NEW PATIENT QUESTIONNAIRE

Your new patient paperwork helps our physicians and care team understand your health history so we can provide the best possible care. Please complete each section as accurately and thoroughly as you can. If you have any questions while filling it out, call us at (984) 444-8824 — we're happy to help. When finished, you may email the forms to **documents@restorespineandpain.com** or bring them with you to your appointment.

Patient Information

Name (Last, First): _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Preferred Phone: _____ Alternative Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Emergency Contact Name: _____ (Relationship): _____ Phone number: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Preferred Language: _____ Race: _____ Ethnicity: _____

Gender: _____

Height: _____ Weight:_____

Employment: ☐ Employed ☐ Disabled ☐ Retired ☐ Student ☐ Unemployed

Paitent Employer: _____

Insurance:

Do you have insurance? ☐ Yes ☐ No

Primary Insurance Name: _____ ID #: _____

Group #: _____ Subscriber: _____

Secondary Insurance Name: _____ ID #: _____

Group #: _____ Subscriber: _____

Is this part of worker's compensation case? ☐ Yes ☐ No

Claim #: _____ Adjuster: _____ Date of Injury: _____

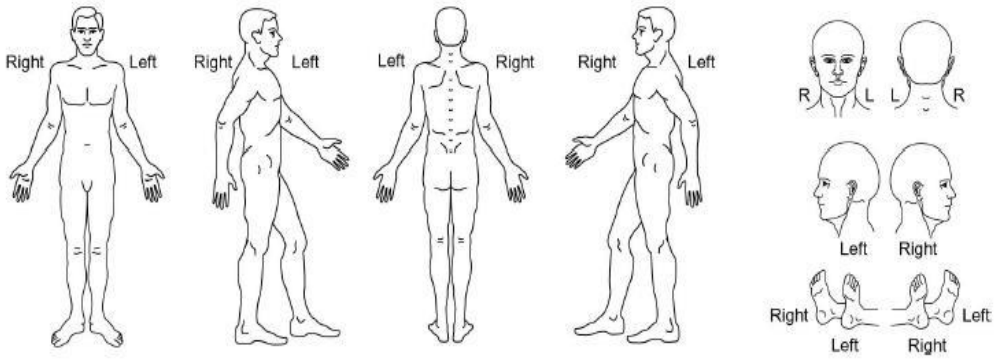
Phone number: _____ Fax number: _____

Claims Mailing Address: _____

Pain History

Chief Complaint (Reason for your visit today)? _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately, when did this pain begin?_____

What caused your current pain episode? ☐ No specific event/trauma ☐ Motor Vehicle Accident ☐ Fall

☐ Work Place Injury ☐ Other: _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description

Describe the character of your pain (eg: dull, stabbing, throbbing, etc):

_____

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

What factors worsen or affect your pain?

_____

What factors relieve your pain?

_____

What are your functional goals you wish to achieve with Pain Management?

_____

What are your goals from today's visit:

☐ Imaging/Tests ☐Physical Therapy ☐Medications ☐Injections ☐ Other: _____

Diagnostic Imaging

Mark all of the following tests that you have had related to your current pain complaints:

☐X-Ray of the: _____ Date: _____ Facility: _____

☐MRI of the: _____ Date: _____ Facility: _____

☐CT Scan of the: _____ Date: _____ Facility: _____

☐EMG/NCV study of the: _____ Date: _____ Facility: _____

☐Other Diagnostic Testing: _____ Date: _____ Facility: _____

☐I have not had ANY diagnostic tests for my current pain complaint

Please mark all of the following treatments you have had for pain relief: ☑

Spine Surgery	☐	Surgery: _____	Year: _____	Surgeon: _____	
Physical Therapy	☐	Location: _____		Month/Year: _____	
Chiropractic Care	☐	Location: _____		Month/Year: _____	
Psychological Therapy	☐	Location: _____		Month/Year: _____	
Acupuncture	☐	Location: _____		Month/Year: _____	
Brace Support	☐	Helpful: Yes ☐	No ☐		
Hot/Cold Packs	☐	Helpful: Yes ☐	No ☐		
Massage Therapy	☐	Helpful: Yes ☐	No ☐		
TENS Unit	☐	Helpful: Yes ☐	No ☐		

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) _____

☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ Nerve Blocks – Area/Nerve(s) - _____

☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____

☐ Trigger Point Injections – Where? _____

☐ Vertebroplasty/Kyphoplasty – Level(s) _____

☐ Other - _____

Which of these procedures listed above have helped with your pain? _____

_____

Please list the names of other Pain Physicians you have seen in the past?

