NEW PATIENT QUESTIONNAIRE
For Dr Benoy Benny

Dear Patient:

Please complete this questionnaire before you come for your appointment. Be sure to call us as soon as possible if you cannot make your appointment. Thank you.

Section 1:
Today's Date: ____________________
Name:______________________________ Date of Birth:___________ Age:________

Day Phone:_______________________ Evening Phone:______________________

Street Address:____

City:___________________________ State:______________ Zip:_____________

Primary Physician's Name & Address:______________________________________

____

Referring Physician's Name & Address:____________________________________

____

Preferred Pharmacy:_________________________________Phone#:__________________

Questions About Your Current Problem

1. Where is your pain? ______________________________
2. When did your current pain problem begin? ___________________________________
3. How did it happen?

____

____

4. Generally speaking, are your symptoms getting better, worse or the same**?** ______________
5. Circle the number between 0 and 10 to indicate your level of pain in this last week:

Worst this week (no pain)	0	1	2	3	4	5	6	7	8	9	10	(worst possible pain)
Best this week (no pain)	0	1	2	3	4	5	6	7	8	9	10	(worst possible pain)
Average this week (no pain)	0	1	2	3	4	5	6	7	8	9	10	(worst possible pain)

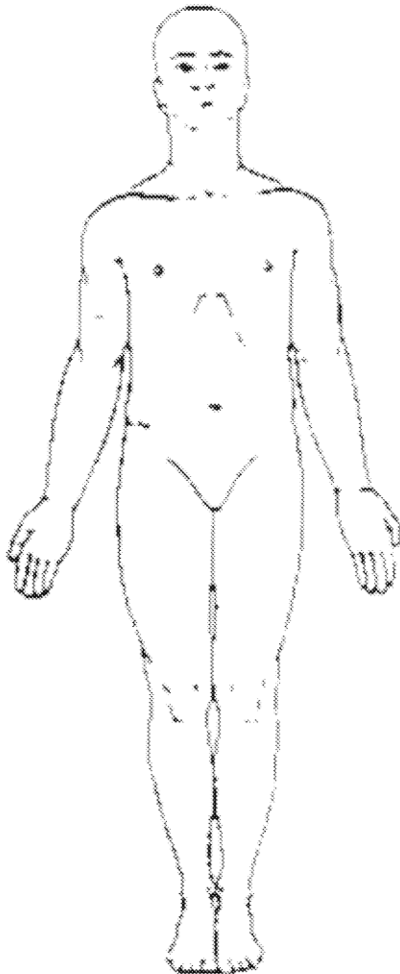
6. What makes your pain worse?____
7. What makes your pain better?____
8. Decribe the quality of your pain (aching, throbbing, burning, stabbing, etc) ?

____

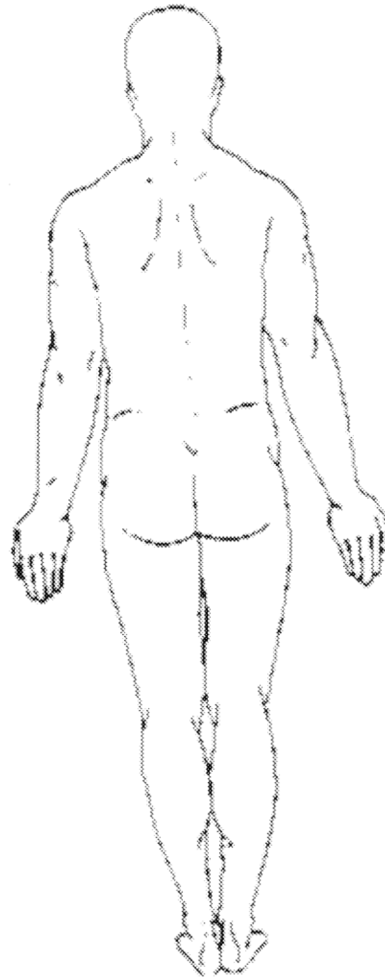
9. Where is your pain located?

Mark the areas on the body where you feel the described sensations using the following markings:

Burning	□ □ □ □	Achiness	1 1 1 1
Numbness	- - - - - -	Pins/Needles	O O O O
Pain	x x x x	Stabbing	vvvvv



Front



Back

Section 2:

A. Only for patients with **NECK or ARM** pain, numbness or weakness:
If you are seeing the doctor for back or leg pain, go to "B"

1. What % of your pain is neck pain and what% is arm pain? (check appropriate box)
□ Neck 0%, Arm 100% □ Neck 10%, Arm 90% □ Neck 25%, Arm 75% □ Neck 40%, arm 60%
□ Neck 50%, Arm 50% □ Neck 60%, Arm 40% □ Neck 75%, Arm 25% □ Neck 90%, arm 10%
□ Neck 100%, Arm 0%

