	alive deceased unknown	alive deceased unknown	alive deceased unknown
ALCOHOLISM						
ANXIETY DISORDER						
ARTHRITIS						
BLEEDING						
CANCER						
DEPRESSION						
DIABETES						
HEART DISEASE						
HIGH BLOOD PRESSURE						
SEIZURE DISORDER						
STROKE						
OTHER						

New Patient Questionnaire

Personal Background History

Your current marital status (circle one): Single Married Divorced Separated Widowed

Number of children, if any: ____________ Number of children living in the home: _______

Your educational level (circle): Highest grade level completed: 6 7 8 9 10 11 12 GED

College: 1 2 3 4 years

Post-graduate Degree: ___________________________

Do you smoke? No Yes (amount per day) ____________________________

Your average daily coffee or tea consumption: Amount (cups) ____________________

Your average daily caffeinated soft drink consumption: Amount (drinks) ______________

Your average weekly alcohol consumption: Amount of beers: _______________________

Amount of glasses of wine: ________________

Amount of mixed drinks: __________________

Have you ever been diagnosed or treated for alcohol abuse? No Yes: When_________

Have you ever been diagnosed or treated for drug abuse? No Yes: When__________

Do you now or have you previously used illicit substances (“street drugs”) such as marijuana?

No Yes: When? ______________ What type of substance? ____________

Patient Signature: ____ Date______/________/______