**Patient Name**: ___________________________ **SS#**_______-____-_________

**Address**: _______________________________________________________

**City**: ______________________________**State**:_____ **Zip**: _______________

**Home#** _______________ **Work#** ________________ **Cell#** ________________

**Date of Birth**: ___/___/_____ **Age**: ____ Male Female

**Marital Status**: S M D W Other

**Spouse/Significant Other**: _____________________ **Phone** # ( ) _________

**Employer**: ________________________________ **Phone** # ( ) _________

**Referring Physician**: ______________________________________________

**How did you hear about us?**__________________________________________

**Primary Physician**: ______________________________________________

**Primary Insurance:** ______________________________________________

**ID#** ___________________________ **Group#** ____________________

**Insured:** ______________________________ **Phone** # ( ) _________

**Relationship** (if other than patient): _________________ **Date of Birth**: ___/___/____

**Secondary Insurance:** _____________________________________________

**ID#** ___________________________ **Group#** ____________________

**Insured:** ______________________________ **Phone** # ( ) _________

**Relationship** (if other than patient): _________________ **Date of Birth**: ___/___/____

**Is this a Workman's Compensation Claim?** Yes No **If Yes, complete additional form**

**Is this a motor vehicle accident claim?** Yes No **If Yes, complete additional form**

**Assignment of Benefits:** I understand I am totally responsible for all charges to my account. I understand that Prima Pain Relief will file my insurance claim as a courtesy to me. I am responsible for any amounts not paid by my insurance. If this account is sent to collection, I understand that I will be responsible for the any fees. I authorize release of my medical information to my physicians and insurance carriers. I also authorize payment of benefits directly to my physicians.

PATIENT SIGNATURE_________________________________ DATE___________

I give my permission for Prima Pain Relief to photocopy my driver's license or other identification photograph to be maintained in my medical records. I understand that this picture will be used in a confidential manner related only to my personal care in the above named office.

PATIENT SIGNATURE_________________________________ DATE___________

**New Patient Questionnaire:**
**Name __________________________Age___________Date______________**
**Height_______________ Weight________________**

**Occupation______________________________**

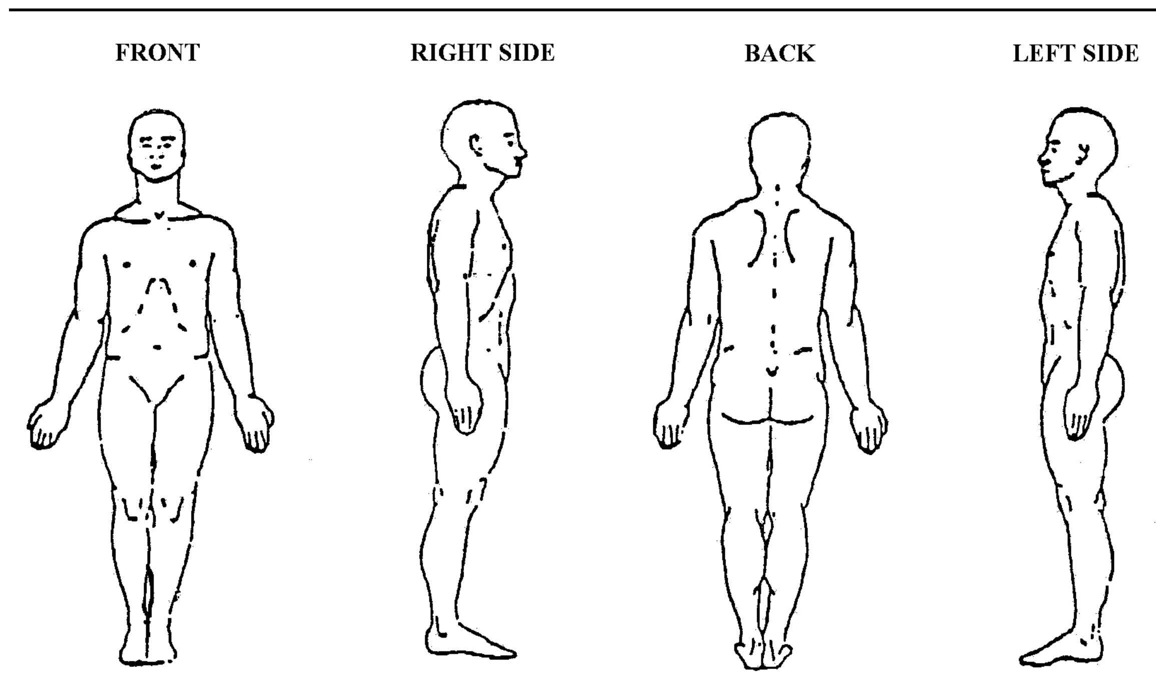
**I. Chief Complaint:**

**1) Where is your pain located? ___________________________________**
**______________________________________________________________**

**2) When and how did it begin? ___________________________________**
**______________________________________________________________**

**3) Does your pain radiate anywhere? _____________________________**

**4) Please mark the area(s) in the diagrams below where you are having pain:**




**5) On a scale from 0-10, with 0 being no pain and 10 being the worst pain imaginable, what number describes your pain?**
**At it's best: _____At it's worst________ Right at this moment: ______**

