New York Spine & Wellness Center

Established Patient Visit Questionnaire

Name: _____ DOB: _____ Date: _____

Since your last office visit have you been diagnosed with any new medical conditions or had any major health events?

_____
_____
_____
_____

Is there a chance you are pregnant? Y☐ N☐ N/A☐

Are you taking a blood thinner? Y☐ N☐
If yes please provide drug name, dosage and prescribing Dr. Name

_____
_____
_____

Are you taking any Aspirin/Aspirin products? Y☐ N☐
If yes please provide drug name and dosage

_____

Is the Aspirin/Aspirin product prescribed by a Dr.? Y☐ N☐
If yes please provide Dr. Name_____

Since your last office visit have you have any new surgeries?

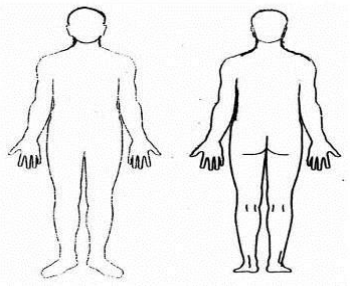
_____
_____
_____
_____
_____
_____

Do you have a Pacemaker? Y☐ N☐
Do you have an Implantable Cardioverter Defibrillator? Y☐ N☐
Do you drink alcohol? Y☐ N☐ Specify Type/Quantity/How Often

_____

Never a smoker ☐ Former Smoker ☐ Current smoker ☐
If current smoker, what/how much _____

Front Back



Please indicate on body where pain is located

Place an X on the scale that best indicates the level of your pain (no pain is :
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 ☐

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.

_____ _____
Patient/Relative/Guardian Signature* Date

_____
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

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