

**Wellstar North Fulton Hospital Pain & Spine Center
New Patient Questionnaire**

Patient Name _____ Today's Date _____

Birthdate _____ Age _____

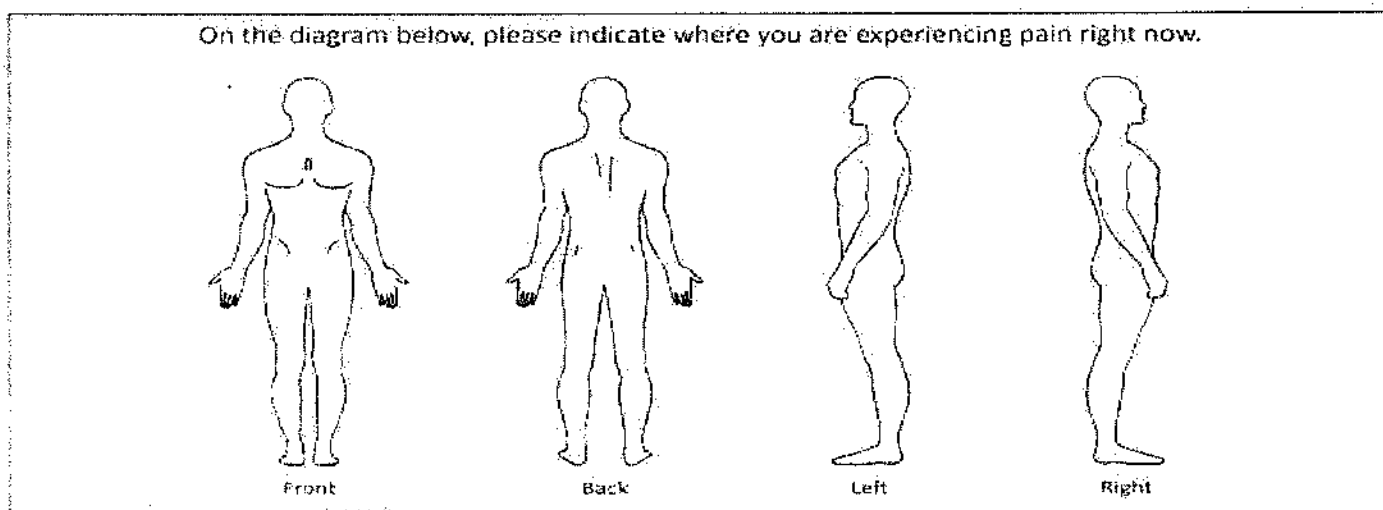
Referring Doctor _____ Internist/Family Doctor _____

Cardiologist/Vascular _____ Neurologist _____

Have you seen a Pain Doctor before? **Yes / No** If yes, provide name and practice _____

How long has your pain been present? _____

Is your pain from an injury or accident? **Yes / No** If yes, briefly describe what happened _____



Does it travel or radiate? **Yes / No** If yes, where to? _____

Describe your pain	What makes your pain WORSE?	What makes your pain BETTER?
<input type="checkbox"/> Aching	<input type="checkbox"/> Bending	<input type="checkbox"/> Exercise
<input type="checkbox"/> Burning	<input type="checkbox"/> Climbing stairs	<input type="checkbox"/> Heat/Ice
<input type="checkbox"/> Dull	<input type="checkbox"/> Going down stairs	<input type="checkbox"/> Lying down
<input type="checkbox"/> Pins & Needles	<input type="checkbox"/> Lifting	<input type="checkbox"/> Massage
<input type="checkbox"/> Numbness	<input type="checkbox"/> Lying down	<input type="checkbox"/> Pain/Prescription meds
<input type="checkbox"/> Shooting	<input type="checkbox"/> Pushing a shopping cart	<input type="checkbox"/> Pushing a shopping cart
<input type="checkbox"/> Stabbing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Sitting
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Standing	<input type="checkbox"/> Standing
<input type="checkbox"/> Other	<input type="checkbox"/> Walking	<input type="checkbox"/> Walking
	<input type="checkbox"/> Other	<input type="checkbox"/> Other