_____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Spine Surgeon _____

☐ Orthopedic Surgeon _____

☐ Neurologist _____

☐ Other _____

☐ Psychiatrist/Psychologist_____

☐ Rheumatologist _____

☐ Neurologist_____

Previously Tried Medications

NSAIDS

☐ Ibuprofen/Advil/Motrin
☐ Meloxicam/Mobic
☐ Naproxen/Aleve
☐ Celecoxib/Celebrex
☐ Acetaminophen/Tylenol
☐ Medrol dose Pack/Steroids

Membrane Stabilizers

☐ Gabapentin/Neurotin
☐ Pregabalin/Lyrica
☐ Topiramate/Topamax

Antidepressants

☐ Duloxetine/Cymbalta
☐ Amitriptyline/Elavil
☐ Nortriptyline/Pamelor
☐ Venlafaxine/Effexor

Muscle Relaxers

☐ Methocarbamol/Robaxin
☐ Cyclobenzaprine/Flexeril
☐ Tizandine/Zanaflex
☐ Baclofen

Opioids

☐ Hydrocodone
☐ Tramadol
☐ Oxycodone
☐ Butrans/Belbuca
☐ Morphine

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

Cancer/Oncology
- ☐ Cancer – Type _____
- ☐ Cancer – Type_____
- ☐ Cancer – Type_____

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders
- ☐ Bleeding Disorder

Gastrointestinal
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ IBS/Crohns Disease

Urological
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis

Neurological
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Balance Disorder
- ☐ Head Injury
- ☐ Headaches
- ☐ Migraines

ENT
- ☐ Glaucoma
- ☐ Vertigo
- ☐ Hearing Problems
- ☐ Nosebleeds

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ ADD/ADHD
- ☐ PTSD

Endocrinology
- ☐ Diabetes – Type_____
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Other Diagnosed Conditions
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Do you have any implantable devices?

☐ Pacemaker/Defibrillator

Manufacture: _____ Date Implanted: _____ Managing Physician:_____

☐ Spinal Cord Stimulator/Peripheral Nerve Stimulator/Bladder Stimulator

Manufacture: _____ Date Implanted: _____ Managing Physician:_____

☐ Intrathecal Drug Delivery System (Pain Pump)

Manufacture: _____ Date Implanted: _____ Managing Physician:_____

☐ Other device _____

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) _____ Date? _____

2) _____ Date? _____

3) _____ Date? _____

4) _____ Date? _____

5) _____ Date? _____

☐ I have **NEVER** had any surgical procedures performed.

Family History

Mark all appropriate diagnoses as they pertain to your parents and siblings:

☐Arthritis ☐Cancer ☐Diabetes

☐Headaches/Migraines ☐High Blood Pressure ☐Kidney Problems

☐Liver Problems ☐Osteoporosis ☐Rheumatoid arthritis

☐Seizures ☐ Stroke

☐Other Medical Problems: _____

☐ I have no significant family medical history

Social History

Occupation: _____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home? _____ If so how many? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use:

☐ Social Use ☐ Daily use of alcohol ☐Never ☐ History of alcoholism ☐ Current alcoholism

Tobacco Use:

☐ Current user ☐ Former user ☐ Never used

☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Illegal Drug Use:

☐ Denies any illegal drug use ☐ Currently uses illegal drugs ☐ Formerly used illegal drugs (not currently

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones?

☐ Aspirin ☐ Plavix/Clopidogrel ☐ Coumadin/Wafarin ☐ Lovenox ☐Eliquis/Apixiban ☐Xarelto/Rivaroxaban

☐ Other _____ Prescribing Provider: _____ Contact Number: _____

Medication Name	**Dose**	**Frequency**
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____
10) _____	_____	_____

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to

Medication Name	Allergic Reaction
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Topical Allergies: ☐ Latex ☐ Iodine ☐ Chlorohexadine ☐ Contrast

Are you allergic to local anesthetic (lidocaine/bupivacaine etc.), contrast, iodine solution, chlorohexadine solution or steroids? ☐ **Yes** ☐ **No**

If Yes, please list what you are allergic to: _____