New York Spine & Wellness Center

Established Patient Visit Questionnaire

Name: _____ DOB: _____ Date: _____

Are you being seen today for Workers Compensation Injury? Y ☐ N ☐ If yes, date of injury_____ body area injured _____

Are you being seen today for No-fault Injury? Y ☐ N ☐ If yes, date of injury_____ body area injured _____

Medical Cannabis has been approved for treatment of Chronic Pain. Are you interested learning more about this? Y ☐ N ☐

Have you ever been diagnosed with Dementia or Alzheimer's disease? Y ☐ N ☐ Is there a chance that you are pregnant? Yes☐ No☐

Has there been any change in your history since your last visit ie, new surgeries, medical diagnoses, pregnancy status, blood thinner medication, aspirin products, pacemaker/defibrillator etc. Y ☐ N ☐ **If yes, explain. If no initial:** _____

_____

List any tests you have had such as MRI's, X-ray's, CT Scan's or have you seen any Physicians that we would need to get copies of office visit note.
Y ☐ N ☐ **If yes please explain** _____

Do you drink alcohol? Y☐ N☐ Specify how much/how often _____

☐Never a smoker ☐Former Smoker ☐Current smoker Specify how much _____

Place an X on the scale that best indicates the level of your pain (no pain is zero, worst pain is 10).

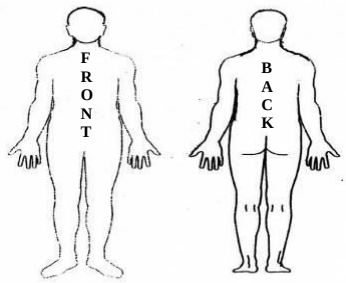
"Today": No Pain---------- Worst Possible Pain
A "Good Day": No Pain---------- Worst Possible Pain
A "Bad Day": No Pain---------- Worst Possible Pain
What pain level can you live with? No Pain---------- Worst Possible Pain

How long have you had this pain? _____
How would you describe your pain?
Numbness ☐ Pins and needles ☐ Burning ☐ Aching ☐ Stabbing ☐ Sharp ☐ Dull ☐
Other: _____
My pain is constant ☐ My pain will come and go away ☐

Do you have a brace that you use for this pain? ☐Yes ☐No ☐I don't remember

Mark on body where your pain is.

****If WC or NF injuries; ONLY MARK those areas covered by your carrier.**



Does anything (position, exercise, medications, etc.) improve your pain? Please specify: _____

_____

Does anything (position, exercise, medication, etc.) worsen your pain? Please specify: _____

_____

Review of Systems: Please indicate any of the following symptoms you are *currently experiencing*:

Constitution	Fever:	No	Yes
	Weight loss	No	Yes
Eyes	Vision Problems	No	Yes
Cardiovascular	Chest Pain:	No	Yes
	Shortness of Breath:	No	Yes
	Palpitations:	No	Yes
	Foot Swelling:	No	Yes
Respiratory	Cough:	No	Yes
	Wheeze:	No	Yes
Gastrointestinal	Constipation:	No	Yes
	Diarrhea:	No	Yes
	Abdominal Pain:	No	Yes
	Nausea:	No	Yes

Genitourinary	Loss of Bowel or Bladder Function:	No	Yes
Musculoskeletal	Neck Pain:	No	Yes
	Back Pain:	No	Yes
	Joint Pain:	No	Yes
Skin	Changes/Problems:	No	Yes
Neurological	Dizziness:	No	Yes
Psychiatric	Depression:	No	Yes
	Anxiety:	No	Yes
Hematology/Lymphatic	Problems:	No	Yes
Endocrine	Flushing:	No	Yes
	Hot Flashes:	No	Yes
	Excessive Sweating:	No	Yes
Allergic/Immunologic	Problems:	No	Yes
Ears, Nose, Mouth, Throat	Problems:	No	Yes

By signing below, I certify that the answers are true and complete to the best of my knowledge.

_____ Date:_____
Patient/Relative/Guardian Signature*

_____
Relationship to Patient

_____
Interpreter (if required) Print Name

_____
Witness (if required) Print Name

*The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity

Provider Initial: _____Date:_____

Rev.10-18-12/REV. 12-16-09/Rev08-26-2009/rev.2-1-10 Rev. 11-04-14 DB/rev.05-05-15db/rev.08-21-15db/rev.02-15-16db/rev.06-09-16nz/Rev.db 11/15/16 rev.db 04/13/17 rev. 9/1/17 rev. 12/12/17 rev. 12/20/17