

NEW PATIENT QUESTIONNAIRE

List any health problems that you have, NOT related to your current pain problem (cancer, diabetes, heart disease, etc.)

List any family medical history problems _____

Please list any surgeries you have had, NOT related to our pain problem _____

Please list any allergies _____

HISTORY OF CURRENT PAIN PROBLEM

Date of Injury/accident or when the symptoms first began _____

Work Related **YES NO**

Describe how your pain problem began (fall, lifting, pulling, woke up with pain) _____

Please describe how your pain feels right now (sharp, dull, burning) _____

PAIN LEVEL RIGHT NOW (Place an "X" on the line)

No Pain	1	2	3	4	5	6	7	8	9	Worst pain ever
0	Minimal Pain		Mild Pain		Moderate Pain		Severe Pain		Unbearable Pain	10

PAIN LEVEL MOST OF THE TIME (Place an "X" on the line)

No Pain	1	2	3	4	5	6	7	8	9	Worst pain ever
0	Minimal Pain		Mild Pain		Moderate Pain		Severe Pain		Unbearable Pain	10

PAIN LEVEL WITHOUT MEDICATIONS (Place an "X" on the line)

No Pain	1	2	3	4	5	6	7	8	9	Worst pain ever
0	Minimal Pain		Mild Pain		Moderate Pain		Severe Pain		Unbearable Pain	10

PAIN LEVEL WHILE TAKING MEDICATIONS (Place and "X" on the line)

No Pain	1	2	3	4	5	6	7	8	9	Worst pain ever
0	Minimal Pain		Mild Pain		Moderate Pain		Severe Pain		Unbearable Pain	10