NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

COMPREHENSIVE PAIN & NEUROLOGY CENTER PLLC
RELIEVE PAIN AND RECLAIM LIFE

Your completed intake questionnaire helps our providers understand your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and if you have any questions of how to complete any part of this form inquire at our front desk or call (615) 410-4990.

Patient Name: ____ **Date of Birth:** ______________________

PAIN DESCRIPTION

Where is your pain located? ☐Head ☐Neck ☐Hand/Shoulder/Arm ☐Chest ☐Back ☐Pelvis ☐Abdomen ☐Leg/Knee/Foot

Where is your WORST pain (check one location)? ☐Head ☐Neck ☐Hand/Shoulder/Arm ☐Chest ☐Back ☐Pelvis ☐Abdomen ☐Leg/Knee/Foot

When did your pain start? ☐< 1 month ☐< 6 month ☐ > 1 year ☐ > 5 years ☐ > 10 years

How did your pain begin? ☐Gradually ☐Suddenly

Since the start, has your pain: ☐Decreased ☐Increased ☐Stayed the same

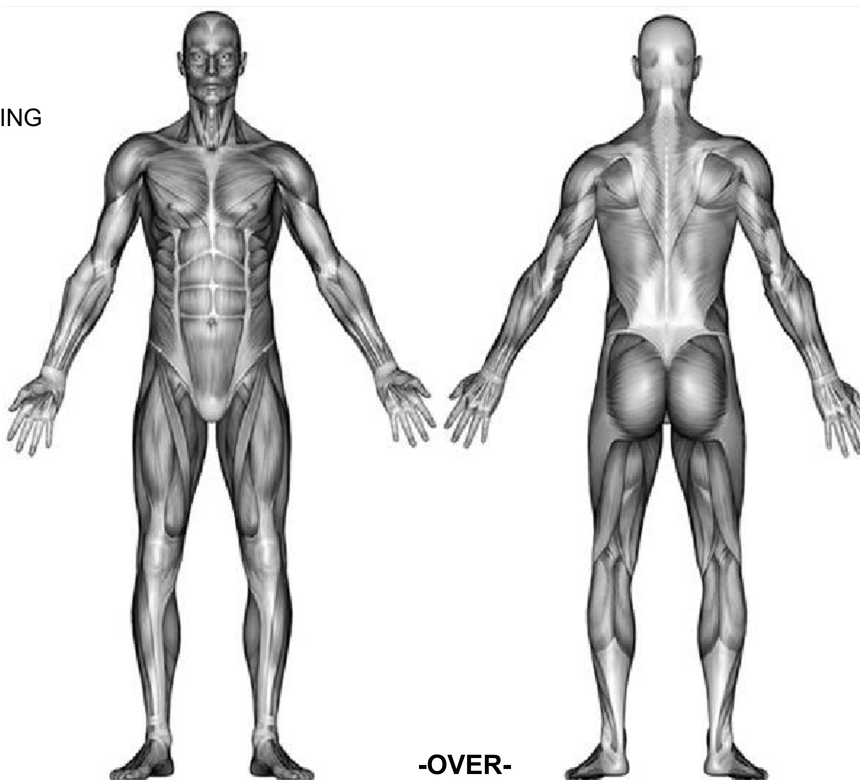
When is your pain the worst? ☐Morning ☐Mid-day ☐Evenings ☐Night

Please check each of the following words that apply to your pain:

☐Throbbing	☐Shooting	☐Stabbing	☐Sharp	☐Cramping	☐Gnawing
☐Punishing/Cruel	☐Splitting	☐Sickening	☐Tingling	☐Jabbing	☐Tender
☐Heavy	☐Tiring/Exhausting	☐Hot/Burning	☐Aching	☐Spasm	☐Squeezing
☐Dull	☐Shock-Like	☐Stinging			

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

N = NUMBNESS
S = STABBING/SHOOTING
B = BURNING



-OVER-

Check each number below to indicate the level or intensity of your pain (0=no pain 10=worst pain):

0 – pain free
1 – very minor
2 – annoying and distracting at times
3 – distracting more often than not
4 – can be ignored if you are focused on other tasks, but still distracting
5 – unable to ignore the pain for more than 30 minutes
6 – cannot ignore the pain but able to work and participate in various activities
7 – hard to focus on tasks, interferes with sleep, but still able to take care of yourself
8 – physical activity is severely limited, able to read and talk with no difficulty
9 – unable to speak, crying/moaning in pain uncontrollably, near delirium
10– unconscious, pain makes you pass out

