

**New Patient Paperwork (page 1 of 2)**

**Patient Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **Date** \_\_\_\_\_

**Who referred you to our office?** \_\_\_\_\_  
**Where is your pain?** \_\_\_\_\_  
**When did your pain begin?** \_\_\_\_\_  
**What caused your pain?** \_\_\_\_\_

**Marital Status?**

- Single     Divorced  
 Married     Widowed

**How have you treated your pain, thus far? (Circle all that apply)**

No treatment to date	Over-the-counter Meds, which ones? _____
Back/Neck Brace	Prescription Medication, which ones? _____
Exercises/stretches	Physical Therapy, with whom? _____
TENS unit	Chiropractics, with whom? _____
Acupuncture	Psychologist/psychiatrist _____
Illegal Drugs /Alcohol use	Injections / Nerve Blocks _____

**I live with** \_\_\_\_\_  
 \_\_\_\_\_

**Do you have any family Members that are disabled?**  
 \_\_\_\_\_

**Do you use tobacco products?**

- Cigarettes, \_\_\_\_\_ # packs per day  
 Chewing tobacco, how much? \_\_\_\_\_

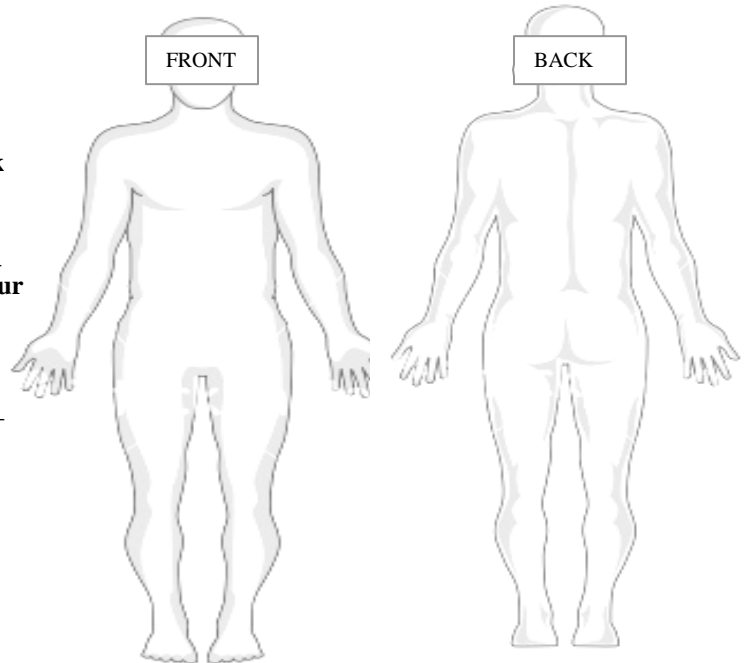
**ON THE DIAGRAM PLEASE MARK WHERE YOU ARE HURTING**

**Do you drink alcohol?** \_\_\_\_\_  
**How much?** \_\_\_\_\_ # drinks per week

**Highest level of Education Completed?** \_\_\_\_\_

**Work Status:**     Not Employed  
 Full Time     Part-Time  
 Retired     Disabled  
 Not working because of pain  
 Limited/ Light Duty

**Is your pain related to a Work Injury?** \_\_\_\_\_  
**If so, when did it occur?** \_\_\_\_\_  
**How long have you been at your job?** \_\_\_\_\_  
**Do you have a lawyer? If so, name of attorney** \_\_\_\_\_  
 \_\_\_\_\_



**Answer the following questions (CIRCLE ALL THAT APPLY)**

**My pain is?**

- |         |             |           |                  |
|---------|-------------|-----------|------------------|
| Sharp   | Dull        | Throbbing | Radiating        |
| Burning | Tingling    | Aching    | Pins and Needles |
| Numbing | Electricity | Cramping  |                  |

**What worsens your pain?**

- |            |              |
|------------|--------------|
| Sitting    | Damp Weather |
| Standing   | Movement     |
| Lying down | Working      |
| Lifting    | Everything   |
| Tension    | Nothing      |

**What relieves your pain?**

- |            |            |
|------------|------------|
| Sitting    | Rest       |
| Standing   | Movement   |
| Lying down | Pain       |
|            | Medication |
| Heat       | Ice        |

**When is your pain present?**

- |              |                     |
|--------------|---------------------|
| Daytime      | When I first awoken |
| Nighttime    | No particular time  |
| During Sleep | Only at work        |
|              | All of the time     |

**My pain makes me feel?**

- |           |            |
|-----------|------------|
| Anxious   | Hopeless   |
| Helpless  | Tired      |
| Depressed | Frustrated |
| Lonely    | Scared     |

**ON THE SCALE BELOW, PLEASE INDICATE HOW BAD YOU ARE HURTING**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
No Pain		Mild		Discomforting		Distressing		Horrible		Excruciating

