New York Spine & Wellness Center

Initial Visit Questionnaire
All questions should be answered by patient.

Pt. Name: _____ Age: _____ Referring MD: _____ Date: _____

1. How long have you had this pain? _____ Can onset of pain be traced to a specific event/injury? Please Specify:_____
   _____

2. How would you describe your pain?
   Burning☐ Stabbing☐ Sharp☐ Dull☐ Sharp☐ Aching☐ Numbness☐ Pins and Needles☐ Other: _____

3. My pain is constant☐ My pain will come and go☐

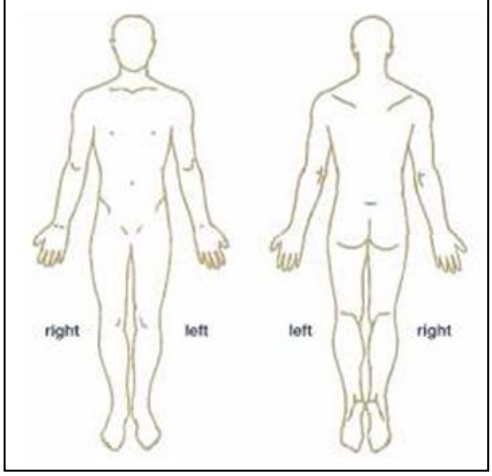
Place an X on the scale that best indicates the severity of your pain.

Today: No Pain ---------- Worst Possible Pain
Good Day: No Pain ---------- Worst Possible Pain
Bad Day": No Pain ---------- Worst Possible Pain

What helps decrease your pain (position, exercise, medications, etc.)?
_____

Does anything (position, exercise, medications, etc.) worsen your pain?
_____

SHOW US WHERE IT HURTS



4. Are there any rashes or blisters over the painful area? _____

5. Does your pain keep you awake? _____

6. What pain treatments have you attempted in the past?

☐Physical Therapy	☐Hypnosis
☐Surgery	☐Acupuncture
☐Biofeedback	☐Chiropractor
☐TENS Unit	☐Massage Therapy
☐Nerve Blocks	☐Behavioral Health

7. Have you ever seen a Hematologist (blood doctor) for blood issues such as clotting or bleeding? Yes☐ No☐
   If yes, explain_____

8. List all medications and dosage: (include over the counter pain relievers/vitamins/supplements)
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____

9. Are you on any blood thinners (i.e. Coumadin, Plavix etc.)? Yes☐ No☐ If yes, what? _____

10. Do you take aspirin, Aleve, naproxen or any products containing aspirin? Yes☐ No☐ How much? _____

11. Do you have any **medication** allergies? Yes ☐ No☐ **Please list medication names and reactions**::
    _____ _____ _____ _____
    _____ _____ _____ _____

12. Are you allergic to any of the following? **Latex** Yes☐ No☐ **Adhesive Tape** Yes☐ No☐ **IVP Dye** Yes☐ No☐

13. **Do you have or ever had any of the following diseases or conditions?**

Y N Heart Attack/Stroke	**Y N** Heart Surgery	**Y N** Heart Murmur	
Y N Alcohol/Drug Abuse	**Y N** Diabetes	**Y N** Artificial Valves	**Y N** GERD
Y N HIV+/Aids	**Y N** Tuberculosis	**Y N** Hepatitis	**Y N** Thyroid Conditions
Y N Frequent Neck Pain	**Y N** Shingles	**Y N** Cancer	**Y N** Liver Conditions
Y N High/Low Blood Pressure	**Y N** Emphysema	**Y N** Anemia	**Y N** Kidney Conditions
Y N Severe/Frequent Headaches	**Y N** Glaucoma	**Y N** Arthritis	**Y N** Chemotherapy
Y N Fainting/Seizures/Epilepsy	**Y N** Psychiatric Problems	**Y N** Ulcers	**Y N** MRSA
Y N Asthma	**Y N** Kidney Problems	**Y N** Lower Back Problems	**Y N** VRE
Y N Pacemaker/ICD	**Y N** Difficulty Breathing	**Y N** Artificial Bones/Joints	

Any other diseases or conditions: _____

OVER ➡

13. Is there a chance that you are pregnant? Yes☐ No☐

14. Please list any surgery's and approximate dates:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

15. Is there a history in your family of?
High Blood Pressure☐ Heart Disease☐ Diabetes☐ Arthritis☐ Cancer☐ Type of Cancer:_____

16. Do you use alcohol or tobacco regularly: Yes☐ No☐ Specify Quantity:_____

17. Is there a history or current use of illegal substances? (Marijuana, Cocaine, narcotics, amphetamines, etc.) Yes☐ No☐
If yes what? _____

18. Have you seen a psychiatrist for your pain? Yes☐ No☐ Have you attempted suicide because of your pain? Yes☐ No☐

19. Are you unable to work because of your pain? Yes☐ No☐

20. Are you currently, or have you previously, been involved in lawsuit regarding your pain? Yes ☐ No ☐

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

Constitution:	Fever:	No	Yes	Comment:	
	Weight loss:	No	Yes	Comment:	
Eyes:	Vision Problems:	No	Yes	Comment:	
Ears/Nose/Throat/Mouth:	Problems:	No	Yes	Comment:	
Cardiovascular:	Chest Pain:	No	Yes	Comment:	
	Shortness of Breath	No	Yes	Comment:	
	Palpitations:	No	Yes	Comment:	
	Foot Swelling:	No	Yes	Comment:	
Respiratory:	Cough/Wheeze:	No	Yes	Comment:	
Gastrointestinal:	Constipation:	No	Yes	Comment:	
	Diarrhea:	No	Yes	Comment:	
	Abdominal Pain:	No	Yes	Comment:	
	Nausea:	No	Yes	Comment:	
Genitourinary:	Problems:	No	Yes	Comment:	
Musculoskeletal:	Problems:	No	Yes	Comment:	
Skin:	Changes/Problems:	No	Yes	Comment:	
Neurological:	Fainting:	No	Yes	Comment:	
	Dizziness:	No	Yes	Comment:	
Psychiatric:	Depression:	No	Yes	Comment:	
Hormonal:	Problems:	No	Yes	Comment:	
Hematology/Lymphatic:	Problems:	No	Yes	Comment:	
Endocrine:	Diabetes:	No	Yes	Comment:	
	Thyroid:	No	Yes	Comment:	

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

_____ _____ _____
Patient/Relative/Guardian Signature* Print Name Date

_____
Relationship to Patient

_____ _____ _____
Interpreter (if required) Print Name Date

_____ _____ _____
Witness Print Name Date

***The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity, please obtain proof of guardianship/POA*

db. 09/09/16