Usually ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Worst pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Least pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Right now ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Please indicate yes or no to the following questions:

Do you have a family history of alcohol abuse? ☐Yes ☐No
Do you have a family history of illegal drug abuse? ☐Yes ☐No
Do you have a family history of prescription drug abuse? ☐Yes ☐No
Do you have a personal history of alcohol abuse? ☐Yes ☐No
Do you have a personal history of illegal drug abuse? ☐Yes ☐No
Do you have a personal history of prescription drug abuse? ☐Yes ☐No
Are you between the ages of 16 and 45? ☐Yes ☐No
Do you have a history of childhood abuse? ☐Yes ☐No
Do you have a history of ADHD, OCD, bipolar, schizophrenia? ☐Yes ☐No
Do you have a history of depression? ☐Yes ☐No

Can you relate the start of your pain to a specific event?
☐None ☐Fall ☐Assault ☐Work injury ☐Hard labor ☐Surgery ☐Car accident ☐Other _______________

Please check any medical devices a doctor had advised you to use in the past:
☐TENS unit ☐Hard back brace (LSO) ☐Cane ☐Walker ☐Wheelchair ☐Splint ☐Ankle/foot support (AFO)

I assume my proper family role: ☐< 10% time ☐50% time ☐>90% time

I am able to participate in recreational activities I like: ☐< 10% time ☐50% time ☐>90% time

I am able to work without problem: ☐< 10% time ☐50% time ☐>90% time ☐N/A

Do you have a history of substance abuse? ☐Yes ☐No

Do you take medications for anxiety (Xanax, Klonopin, etc)? ☐Yes ☐No

Do you have a history of sleep apnea? ☐Yes ☐No

My pain disrupts: ☐Walking ☐Sleep ☐Mood ☐Chores ☐Exercise ☐Work ☐Family time ☐Hobbies ☐Dressing ☐Driving

Have you ever been fired from a pain treatment program? ☐Yes ☐No
If yes please explain: ____

In the last 30 days have you been prescribed pain medication? ☐Yes ☐No

Last dose of pain medication: ☐Today ☐Last night ☐2 nights ago ☐> 1 week

PAIN RELIEF

Medication Trials

Opioids

☐Tramadol (Ultram) ☐Codeine (Tylenol 3) ☐Merperidine (Demerol) ☐Nalbuphine (Nubain)
☐Morphine (Kadian/Avinza/Ms Contin) ☐Hydrocodone (Lortab/Reprexain/Vicodin) ☐Methadone
☐Butorphanol (Stadol) ☐Oxycodone (Percocet/Endocet/Oxycontin/Roxicodone) ☐Levorphanol
☐Fentanyl (Duragesic) ☐Tapentadol (Nucynta) ☐Hydromorphone (Diluadid/Exalgo)
☐Oxymorphone (Opana) ☐Buprenorphine (Suboxone/Butrans/Belbuca) ☐Nucynta

NSAIDs

☐Aspirin ☐Meloxicam (Mobic) ☐Ibuprofen ☐Diclofenac (Zipsor/Cambia) ☐Indomethacin (Indocin)
☐Naproxen (Aleve/Anaprox/Midol) ☐Ketoprofen ☐Celecoxib (Celebrex) ☐Diflunisal (Dolobid)
☐Salsalate ☐Sulindac (Clinoril) ☐Tolmentin ☐Etodolac (Lodine) ☐Nabumetone (Relafen)
☐Ketorolac (Toradol/Ketoprofen) ☐Oxaprozin (Daypro)

Muscle Relaxers

☐Chlorzoxazone (Parafon Forte) ☐Metaxalone (Skelaxin) ☐Tizanidine (Zanaflex) ☐Baclofen
☐Methocarbamol (Robaxin) ☐Carisprodol (Soma) ☐Orphenadrine (Norflex) ☐Diazepam (Valium)
☐Cyclobenzaprine (Flexeril)

Antidepressant/Antianxiety

☐Amitriptyline (Elavil) ☐Nortriptyline (Pamelor) ☐Desipramine (Norpramin) ☐Clomipramine (Anafranil)
☐Imipramine (Tofranil) ☐Duloxetine (Cymbalta) ☐Venlafaxine (Effexor) ☐Desvenlafaxine (Pristiq)
☐Milnacipram

