Alaska Center for Pain Relief

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New Patient Health Questionnaire

Name:_____ **Date:**_____

Street Address(No PO BOX):_____

City:_____**State**_____**Zip**_____ **Home Phone:**_____

Sex:_____**Age:**_____**Birth Date:**_____ **Work Phone:**_____

Insurance:_____ **Cell Phone:**_____

Referring Physician:_____

How long have you had your current problem? _____

****Is this related to an Auto Claim or Workers Comp Claim?**_____

Please describe in your own words the nature of your pain: _____

_____

_____

_____

What is your pain level today on a scale of 0-10 (0 being None and 10 being the worst): _____

Circle the words that best describe your pain: Aching Constant Cramping Dull Burning Numbness/Tingling Pressure Sharp Shooting Spasms Stabbing Throbbing Weakness
Other: _____

Circle any aggravating factors: Cannot Identify Sitting Standing Lying Down Walking Carrying Twisting Pushing/pulling Gripping Grasping Squeezing Throwing ROM Weight-Bearing Exercise Previous surgery Computer use Changing clothes Getting out of bed Going from sitting to stand Morning Nighttime Cold weather Damp weather

Circle any alleviating factors: Nothing helps Sitting Standing Lying down Position change Heat Ice Rest Elevation Exercise Stretching Limited weight bearing PT/OT Chiropractic care ESI OTC medication Narcotics NSAIDS Cortisone injection Viscosupplement injection Orthotics Previous surgery Brace Sling

Who is your Primary Care Provider and their address: _____

Who is you Primary Pharmacy/Location: _____

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Please List any drug allergies and their reactions:

Name	Reaction

Please list your Medications:

Name	Dosage(s)	How Often

Is there a history of any of the following in a blood relative? (Please check if yes)

__Alcoholism __Breast Cancer __Stroke __Psychiatric Illness
__High blood pressure __Chronic Pain __Depression __Heart Attack
__Migraine __Disability __Diabetes __Colon cancer
__Other:_____

Social History:

Are you right or left handed? _____

Marital Status (check one or more): __Single __Married __Widowed __Divorced __Living together

Tobacco use currently? ____Yes ____No How Much?_____

Previous smoker? ____Yes ____No Quit date:_____ How many years did you smoke? _____

Alcohol Intake: ____None ____Occasional ____Moderate ____Heavy

Do you have difficulty concentrating, remembering, or making decisions? ____ Yes ____ No

Do you have difficulty walking or climbing stairs? ____Yes ____No

Do you have difficulty dressing or bathing? ____Yes ____No

Do you have difficulty doing errands alone? ____Yes ____No

Who do you currently work for?_____
Do you live alone or with others? _____If others, who? _____

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Please list any surgeries you have had in the past:

Surgery	Date

Have you had any Imaging done for what we are seeing you for today ? ____Yes ____No

Where?_____When?_____

Have you had previous injections done for what we are seeing you for today? ____Yes ____No

If yes, did it help? ____Not at all ____Helped a little ____Helped temporarily ____Helped significantly

Have you had Previous Physical Therapy for what we are seeing you for today? ____Yes ____No

If yes, did it help? ____Not at all ____Helped a little ____Helped temporarily ____Helped significantly

General Medical History: Check any conditions you have ever had:

__AIDS/HIV
__Acid Reflex (GERD)
__Angina
__Anxiety Disorder
__Arthritis
__Asthma
__Atrial Fibration
__Back Pain
__Bipolar Disorder
__Bleeding Disorder
__Blood Clots
__Bowel Obstruction
__COPD
__Cancer
__Compression Fracture
__Congestive heart Failure
__Coronary Artery Disease
__Depression
__Diabetes
__Endometriosis
__Fibromyalgia
__Glaucoma
__Gout
__Headaches
__Heart Attack
__Heart Disease
__Heartburn
__Hepatitis
__High Cholesterol
__History of MRSA
__Hypertension
__Kidney Disease
__Liver Disease
__Lung Problems
__Multiple Sclerosis
__Osteoporosis
__Psychiatric Illness
__Seizures
__Stroke
__Substance Abuse
__Thyroid Problems
__Trigeminal Neuralgia
__Ulcerative Colitis
__Vascular Disease

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Please review the following Review of Systems and check all that apply currently:

Constitutional
__Fever
__Night Sweats
__Weight Gain (__lbs)
__Weight Loss (__lbs)
__Exercise intolerance

Psychiatric
__Depression
__Sleep disturbance
__Restless sleep
__Alcohol abuse
__Anxiety
__Suicidal thoughts

Allergic/Immunologic
__Runny nose
__Sinus pressure
__Itching
__Hives
__Frequent sneezing

ENMT
Ear
__Difficulty hearing
__Ear pain
Nose
__Frequent nosebleeds
__Nose problems
__Sinus problems
Mouth/Throat
__Sore throat
__Bleeding gums
__Snoring
__Dry mouth
__Oral abnormalities
__Mouth ulcers
__Teeth abnormalities
Eyes
__Dry eyes
__Irritaion
__Vision change

Respiratory
__Cough
__Wheezing
__Shortness of breath
__Coughing up blood
__Sleep apnea

Cardiovascular
__Chest pain
__Rapid heart rate

Gastrointestinal
__Abdominal Pain
__Vomiting
__Change in appetite
__Black or tarry stools
__Frequent diarrhea
__Vomiting blood
__Dyspepsia
__GERD

Musculoskeletal system
__Muscle aches
__Muscle weakness
__Arthralgias/Joint pain
__Back pain
__Swelling in the extremities
__Muscle spams
__Grating sensation felt
__Muscle tightness
__Neck stiffness

Neurological symptoms
__Weakness
__Numbness
__Seizures
__Dizzness
__Frequent or severe headaches
__Migraines
__Restless legs
__Tremor

Hematologic symptoms
__Easy bruising
__Excessive bleeding

Endocrine
__High blood sugar trend

Integumentary
__Abnormal mole
__Jaundice
__Rash
__Itching
__Dry skin
__Growth/lesions
__Laceration

Signature of Patient/Legal Patient Representative: _____Date:_____

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Name:_____ **Date:**_____

Please use the appropriate symbol(s) to mark your pain on the Diagram below. Include all affected areas.

Numbness n n **Pins & Needles** OOO **Aching** ____
Cramping . . . **Burning** xxxx **Stabbing** ////