2. There is: □ No arm pain Arm pain is as follows (check the following):
□ Rt. 0%, Lt. 100% □ Rt. 10%, Lt. 90% □ Rt. 25%, Lt. 75% □ Rt. 40%, Lt. 60%
□ Rt. 50%, Lt. 50% □ Rt. 60%, Lt. 40% □ Rt. 75%, Lt. 25% □ Rt. 90%, Lt. 10%
□ Rt. 100%, Lt. 0%

The arm pain is present in the (check the following):

Right: □ Upper back □ Shoulder □ Upper arm □ Foreman □ Hand/finger
Left: □ Upper back □ Shoulder □ Upper arm □ Foreman □ Hand/finger

3. Raising the arm:□ Improves the pain □ Worsens the pain □ Does not affect the pain

4. Moving the neck:□ Improves the pain □ Worsens the pain □ Does not affect the pain

5. There is: □ No weakness of the arms and hands □ Weakness of the (check the following)
Right: □ Shoulder □ Upper arm □ Forearm □ Hand/finger
Left: □ Shoulder □ Upper arm □ Forearm □ Hand/finger

6. There is: □ No numbness of the arms and hands □ Numbness of the (check the following)
Right: □ Upper arm □ Forearm □ Thumb □ Index finger □ Long finger □ Ring finger □ Sm finger
Left: □ Upper arm □ Forearm □ Thumb □ Index finger □ Long finger □ Ring finger □ Sm finger

8. There (□ is a □ is not) problem with balance or tripping frequently.

9. There are: (□ Frequent □ Occasional □ No) headaches in the back of the head.

PLEASE GO TO SECTION 3

B. For patients with **BACK OR LEG PAIN**, numbness or weakness.
(If you are seeing the doctor for neck problems, please complete "A")

1. What % of your pain is back pain and what % is leg or buttock pain? (check appropriate box):
□ Back 0%, Leg 100% □ Back 10%, Leg 90% □ Back 25%, Leg 75% □ Back 40%, Leg 60%
□ Back 50%, Leg 50% □ Back 60%, Leg 40% □ Back 75%, Leg 25% □ Back 90%, Leg 10%
□Back 100%, Leg 0

2. There is: □ No leg pain □ Leg pain as follows (check the following):
□ Rt. 0%, Lt. 100% □ Rt. 10%, Lt. 90% □ Rt. 25%, Lt. 75% □ Rt. 40%, Lt. 60%
□ Rt. 50%, Lt. 50% □ Rt. 60%, Lt. 40% □ Rt. 75%, Lt. 25% □ Rt. 90%, Lt. 10%
□ Rt. 100%, Left 0%

The pain is present in the (check the following):
Right: □ Buttock □ Thigh-front □ Thigh-back □ Calf □ Foot
Left: □ Buttock □ Thigh-front □ Thigh-back □ Calf □ Foot

3. There is: □ No weakness of the legs □ Weakness of the (check the following):
Right: □ Thigh □ Calf □ Ankle □ Foot □ Big toe
Left: □ Thigh □ Calf □ Ankle □ Foot □ Big toe

4. There is □ No numbness of the legs □ Numbness of the (check the following):
Right: □ Thigh □ Calf □Foot
Left □ Thigh □ Calf □Foot

5. The worst position for the pain is: □ Sitting □ Standing □ Walking

6. How many minutes can you stand in one place without pain? □ 0-10 □ 15-30

□ 30-60 □ 60+

7. How many minutes can you walk without pain? □ 0-10 □ 15-30 □ 30-60 □ 60+

8. Lying down: □ Eases the pain □ Does not ease the pain □ Sometimes eases the pain

9. Bending forward: □ Increases the pain □ Decreases the pain □Doesn't affect the pain

Section 3:Treatment History

10. Please check (√) all treatments you have received for this problem:

□ Medication
□ Physical Therapy and/or Occupational Therapy. Where and Dates___________________________
What did they teach you to do? ____
□ Injections or Nerve Blocks. Where and Dates ____
Do you know what injections were done? ____
Do you know if they used X-ray (fluoroscopic) guidance? ________________________________
Surgery? If yes, what? ____
□ Manipulation or other chiropractic treatment
□ TENS
□ Psychological/Psychiatric Counseling
□ Acupuncture
□ Pain Program . Dates:___________________________
What did they do? ____
□ Massage
□ Homeopathic or other alternative medicine (please list): ___________________________________

Section 4:Functional Status:

□ yes □ no Do you have trouble getting to sleep because of pain
□ yes □ no Do you exercise? If yes how often ____________________________________

Section 5: Diagnostic Tests – done for your problem:

Test	*When done?*	*What hospital/clinic?*	*Findings*
X-Ray (What body part?)	_____________	_______________________________	________________
CT (CAT Scan)	_____________	_______________________________	________________
MRI	_____________	_______________________________	________________
EMG	_____________	_______________________________	________________
Other tests	_____________	_______________________________	________________

Section 6: Please list all the medications you **currently** take for **any reason** (including non-prescription drugs).

