



New Patient Questionnaire/Neuroscience Center
Physiatry

Name: _____ DOB: _____

Primary Care Physician: _____

Who referred you to our clinic? (Referring Physician): _____

For what problem are you being referred? _____

Health Insurance: Primary _____ Secondary _____

Are you right or left handed? _____

When did your pain problems begin? ____ / ____ / ____

How did your pain begin: [] Gradually [] Accident/Injury: Date: ____ / ____ / ____

Describe briefly the incident that led to your pain: _____

What type of testing has been done and when?

- [] X-rays: ____ / ____ / ____ [] CT ____ / ____ / ____ [] MRI ____ / ____ / ____
[] EMG/NCS: ____ / ____ / ____ (muscle and nerve test) [] Discogram: ____ / ____ / ____ [] Milligram: ____ / ____ / ____
[] Lab Studies: ____ / ____ / ____

What treatment has there been:

Anti-Inflammatory medications: [] Ibuprofen [] Naprosyn [] Vioxx [] Celebrex [] Relafen
[] Other: _____

Muscle relaxant medications: [] Flexeril (Cyclobenzaprine) [] Skelaxin [] Zanaflex (Tizanidine)
[] Other: _____

Anti-Depressant Medications: _____ Narcotic Medications: _____

- [] Exercise [] Cold/Heat [] Ultrasound
[] Back brace [] Traction [] Massage
[] Epidural [] Acupuncture [] Surgery
[] Counseling [] Work Hardening [] Biofeedback/relaxation
[] Chiropractic [] Pain Management [] Trigger Point Injection
[] Tens

Please list all other physicians/health care providers you have seen for this problem

On a scale of 0 - 100, how satisfied are you with the overall quality of your life?
(0 = not at all, 100 = completely satisfied) _____

Since the beginning, is your pain: [] Better [] Worse [] Unchanged

Is your pain Constant? (circle one) YES NO

If no, select the percent of time you experienced pain in the last 24 hours.

10% 20% 30% 40% 50% 60% 70% 80% 90%

WHEN is your pain at its worst?

[] Morning [] Afternoon [] Evening [] Night



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Please answer the following questions with respect to your pain. Please circle only one number for each item.

1. Rate the level of pain you have had in the past **24 hours** (0=no pain, 10=unbearable)

0 1 2 3 4 5 6 7 8 9 10

2. Over the past **24 hours**, how would you rate your pain when it was at the **worst?**

(0=no pain, 10=unbearable)

0 1 2 3 4 5 6 7 8 9 10

3. Over the past **month**, how would you rate your pain when it was the **best?** (0=no pain, 10=unbearable)

0 1 2 3 4 5 6 7 8 9 10

4. Over the past **month**, how would you rate your pain when it was the **worst?** (0=no pain, 10=unbearable)

0 1 2 3 4 5 6 7 8 9 10

WHICH of the following make your pain:

Better Sitting Standing Lying Walking Lifting Bending

Worse: Sitting Standing Lying Walking Lifting Bending

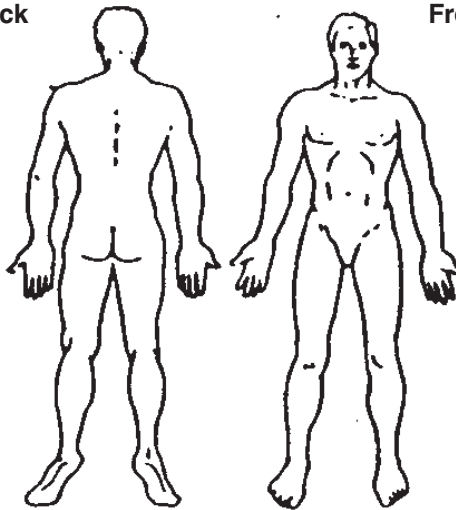
What else makes your pain better? _____

What else makes your pain worse? _____

Please Shade in the area of your pain
<<<Aching ///burning ^ ^ ^ sharp ooo dull ***pins/needles

Back

Front



Do you also have:

Weakness

Bowel or Bladder Problems

Diminished appetite

Anxiety

Weight Loss or gain

Depression

Fatigue

Poor Sleep

Unexplained fevers/chills

Numbness

Do symptoms change with cough or sneeze? Yes No



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CURRENT EMPLOYER _____ **Job title:** _____

Date started current job: ____ / ____ / ____ Restrictions, if any: _____

Are you receiving disability payments from:

- Workers Compensation:** Yes No Social
- Security Disability: Insurance** Yes No
- Insurance Company Policy:** Yes No

Is there pending litigation or ruling involving your injury/condition? Yes No

Because violence is so common in many people's lives, we ask this question to all patients:

In the last year has anyone harmed you or threatened you? Yes No

Do you have a signed donor card? Yes No

Do you have advanced directives in place? Yes No N/A, under 18 years old
If not, would you like information? Yes No

Patient Signature: _____ **Date:** _____

Date Updated/Initial: _____ **Date Updated/Initial:** _____

WORKSHEET ONLY
Not a permanent part of the
medical record



Pain Disability Index

Name: _____

Date: _____

Instructions: The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each category, please circle the number which describes the levels of disability you typically experience. A score of 0 means no disability at all and a score of 10 means that all the activities in which you would have normally been involved have been totally disrupted or prevented by your pain.

1. **Family/Home responsibilities.**

Activities related to the home or family, including chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Total disability

2. **Recreation.** Hobbies, sports and similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Total disability

3. **Social activity.** Participation with friends and acquaintances other than family members, including parties, theater, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Total disability

4. **Occupation.** Activities that are part of or directly related to one's job, including non-paying jobs such as that of homemaker or volunteer work.

No disability 0 1 2 3 4 5 6 7 8 9 10 Total disability

5. **Sexual activity.** This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Total disability

6. **Self-care.** Activities of daily maintenance and independent daily living (taking a shower, driving, getting dressed, etc.).

No disability 0 1 2 3 4 5 6 7 8 9 10 Total disability

7. **Life-support activities.** Basic life-support behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Total disability