**6) How often does the pain occur: __Continuously __ Several times a day ___Intermittent___ occasionally ___ Less than daily**

**7) When is your pain worse?**
**___Morning ___Afternoon ___ Evening ___No Usual Pattern ____ All the time**

**8) How has the pain intensity changed since it began?**
**____ Better ____Worse ___ No change**

**9) Select one or more items below to describe your pain:**
**___Aching ___Burning ___Cramping ___Dull ___Electric Shock ___Sharp ___Shooting**
**____Stabbing ___Throbbing ___Other_____________________________________________**

**10) What makes the pain worse?**
**___Standing ___Sitting ___Walking ___Movement ___Lying Down ___Bending Forward**
**___Arching Backward ___Coughing/Sneezing ___Using Bathroom**
**___Other______________________________________________________________________**

**11) What makes the pain better?**
**___Standing ___Sitting ___Walking ___Movement ___Lying Down ___Bending Forward**
**___Arching Backward ___Coughing/Sneezing ___Using Bathroom**
**___Other______________________________________________________________________**

**12) What tests have been done and when?**
**Test: ___X-ray ___MRI ___CT ___Myelogram ___EMG ___Bone Scan ___Other**
**Date: ______ ______ ______ _________ ______ ________ ________**

**13) Do you have any of the following symptoms associated with your pain?**
**___Numbness / Tingling If yes, where? _____________________________________________**
**___Weakness If yes, where? ____________________________________________________**
**___Bowel/Bladder Incontinence When did it start?________________________________**

**14) List the names of other doctors or specialists you have seen for your pain or who have Treated your pain: ____________________________________________________________**
**______________________________________________________________________________**

**15) Please check all procedures or modalities you have tried to manage or treat your pain:**

| | Did it help? | | Did it help? |
|---|---|---|---|
| ___Acupuncture | ____________ | __Massage | ____________ |
| ___Biofeedback | ____________ | __Meditation | ____________ |
| ___Chiropractor | ____________ | __Nerve Blocks | ____________ |
| ___Epidural | ____________ | __Physical Therapy | ____________ |
| ___Facet Block | ____________ | __Psychotherapy | ____________ |
| ___Ice/Heat | ____________ | __Surgery | ____________ |
| ___Medications | ____________ | __TENS | ____________ |

**___Other__________________________________________________________**

**16) Are you involved in any litigation or lawsuit regarding your pain? Yes___ No____**

**17) Are you seeking Worker's Compensation as a result of your pain? Yes___ No____**

**18) Are you out of work? Y N Date_____________________**

**19) Who put you out of work?__________________________________________**

**II. Medical Illnesses (check all that apply):**

___Thyroid
___Liver (Hepatitis, cirrhosis)
___Psychiatric (depression, anxiety, suicide)
___High Blood Pressure
___High Cholesterol
___Diabetes (diet, medication, insulin)
___Cancer (Type_________________)
___Lung (asthma, emphysema, COPD)
___Heart (angina, heart attack, irregular heart beat, pacemaker, heart failure
___Stomach (ulcer, GERD/reflux)
___Kidney (stones, failure, dialysis)
___Neurologic (stroke, seizure, neuropathy)
___Arthritis (rheumatoid, fibromyalgia)

**III. Prior Surgeries:**

| **Type:** | **Date:** | **Type:** | **Date:** |
|---|---|---|---|
| ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ |

**IV. Medications**

**Allergies:**____________________________

**Current *Non-pain* Medications:**

______________________________________
______________________________________
______________________________________
______________________________________

**Do you take any of the following?**

___Aspirin ___Coumadin
___Plavix ___Heparin
___Aggrenox ___ Pletal
___Lovenox ___ Ticlid

**Current *Pain* Medicatons:**

______________________________________
______________________________________
______________________________________
______________________________________

**Previous Pain Medications:**

______________________________________
______________________________________
______________________________________
______________________________________

**V. Social History (check all that apply):**

___Use tobacco? Amount__________
___Use alcohol? Amount__________
___ Use illegal drugs? Type________
___ Been treated for alcohol or drug addiction

**VI. Family History (check all that apply):**

Cancer___ Who?___________________
Diabetes ___ Who?_________________
Heart Disease___ Who?______________
Hypertension___ Who?____________
Stroke___ Who?_________________
Alcohol/Drug abuse___ Who?______

**VII. Review of Systems (circle all that apply):**

GEN: Weight changes, fatigue
SKIN: Bruising, rashes
HEAD/EYES: Headache, blurry vision
ENT: Ears ringing, sinusitis, sore throat
RES: Chronic cough, shortness of breath
CV: Chest pain, palpitations
HEM: Anemia, easy bruising/bleeding
GI: Heartburn, nausea, constipation
GU: Blood in urine, painful urination
M.S. Joint pain, arthritis
NEURO: Stroke, seizures, weakness
PS: Depression, anxiety, sleep problems
END: Thyroid problems, diabetes
VASC: Leg cramps, aneurysms

**Form Completed By: (circle one) Patient ___Other**

**Signature:** ________________________ **Date:** ________________________