Drug Name	Dose	How Often	Pain meds only- - Does it help?
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know

Please lists all known allergies:-____

Section 7: Medical Health History: Please check appropriate answer:

□ yes □ no Tumors or Cancer? If yes, what type?
□ yes □ no any infection in the last year? If yes, what**?**_____
□ yes □ no Epilepsy?
□ yes □ no Treated for headaches?
□ yes □ no Head injury with loss of consciousness?
□ yes □ no thyroid problem
□ yes □ no Treated for a psychiatric disorder?
□ yes □ no Circulatory problems?
□ yes □ no Do you have a history of stroke?
□ yes □ no Heart problem? If yes, describe:
□ yes □ no Aortic aneurysm?
□ yes □ no Currently do you have high blood pressure?
□ yes □ no Do you have high cholesterol? If yes, what is it?
□ yes □ no Are you diabetic? If yes, are you insulin dependent? □ yes □ no
□ yes □ no History of respiratory disorders? (Asthma, Emphysema)
□ yes □ no Intestinal disorder?
□ yes □ no Gastrointestinal reflux? (GERD)
□ yes □ no AIDS or related diseases (HIV positive)?
□ yes □ no Hepatitis?
□ yes □ no Any disease of the nerves or muscles? If so, what _______________
□ yes □ no Arthritis? What type____
□ yes □ no Gout?
□ yes □ no Any injuries to other bones or joints?
□ yes □ no History of serious injury
□ yes □ no Do you have any other health problems not mentioned above?
If yes, please explain:
□ yes □ no Have you ever been hospitalized? _______________________________

List Surgeries :
____
____
____

Section 8: Review of Systems:

Check all that apply: □ None apply

□ **Fever or chills** □ **Bowel incontinence** □ **urinary incontinence**
□ Frequent Constipation □ Hot or cold spells
□ Change of Vision □ Swollen ankles □ Hemorrhoids □ Recent wt. change
□ Loss of hearing □ Calf cramps w/walking □ Frequent urination □ Nervous exhaustion
□ Ear pain □ Poor appetite □ Burning on urination *Women only*
□ Hoarseness □ Tooth ache □ Difficulty starting urination □ Irregular periods
□ Nosebleeds □ Gum trouble □ Get up more than once every night to urinate □ Vaginal disch
□ Difficulty swallowing □ Nausea or vomiting □ Freq. spotting
□ Morning cough □ Stomach pain □ Frequent headaches □ Other
□ Shortness of breath □ Ulcers □ Blackouts _______________
□ reading glasses □ Frequent belching □ Seizures _______________
□ Heart or chest pain □ Frequent diarrhea □ Frequent rash _______________

How well are you sleeping?
____

*MD Initials and date*___________________

Section 9: Family History:

Has any family member had any of the following? Please check (√) each that apply

□ yes □ no Any blood relatives who have had a heart attack before age 55?
□ yes □ no Disabling back pain?
□ yes □ no Disability from work for other reasons?
□ yes □ no Arthritis
□ yes □ no Muscle or nerve disease. If so, what____
Cancers
Rheumatological conditions
□ yes □ no Any other disease which might affect your treatment? Please list:______________________

Section 10: Social History: Please check (√) each that apply:

Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated

Who do you live with? □ Alone □ Children (Ages____________________)
□ Spouse □ Parents
□ Significant Other □ Friends or Relatives □ Other______________

Where do you live? ___________________________________
Distance from this clinic?_______________________________

How much alcohol do you usually drink per week? _________________________________

□ yes □ no Have you been treated for drug or alcohol abuse?
□ yes □ no Do you use street drugs?
□ yes □ no Have you been a cigarette smoker in the past 5 years?
□ yes □ no Currently, do you smoke? If yes, how much per day _______________

Last school year completed?______________________(i.e.: 11th grade, college, etc.
Please check (√) if you have: □ GED □ Technical School Degree/Certificate

Aside from your current problem, what are the most stressful things in your life_________________________
____

Section 11: Work Status:

Are you working currently? If so full time or part time?
If not working why not? ____
□ yes □ no Do you believe this problem is caused by your work?
□ yes □ no Are you out of work because of this problem? If yes, since what date?___________________
□ yes □ no If working, are you on physician ordered restrictions because of this problem? If yes, please list restrictions:____
Would you like to go back to work? If yes, when? ____________________

Job Title (current):____

Employer / Company Name:______________________________Address:______________________________

Length of employment: Years_____________ Months__________________________

Section 12: Financial/Legal:

□ yes □ no Are currently receiving compensation for your pain problem?

□ yes □ no Are you involved in any legal action (e.g. court case) related to your pain?

Approx Weight : ______________ **Approx Height**: ________________________

Section below is For Physician use only:

Examination:

Vital Signs: BP: ______/______ HR: _________

General:

HEENT:

Skin:

Neurologic:

Sensation

Reflexes

others

MSK: (Upper and Lower extremity)

Strength

ROM

Special Tests

Other exam findings:

Assessment: (include objective findings(x- rays and or MRI's) if any)

Plan:

1.

2.

3.

Please send cc to referring physician

Please list your name, Attending name, Patient name, Location of clinic, MRN #, DOB,

Conf #: ____________________