Circle AVERAGE pain level on a **GOOD** day: 0 1 2 3 4 5 6 7 8 9 10
 Circle AVERAGE pain level on a **BAD** day: 0 1 2 3 4 5 6 7 8 9 10

Are your current pain medications causing any side effects? **Yes / No / N/A**

If yes, please list _____

Are your current medications for this pain increasing your ability to function? **Yes / No / N/A**

If yes, describe how they increase your function? _____

CIRCLE Previous Treatments below that you have tried for your current pain

TREATMENT	HELPED ?	DATE	TREATMENT	HELPED ?	DATE
Ice Packs	Y / N		Chiropractor	Y / N	
Heating Pad	Y / N		Massage	Y / N	
Injection: Epidural	Y / N		Acupuncture	Y / N	
Injection: Trigger Point	Y / N		Spinal Cord Stimulator	Y / N	
Injection: Other	Y / N		TENS Unit	Y / N	
Opioids (oxycodone, hydrocodone, etc.)	Y / N		Ibuprofen, Motrin, Aleve, Tylenol, etc.	Y / N	
Physical Therapy (# of sessions/Duration)	Y / N	*	OTHER	Y / N	

Are you **Diabetic**? **Yes / No**

Are you currently taking any **Blood Thinners**? **Yes / No** If yes, please list _____

Are you ALLERGIC to any of the following? If Yes, list reaction below.

Betadine Yes / No	Latex Yes / No
CT/Contrast Dye Yes / No	Lidocaine/Marcaine Yes / No
Steroids Yes / No	

Are you ALLERGIC to any Medications Yes / No (If Yes, list medication and reaction below)

Medication	Reaction	Medication	Reaction

Pharmacy Name _____ **City** _____ **Phone** _____

CURRENT MEDICATIONS (Attach list as needed)

Medication Name	Dose	Times per Day	Medication Name	Dose	Times per Day

Medical History

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Abnormal ECG | <input type="checkbox"/> Concussion | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Conversion Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> History of Blood Transfusion | <input type="checkbox"/> Pulmonary Artery Hypertension |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> A-V Malformation | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Disc problem- Cervical | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Carotid Disease | <input type="checkbox"/> Disc problem – Lumbar | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Disc problem- Thoracic | <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> TIA |

Other Medical History: _____

Surgical History

Surgery	Date	Surgery	Date

Do you drink alcohol? **Yes / No** Wine / Beer / Shots of Liquor How many per week? _____

Do you use any recreational drugs? (marijuana, cocaine, heroin, etc) **Yes / No** Please list: _____

Tobacco use: **Current/Former/Never** Packs per day _____ Number of years _____ Quit Date _____

Smokeless Tobacco use: **Current/Former/Never** Quit Date _____

Over the last 2 weeks how often have you been bothered by the following:

Little interest or pleasure in doing things: •Not at all •Several Days •More than half the days •Nearly every day

Feeling down, depressed or hopeless: •Not at all •Several days •More than half the days •Nearly every day

Patient Signature _____ Date/ Time _____

Reviewed by _____ RN Date/ Time _____

- 0 – Pain Free

Mild Pain – Nagging, annoying, but doesn't really interfere with daily living activities.

- 1 – Pain is very mild, barely noticeable. Most of the time you don't think about it.
- 2 – Minor pain. Annoying and may have occasional stronger twinges.
- 3 – Pain is noticeable and distracting, however, you can get used to it and adapt.

Moderate Pain – Interferes significantly with daily living activities.

- 4 – Moderate pain. If you are deeply involved in an activity, it can be ignored for a period of time, but is still distracting.
- 5 – Moderately strong pain. It can't be ignored for more than a few minutes, but with effort you still can manage to work or participate in some social activities.
- 6 – Moderately strong pain that interferes with normal daily activities. Difficulty concentrating.

Severe Pain – Disabling; unable to perform daily living activities.

- 7 – Severe pain that dominates your senses and significantly limits your ability to perform normal daily activities or maintain social relationships. Interferes with sleep.
- 8 – Intense pain. Physical activity is severely limited. Conversing requires great effort.
- 9 – Excruciating pain. Unable to converse. Crying out and/or moaning uncontrollably.
- 10 – Unspeakable pain. Bedridden and possibly delirious. Very few people will ever experience this level of pain.