Antiseizure

☐Gabapentin (Neurontin/Gralise) ☐Pregabalin (Lyrica) ☐Valproic Acid (Depakote) ☐Levetiracitam (Keppra)
☐Topiramate (Topamax) ☐Phenobarbital (Primidone) ☐Carbamazepine (Tegretol)
☐Oxcarbamazepine (Trileptal) ☐Zonisamide (Zonegran)

Pain relief from medications: ☐Minimal ☐Moderate ☐Significant
Side effects with pain medications: ☐Yes ☐No If yes, please list ______________________________
Pain relief from physical therapy: ☐Not attempted ☐Minimal ☐Moderate ☐Significant
Pain relief from chiropractor: ☐Not attempted ☐Minimal ☐Moderate ☐Significant
Pain relief from neck/back surgery: ☐Not attempted ☐Minimal ☐Moderate ☐Significant
Pain relief from psychological therapy: ☐Not attempted ☐Minimal ☐Moderate ☐Significant
Pain relief from procedures: ☐Not attempted ☐Minimal ☐Moderate ☐Significant

Procedure treatment history

☐I have not had any prior interventional procedures
☐Epidural Steroid Injection (Check levels that apply)
☐Cervical ☐Thoracic ☐Lumbar ☐Caudal
☐Transforaminal Steroid Injection
(Check levels that apply)
☐Cervical ☐Thoracic ☐Lumbar
☐Facet Steroid Injection (Check levels that apply)
☐Cervical ☐Lumbar
☐Radiofrequency Ablation (Check levels that apply)
☐Cervical ☐Lumbar
☐Kyphoplasty/Vertebralplasty
Levels ________________________

☐Sympathetic Nerve Injections
☐Stellate Ganglion ☐Lumbar ☐Ganglion Impar
☐Trigger Point Injection
☐Joint/Bursal Injection
☐Discogram
☐Peripheral Nerve Injection
☐Pain Pump
☐Botox
☐Spinal Cord Stimulation (Check One)
☐Trial ☐Implant

OVER

CURRENT MEDICATIONS

Please indicate which of the following blood-thinners you are taking (if any):

☐None ☐Coumadin/Warfarin ☐Effient ☐Lovenox ☐Plavix ☐Pletal ☐Pradaxa ☐Prasugrel
☐Ticlid ☐Aspirin ☐Other______________________

Please list any medications you are taking on a regular basis:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________

Please list any vitamins, natural products or over-the-counter medications:

1.________________________
2.________________________
3.________________________

ALLERGIES

Do you have any known medication allergies? ☐Yes ☐No
If so, please list below:

	Medication	Allergic reaction type
1.	____________________	____________________
2.	____________________	____________________
3.	____________________	____________________

Do you have any topical allergies? ☐Iodine ☐Chloroprep ☐Latex ☐Tape
Allergies to shellfish? ☐Yes ☐No

PAST MEDICAL HISTORY

Please check the following conditions/diseases that you have been diagnosed with in the past:

General
☐HIV/AIDS
☐Diabetes
☐Cancer

Head/Eyes/Ears/Nose/ Throat
☐Head injury
☐Glaucoma
☐Hearing impairment

Hematological
☐Bleeding disorder
☐Anemia
☐Blood clots

Hepatic/Pancreatic
☐Hepatitis B/C
☐Liver cirrhosis
☐Pancreatitis

Gastrointestinal
☐IBS
☐GERD (Acid reflux)
☐GI Bleeding
☐Constipation

Respiratory
☐Asthma
☐COPD
☐Bronchitis
☐Pneumonia
☐Tuberculosis

Neurological/Psychiatric
☐Stroke
☐Epilepsy
☐Multiple Sclerosis
☐Peripheral Neuropathy
☐RSD/CRPS
☐Depression
☐Anxiety
☐Schizophrenia
☐Alcohol/Drug Abuse

Musculoskeletal
☐Bursitis
☐Joint Pain
☐Fibromyalgia
☐Osteoarthritis
☐Osteoporosis
☐Rheumatoid Arthritis
☐Vertebral Comp FX

Cardiovascular
☐Heart Attack
☐High Blood Pressure
☐High Cholesterol
☐Coronary Artery Disease
☐Pacemaker/Defibrillator
☐Murmur

Genitourinary/Nephrology
☐Dialysis/Kidney Failure
☐Bladder Infections
☐Kidney Infection
☐Kidney Stones
☐Urinary Incontinence

Other: ____

PAST SURGICAL HISTORY

Please check any surgical procedures you may have done in the past:

