RESTORE
SPINE AND PAIN

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

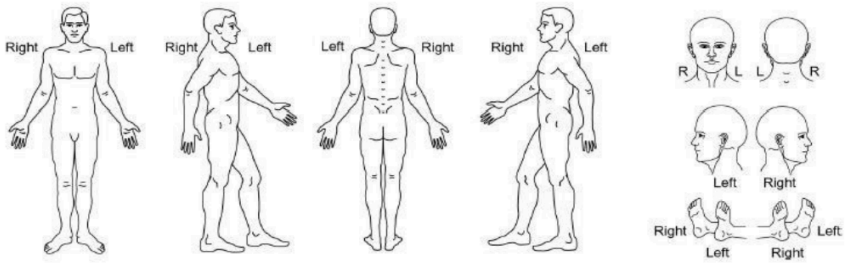
Preferred Language: _____ Race:_____ Ethnicity:_____ Gender:_____ Height:_____ Weight:_____

Employment: ☐ Employed ☐ Disabled ☐ Retired ☐ Student ☐ Unemployed Patient Employer: _____

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: ☐ Sharp ☐ Achy ☐ Dull ☐ Throbbing ☐ Shooting ☐ Burning ☐ Stabbing

Other: _____

How often does the pain occur? ☐ Constant ☐ 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 previously

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

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 _____ ☐ Psychiatrist/Psychologist _____

☐ Orthopedic Surgeon _____ ☐ Rheumatologist _____

☐ Neurologist _____ ☐ Pain _____

Previously Tried Medication

☐ Acetaminophen/Tylenol ☐ Medrol dose Pack/Steroids

NSAIDS

☐ Ibuprofen/Advil/Motrin ☐ Meloxicam/Mobic ☐ Naproxen/Aleve ☐Celecoxib/Celebrex

Membrane Stabilizers

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

Muscle Relaxers

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

Antidepressants

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

Opioids

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

Past Medical History

☐Hypertension	☐Hypothyroidism	☐IBS/Chron's Disease	☐Neuropathy
☐High Cholesterol	☐Hyperthyroidism	☐Stomach Ulcers	☐CRPS
☐Heart Disease	☐Gout	☐GI Bleed	☐Anxiety
☐Heart Attack (MI)	☐Acid Reflux (GERD)	☐Liver Diseases	☐Depression
☐Heart Failure	☐Osteoporosis	☐Hepatitis	☐Bipolar Disorder
☐DVT/PE	☐Asthma	☐Seizures	☐Arthritis
☐Peripheral Vascular Disease	☐Migraines	☐Rheumatoid Arthritis	☐Cancer _____
☐Stroke/TIA	☐COPD	☐Dementia	☐Fibromyalgia
☐Diabetes	☐Sleep Apnea	☐Multiple Sclerosis	☐Lupus
☐Scoliosis	☐HIV/AIDS	☐MRSA/Sepsis	☐Shingles
☐Kidney Disease	☐Anemia	☐Vision loss/Glaucoma	☐Other _____

Do you have any implantable devices?

☐Pacemaker/Defibrillator

Manufacturer: _____ Date Implanted: _____ Managing Physician: _____

☐Spinal Cord Stimulator/Peripheral Nerve Stimulator/Bladder Stimulator/Intrathecal Drug Delivery System (Pain Pump)

Manufacturer: _____ 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? _____ 3. _____ Date? _____
2. _____ Date? _____ 4. _____ 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	☐Seizures
☐Headaches/Migraines	☐High Blood Pressure	☐Kidney Problems	☐ Stroke
☐Liver Problems	☐Osteoporosis	☐Rheumatoid arthritis	☐Other: _____

☐I have no significant family medical history

Social History

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

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ 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	Medication Name	Dose	Frequency
1. _____	_____	_____	5. _____	_____	_____
2. _____	_____	_____	6. _____	_____	_____
3. _____	_____	_____	7. _____	_____	_____
4. _____	_____	_____	8. _____	_____	_____

Allergies

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

If so, please list all medications you are allergic to:

Medication Name	Allergic Reaction	Medication Name	Allergic Reaction
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Are you allergic to local anesthetic (lidocaine/bupivacaine etc.), contrast, iodine solution, Chlorhexidine solution or steroids?

☐ Yes ☐ No

If Yes, please list what you are allergic to:

_____

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Phone: (984) 444-8824 | Fax: (984) 202-2882
relief@restorespineandpain.com | www.restorespineandpain.com

📍 1505 Werrington Drive Holly Springs, NC 27540

Patient parking is available on the streets along Restore Spine and Pain's office. Parking spots are available behind the office and across the street behind the medical plaza. Please feel free to call for any questions or guidance.