

Physical Medicine & Rehabilitation/Pain New Patient Questionnaire

Name: _____ Date: _____

 What is your main problem and what questions would you like to talk about today? _____

When and how did the problem start? _____

 If you have pain, do certain activities or positions (such as sitting, standing, lying down) make the pain better or worse? Please explain: _____

Family history: Check any medical problems that your grandparents, parents, brothers or sisters have or had:

- Depression or other psychiatric problems
 Nervous system disorders
 Addiction problems
 Pain problems
 Other: _____

 Do you smoke? Yes No
 Do you drink alcohol? Yes No
 Do you use drugs? Yes No

How often have you used marijuana in the last year? _____

How often have you used recreational drugs (such as heroin, cocaine, or methamphetamine) or used a prescription medicine for non-medicinal purposes in the last year? _____

What is your occupation? _____

How much work have you missed because of this problem? _____

 What is your living situation?
 Live alone
 Live with spouse or significant other
 Live with family
 Have live-in help
 Live in skilled nursing facility or adult family home
 Have support nearby

 How many levels is your home? ____ Are there steps to enter? Yes No Other barriers: _____

 Hobbies, social activities, exercise, what you like to do for fun? _____

Have you had any of the following symptoms in the last 30 days? (Please check all that apply.)

General
<input type="checkbox"/> Fever
<input type="checkbox"/> Weight loss
<input type="checkbox"/> Weight gain
<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Problems sleeping or staying asleep
<input type="checkbox"/> Fall asleep too easily

Respiratory
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Cough
<input type="checkbox"/> Snoring

Skin
<input type="checkbox"/> Dry skin
<input type="checkbox"/> Rash
<input type="checkbox"/> Itching
<input type="checkbox"/> Ulcer/wounds
<input type="checkbox"/> Breast swelling or lump

Eyes, Ears, Nose, Mouth & Throat
<input type="checkbox"/> Double vision
<input type="checkbox"/> Blindness one/both eyes
<input type="checkbox"/> Loss of hearing
<input type="checkbox"/> Loss of smell
<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Dental problems

Gastrointestinal
<input type="checkbox"/> Nausea
<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Change in bowel movement
<input type="checkbox"/> Loss of bowel control
<input type="checkbox"/> Constipation

Neurologic
<input type="checkbox"/> Numbness or tingling
<input type="checkbox"/> Weakness
<input type="checkbox"/> Memory problems
<input type="checkbox"/> Confusion
<input type="checkbox"/> Difficulty walking or stumbling
<input type="checkbox"/> Falling
<input type="checkbox"/> Clumsiness
<input type="checkbox"/> Leg pains when walking
<input type="checkbox"/> Headache

Cardiovascular
<input type="checkbox"/> Heart racing/irregularities
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Ankle swelling

Genitourinary
<input type="checkbox"/> Urinary urgency
<input type="checkbox"/> Having to urinate often at night
<input type="checkbox"/> Loss of bladder control
<input type="checkbox"/> Difficulty urinating

Mental Health
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Stress in home/work life

Musculoskeletal
<input type="checkbox"/> Joint redness or swelling
<input type="checkbox"/> Muscle tenderness
<input type="checkbox"/> Pain with movement
<input type="checkbox"/> Morning stiffness

Endocrine
<input type="checkbox"/> Increased thirst
<input type="checkbox"/> Problems with sexual function

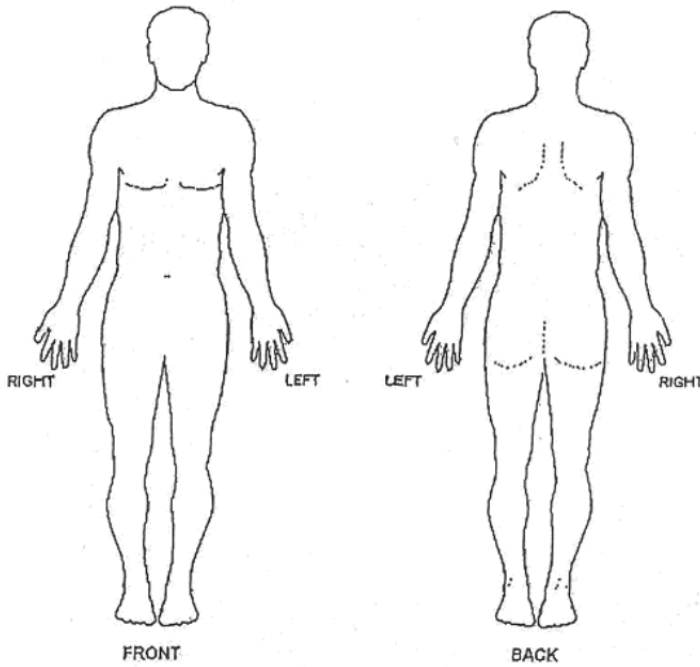
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Pain Diagram

Please use these symbols to mark where you have any of the following symptoms on the diagram below:

Numbness/tingling
 Achy pain
 Sharp pain

 xxxxxx
 //////////////



Pain and Functional Scale

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10
 No pain Pain as bad as you
can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10
 Does not Interfere Completely
interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10
 Does not Interfere Completely
interferes