Spine/Back Surgery

☐Discectomy (Levels) ____________________

☐Laminectomy (Levels) ____________________

☐Spinal Fusion (Levels) ____________________

Joint Surgery

☐Shoulder ____________________

☐Knee ____________________

Abdominal Surgery

☐Gallbladder ____________________

☐Appendectomy ____________________

☐Bypass Surgery ____________________

Female Surgeries

☐C Section ____________________

☐Hysterectomy ____________________

☐Laparoscopy ____________________

Heart Surgery

☐Valve Replacement ____________________

☐CABG ____________________

☐Stent Placement ____________________

Other Surgeries

☐Hemorrhoidectomy ____________________

☐Hernia Repair ____________________

☐Thyroidectomy ____________________

☐Tonsillectomy ____________________

☐Vascular ____________________

FAMILY HISTORY

Mark all appropriate diagnoses for your biological mother and father only:

	Cancer	Diabetes	Heart Disease	High Cholesterol	Hypertension	Kidney Problems	Liver Problem	Osteoporosis	Rheumatoid Arthritis	Seizure	Stroke	Substance Abuse
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other Medical Problems: ____

SOCIAL HISTORY

Education: ☐GED/High School ☐Some College ☐College Grad ☐Professional School ☐Graduate School

Do you have a lawsuit/personal injury claim/worker's compensation regarding your pain? ☐Yes ☐No

If so, has the lawsuit/claim been settled? ☐Yes ☐No

Are you using alcohol on a regular basis? ☐Yes ☐No

Tobacco Use: ☐Current ☐Former ☐Never

How many cigarettes do you smoke per day? ☐1-5 ☐10-20 ☐20-40 ☐>40

How often do you smoke? ☐Everyday ☐Occasionally

Are you interested in quitting smoking today? ☐No ☐Yes ☐Yes, but not today ☐Yes, I am getting help

How many times have you tried to quit? ☐Never ☐Once ☐A few times ☐Many

Which methods have you used? ☐None ☐Nicotine Gum ☐Nicotine Patch

☐Nicotine Inhaler ☐Nicotine Nasal Spray ☐Nicotine Lozenge ☐Chantix/Varenicline

☐Wellbutrin/Buproprion ☐Cold Turkey ☐Counseling/Therapy ☐Hypnosis ☐Laser Therapy

Have you ever used street drugs on a regular basis? ☐Yes ☐No

History of physical abuse? ☐Yes ☐No

What is your marital status? ☐Never married ☐Married ☐Separated ☐Divorced ☐Widow

OVER

REVIEW OF SYSTEMS

Constitutional ☐Fevers ☐Chills ☐Weight gain ☐Weight loss ☐Fatigue ☐Night sweats

Eyes ☐Vision changes

Ears/nose/throat/neck ☐Nosebleeds ☐Sore throat ☐Earache ☐Hearing problem ☐Ringing in ears ☐Sinus problems

Cardiovascular ☐Fainting ☐Chest pain ☐Irregular heartbeat ☐Foot swelling ☐DVT

Gastrointestinal ☐Abdominal cramps ☐Heart burn ☐Constipation ☐Diarrhea ☐Nausea ☐Vomiting

Respiratory ☐Shortness of breath ☐Cough ☐Wheezing ☐Pulmonary embolism

Musculoskeletal ☐Muscle pain ☐Joint swelling ☐Muscle spasms ☐Joint stiffness

Sleep ☐Snoring ☐Insomnia ☐Restless legs syndrome ☐Waking up with dry mouth ☐Waking up with headache

Genitourinary/nephrology ☐Urine flow changes ☐Blood in urine ☐Erectile dysfunction ☐Painful urination

Neurological ☐Dizziness ☐Tremors ☐Problems thinking ☐Arm/leg jerking ☐Falls/balance problems ☐Numbness/tingling

Psychiatric ☐Suicidal thoughts ☐Depressed mood ☐Anxious feeling ☐Eating disorder

Is there any possibility you could be pregnant? ☐Yes ☐No ☐N/A

DIAGOSTIC TESTS AND IMAGING

MRI of the________________________________mo/yr_______________facility_____________________

X-ray of the ________________________________mo/yr_______________facility_____________________

CT of the ________________________________mo/yr_______________facility_____________________

EMG/NCV________________________________mo/yr_______________facility_____________________

Other diagnostic testing ____

DO NOT WRITE BELOW THIS LINE

VITALS T____________ BP____________P_____________ HT_____________ WT_____________

PMP Reviewed Yes No UDS Completed? Yes No

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Provider Signature