New Patient Visit

NAME: ____

Occupation: ___________________________ Employer: _____________________________________

Education Level: _______________________ Retired: Yes or No If yes, date: _______________

Marital Status: ______________________ Children: Son(s) __________ Daughter(s) ___________

Date of Injury: __________________ Is this a work comp injury or auto accident: Yes or No (circle one)

Primary Care Physician: ____

Tobacco Use: Yes or No (circle one) Packs per day: _____________ Years smoked: _____________

Alcohol Use: Yes or No (circle one) Ho w many drinks: ________________ How often: ________________

Illicit Drug Use: Yes or No (circle one) Type of drugs: _________________ How often: ________________

Exercise Level: Yes or No (circle one) What type: ____________________How often:_________________

Past Medical History: (Check all that apply)

- ☐ AIDS/HIV
- ☐ ALCOHOLISM
- ☐ ALZHEIMERS
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BLEEDING PROBLEMS
- ☐ BLOOD CLOTS
- ☐ BREAST CANCER
- ☐ CERVICAL CANCER
- ☐ COLON CANCER
- ☐ LUNG CANCER
- ☐ CONSTIPATION
- ☐ COPD
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIVERTICULITIS
- ☐ DIZZY/FAINTING
- ☐ DRUG ABUSE
- ☐ ERECTILE DYSF.
- ☐ FIBROMYALGIA
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HYPOGLYCEMIA
- ☐ HYPOTHYROIDISM
- ☐ IRREGULAR MENSES
- ☐ KIDNEY DISEASE
- ☐ KIDNEY STONES
- ☐ LEUKEMIA
- ☐ LUNG PROBLEMS
- ☐ OSTEOARTHRITIS
- ☐ PREGNANCY
- ☐ PROSTATE PROBLEM
- ☐ SEIZURES
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ OTHER ______________________________

Previous pain management: (Check all that apply)

- ☐ ACCUPUNCTURE
- ☐ CHIROPRACTOR
- ☐ DISCOGRAM
- ☐ EPIDURAL
- ☐ FACET INJECTION
- ☐ HEAT TREATMENT
- ☐ ICE TREATMENT
- ☐ IDET/NUCLEOPLASTY
- ☐ OCCIPITAL NERVE BLOCK
- ☐ PHYSICAL THERAPY
- ☐ PUMP TRIAL
- ☐ RFTC (RADIOFREQUENCY)
- ☐ SCS TRIAL
- ☐ SCS IMPLANT
- ☐ SYMPATHETIC BLOCK
- ☐ TENS UNIT
- ☐ TRIGGER POINT
- ☐ OTHER: ________________________________

Family History: Circle **M** for mother and **F** for father

M / F – AIDS/HIV

M/ F – Alcoholism

M/ F – Alzheimer's

M / F – Arthritis

M / F – Asthma

M / F – CA Breast

M / F – CA Bone

M / F – CA Cervical

M / F – CA Colon

M / F – CA Lung

M /F – CA Liver

M /F – CA Ovarian

M /F –CA Prostate

M /F – Colitis

M /F – Depression

M / F - Diabetes

M / F – Drug Abuse

M / F - Gout

M / F – Heart Disease

M / F – Hodgkin's disease

M / F - Hypertension

M / F – Kidney Disease

M/ F – Liver Disease

M / F - Migraines

M / F – Muscle Disease

M / F - Obesity

M /F - Osteoporosis

M / F - Osteoarthritis

M / F – Parkinson's

M / F – Seizures

Surgical History (Include dates):

____

____

____

Are you allergic to any medications?

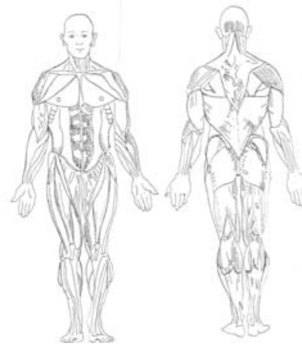
____

Medication:	**Dose:**	**Frequency:**

Pain Location: (If you only have 1 pain region, use section 1. If you have more pain areas use sections 2 to 4.)

1. ___________________________________ Increased Decreased Unchanged (circle one)

Pain Level Today (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

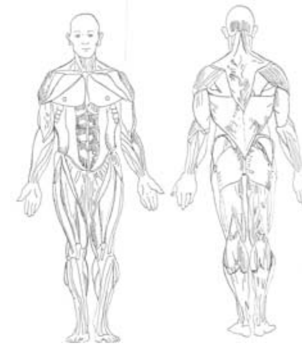


How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm
Burning	Dull	Sharp	Tightness
Coldness	Hot	Shooting	Tingling
Throbbing	Weakness		

2. ___________________________________ Increased Decreased Unchanged (circle one)

Pain Level Today (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

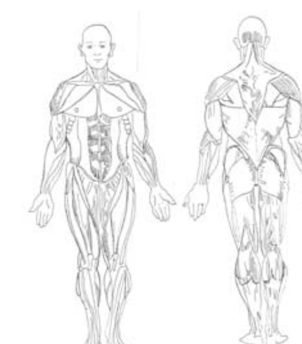


How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm
Burning	Dull	Sharp	Tightness
Coldness	Hot	Shooting	Tingling
Throbbing	Weakness		

3. ___________________________________ Increased Decreased Unchanged (circle one)

Pain Level Today (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

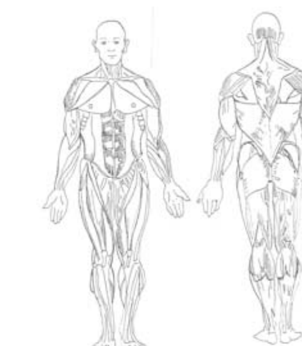


How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm
Burning	Dull	Sharp	Tightness
Coldness	Hot	Shooting	Tingling
Throbbing	Weakness		

4. ___________________________________ Increased Decreased Unchanged (circle one)

Pain Level Today (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)



How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm
Burning	Dull	Sharp	Tightness
Coldness	Hot	Shooting	Tingling
Throbbing	Weakness		

Have you had Physical, Occupational, or Speech therapy this year?

Does your pain radiate to different parts of your body? Yes or No I f Yes, where?

Pain Frequency: Constant Intermittent Occasional (circle one)

Is your injury work related: Yes or No (circle one)

Pain is aggravated by: (circle all that apply)

Bending Driving Lying Down Overhead Activity

Sitting Standing Walking Working Other: ____

Pain is alleviated by what: (example: heat, ice, meds, massage, nothing)

Daily Activities are limited by how many percent: % (In increments of 10)

Do you have difficulty sleeping? Yes or No (circle one)

Are you depressed? Yes or No (circle one)

Goals: (circle all that apply)

Decrease medications Decrease pain Increase physical activities

Return to sports Return to work Return to school

Is there anything else you would like the physician/physical therapist to know?