PRIVIUM
SPINE.PAIN.REHAB.

**Office use* Provider _____

Appt time_____Entered _____

Ht_____Wt_____

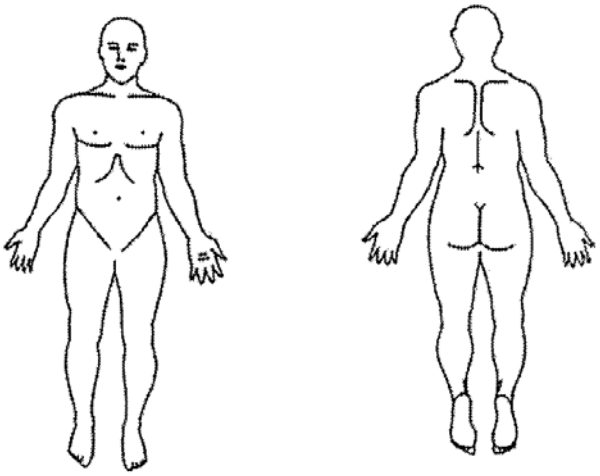
BP_____

NEW PATIENT PAIN QUESTIONNAIRE

Patient Name_____**DOB**_____**Date** _____

Chief Complaint (main problem seeking treatment)_____**Side** ☐ right ☐ left

On the Diagram, shade in or circle the area where you feel pain:



R L **L R**

Preferred Pharmacy Name:

_____

Preferred Pharmacy Address:

_____

Preferred Pharmacy Phone:

_____

---- (0 = no pain 10 = unbearable pain) ----

Pain level today

0 1 2 3 4 5 6 7 8 9 10

Over the last 4 weeks, please identify your pain levels below:

Severe pain level (on a bad day)

0 1 2 3 4 5 6 7 8 9 10

Average pain level (on an average day)

0 1 2 3 4 5 6 7 8 9 10

Email _____

The onset of your pain was:

☐Motor vehicle accident

Date of Accident _____

Where you wearing a seatbelt: ☐Yes ☐No

Position during the accident:

☐Driver ☐Passenger in front seat ☐Passenger in back seat

☐Falling from a height

☐Injury at work

Date of injury _____

What injury occurred? _____

☐Insidious onset

☐Lifting an object ☐Playing a sport ☐Slipping and falling ☐Trauma ☐Tripping/uneven surface

Your pain occurs: ☐constantly ☐intermittent ☐worse with activity ☐worse at the end of the day ☐worse during a activity ☐worse during cold seasons ☐worse during the day ☐worse during the night ☐worse in the morning

Describe your pain: ☐aching ☐burning ☐cramp-like ☐dull ☐in a glove distribution ☐in a stocking distribution ☐pins & needles-like ☐sharp ☐shooting ☐stabbing

Your pain has been occurring for: _____ ☐day's ☐week's ☐month's ☐years

Symptoms	Associated with your pain	**Symptoms**	Associated with your pain
Arm numbness		Insomnia	
Awakens you from sleep		Leg numbness	
Change in bladder function		Sexual Dysfunction	
Changes in bowel function		Shoulder numbness	
Changes in temperature in the affected area		Shoulder numbness	
Depression		Suicidal ideation	
Finger numbness		Sweating in affected area	
Flushing in affected area		Toe numbness	

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What activities aggravate/relieve your symptoms?

ACTIVITIES	AGGRAVATES YOUR PAIN	RELIEVES YOUR PAIN
All Movements		
Bending Forward		
Exercise		
Lifting Objects		
Lying Flat		
Rest		
Rotating the neck		
Sitting		
Standing for long periods		
Walking long distances		

What treatments have you used to treat the symptoms?

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
ACTIVITY MODIFICATION			
BRACE			
What type of Brace?	☐Back Brace ☐Neck Brace ☐Cervical traction ☐TENS unit ☐Ankle Brace (R or L) ☐Wrist Brace (R or L) ☐Knee Brace (R or L)		
How long have you had the product?			
Are you obtaining relief?			
Are your products in good condition?			
CHIROPRACTIC MANIPULATION			
PHYSICAL THERAPY			
PILATES			
WEIGHT REDUCTION			
YOGA			
HEAT TREATMENT			
ICE TREATMENT			
ACUPUNCTURE			
MEDICATIONS	Check mark all medication that apply below		

Opioids		NSAIDs/Tylenol		Muscle Relaxants
☐ Tramadol	Δ Methadone	Δ Tylenol	Δ Lodine	Δ Soma
☐ Demerol	Δ Morphine	Δ Aspirin	Δ Orudis	Δ Lorzone
☐ Codeine	Δ Nucynta	Δ Ibuprofen	Δ Relafen	Δ Flexeril
☐ Fentanyl (Duragesic)	Δ Butrans	Δ Naproxen	Δ Celebrex	Δ Baclofen
☐ Hydromorphone (Dilaudid,)	Δ Suboxone	Δ Daypro	Δ Toradol	Δ Zanaflex
☐ Hydrocodone (Vicodin)		Δ Indocin		Δ Robaxin
☐ Oxycodone (Percocet, Oxycontin)		Δ Feldene		Δ Skelaxin
☐ Oxymorphone (Opana)		Δ Voltaren		Δ Valium (Diazepam)

Antidepressants		Other	
☐ Elavil (Amitriptyline)	Δ Paxil	Δ Neurontin (Gabapentin)	Δ Lyrica
☐ Pamelor (Nortriptyline)	Δ Prozac	Δ Tegretol	Δ Ativan
☐ Desipramine	Δ Serzone	Δ Dilantin	Δ Xanax
☐ Impramine (Tofranil)	Δ Cymbalta	Δ Topamax	Δ Imitrex
☐ Zoloft	Δ Savella	Δ Depakote	Δ Ergotamine

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Do you have any adverse effects since starting any treatment?

☐Constipation ☐drowsiness ☐mental slowness ☐other

What procedures have you had to treat the pain?

PROCEDURE	Mark if applicable
No Procedure	
Epidural Steroid Injection	
Facet Joint Injection	
Medial Branch Block Trial	
Peripheral Nerve Injection	
Rhizotomy	
Fusion, anterior	
Fusion, posterios	
Fusion, combined anterior and posterior	
Laminectomy	
Microdiscectomy	
Other	

What imaging studies have you had for the pain?

☐Bone scan

☐CT Scan

☐EMG

☐ MRI

How has the pain limited you? (check mark all that apply)

Activities	Limit Pain	Activities	Limit Pain
No limitations		Inability to attend school	
Attending school on a limited basis		Inability to perform daily activities (ADL's)	
Difficulty getting up from chair		Inability to work	
Difficulty sitting		Requiring constant assistance	
Difficulty standing		Requiring occasional assistance	
Difficulty walking		Working on a limited basis	
Difficulty with daily activities (ADL's)		Working light duty	
Difficulty with recreational sports		other	
Functional limitations			

Who have you seen for this problem? ☐Chiropractor ☐Emergency Room ☐General Surgeon ☐ Internist

☐Orthopedic Doctor ☐Pediatrician ☐Primary care ☐ Therapist ☐Trainer ☐Urgent Care Center ☐Walk in clinic