NEW PATIENT PAIN QUESTIONNAIRE

Total Pain & Spine Care of Florida

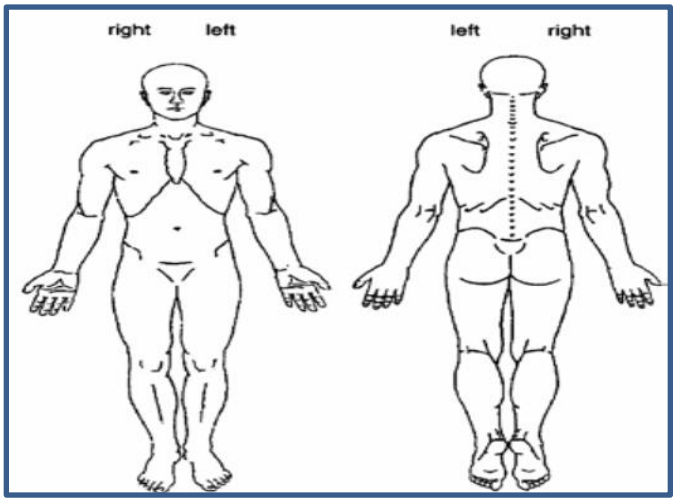
Last Name	First Name	Middle Name	Male/Female	Age

Referring Physician: _____

Family Physician: _____

When did your pain begin? _____
Was there an inciting event? _____
Is the pain the same/better/worse? _____

Shade the locations you have pain:



How would you rate your pain?
0 1 2 3 4 5 6 7 8 9 10
No Pain Worst pain imaginable

What are your goals?

_____

_____

What makes your pain **better**? (i.e. sitting, lying down, heat, cold, standing, etc) _____
_____

What makes your pain **worse**? (i.e. movement, walking, bending over, weather, etc) _____
_____

Circle the words below that describe your pain:

Burning	Aching	Sharp	Constant
Electric	Throbbing	Stabbing	Occasional
Prickling	Dull	Shooting	Frequent
Numbing	Cramping	Stinging	Rare

Circle the activities that are affected by your pain:

Sleep	Leisure	House chores
Work/school	Socializing	Sexual activity

Other:_____

Are you on blood thinners? (Y/N) If yes, which one? _____

Circle medications you have used for pain:

Tylenol	Ibuprofen	Naproxen	Celecoxib
Tramadol	Codeine	Dilaudid	Fentanyl
Hydrocodone	Methadone	Morphine	Oxycodone
Buprenorphine	Nortriptyline	Lyrica	Gabapentin
Amitriptyline	Desipramine	Topamax	Baclofen
Duloxetine	Venlafaxine	Flexeril	Tizanidine

Other:_____

Past Medical History

Diabetes (high blood sugar) Yes No

Obstructive Sleep Apnea (OSA) Yes No

Cancer Yes No

Type: _____

Other Medical Conditions (please list)

_____
_____
_____
_____

Allergies (including medication allergies)

_____
_____
_____

NEW PATIENT PAIN QUESTIONNAIRE

Total Pain & Spine Care of Florida

Last Name	First Name	Middle Name	Male/Female	Age
_____	_____	_____	_____	_____

PAST PAIN TREATMENTS

Treatment	Improvement?	No change?	Worse?	Dates of Treatment	Location
Physical Therapy					
Acupuncture					
Chiropractic Care					
Massage Therapy					
Heat/Ice					
Pool Therapy					
TENS unit					
Brace/ Orthotic					
Epidural Steroid Injection					
Facet joint/medial branch nerve block					
Radiofrequency Ablation (RFA)					
Joint Injections					
Trigger point injection					
Spinal Cord Stimulation					
Surgery					

NEW PATIENT PAIN QUESTIONNAIRE

Total Pain & Spine Care of Florida

Last Name	First Name	Middle Name	Male/Female	Age
_____	_____	_____	_____	_____

Current Medications

Medication	Dose in Mg	How often? Times/day	What is the medication for?	Dates started	Prescribing Provider

Previous Surgeries and Date of Surgery:

NEW PATIENT PAIN QUESTIONNAIRE

Total Pain & Spine Care of Florida

Last Name _____ First Name _____ Middle Name _____ Male/Female _____ Age _____

_____
_____
_____
_____
_____
_____
_____
_____
_____

Social History

Do you use tobacco products? (Y/N) _____

If former smoker, quit date? _____

Do you drink alcohol? (Y/N) _____

Do you use illegal drugs? (Y/N) _____

What is your occupation? _____

Do you have disability or a pending legal case? (Y/N)

Family History

Circle any of the following that run in your family:

Similar pain	Arthritis	Cancer
Depression	Stroke	Heart disease
Diabetes	Bleeding disorder	Substance abuse

Patient Signature: _____

Date: _____ **Time:** _____

Provider Signature: _____

Date: _____ **Time:** _____

Review of Systems

Circle all present (or recent) signs or symptoms

Constitutional

Change in Appetite	Chills	Sweating
Fever	Fatigue	Weight Change

HEENT

Facial Swelling	Neck pain	Neck stiffness
Ear discharge	Hearing loss	Ear Pain
Congestion	Sinus Pressure	Sore Throat

Eyes

Eye Pain	Eye Redness	Photophobia
Visual disturbance		

Respiratory

Apnea	Chest tightness	Cough
Shortness of breath	Wheezing	

Cardiovascular

Chest pain	Pacemaker	Palpitations
Anticoagulation	Hypertension	Cardiac Stent

Gastrointestinal

Abdominal Pain	Diarrhea	Nausea/vomiting
Ulcers	Constipation	Rectal Pain

Endocrine

Heat intolerance	Cold Intolerance	Increased urination
High glucose	Thyroid disease	

GU

Difficulty urinating	Hesitancy	Flank pain
Frequency	Urgency	Incontinence

Musculoskeletal

Arthralgia	Back Pain	Gait Disturbance
Joint Swelling	Myalgia	Fibromyalgia

Skin

Color Changes	Rash	Pallor
Wounds	Pain to light touch	Swelling

Allergy/Immune

Tape allergies	Food allergies	Immunocompromised

Neuro

Headache	Lightheadedness	Numbness
Seizures	Dizziness	Weakness
Tremors	Speech Changes	Confusion

Hematologic

Blood thinners	HIV	Bleeding disorder

Psychiatric

Agitation	Suicidal thoughts	Confusion
Dec. Concentration	Sleep disturbance	Hallucinations
Substance abuse	Nervous	Depression