HORIZON
Spine and Pain Specialists

New Patient Questionnaire

Patient name: ____ **Date of birth:** _______________________

Primary care physician: ____

Referring physician: ____

This visit is related to a: ☐Workers' compensation injury ☐Motor vehicle accident

Chief complaint/Reason for visit:

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Side: ☐left ☐right

The onset of your pain was:

- ☐ Suddenly following an injury
- ☐ Suddenly without an injury
- ☐ Gradually following an injury
- ☐ Other:
- ☐ Gradually without an injury
- ☐ After a work-related injury
- ☐ After a motor vehicle accident

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Your pain has been occurring for: ☐days ☐weeks ☐months ☐years

Your pain occurs: ☐intermittent ☐continuous ☐occasional ☐rare

Describe your pain: ☐throbbing ☐dull ☐aching ☐shooting ☐stabbing ☐burning

Is your pain: ☐mild ☐moderate ☐severe ☐unbearable

Pain level:

	1	2	3	4	5	6	7	8	9	10
Today	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Over the last 2 weeks, please identify severe pain level	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Over the last 2 weeks please identify average pain level	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you experience:

- ☐ Numbness
- ☐ Weakness
- ☐ Tingling
- ☐ Pins/needles
- ☐ Burning
- ☐ Swelling

What activities increase your symptoms:

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Lifting
- ☐ Bending forward
- ☐ Bending backward
- ☐ Bending to the right
- ☐ Bending to the left
- ☐ Driving
- ☐ Cold/damp weather
- ☐ Coughing/sneezing

What activities decrease your symptoms:

- ☐ Nothing
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Rest
- ☐ Avoiding strenuous activity
- ☐ Lying with pillow between legs
- ☐ Heat
- ☐ Ice application
- ☐ Stretching
- ☐ Pain medication
- ☐ Massage
- ☐ Chiropractic manipulation
- ☐ Acupuncture
- ☐ Swimming

Medications tried:

- ☐ Oral NSAIDS (Ibuprofen/prescription strength Motrin)
- ☐ Over the counter agents (Tylenol/Apspirin)
- ☐ Muscle relaxants (Flexeril/Skelaxin)
- ☐ Prescription pain medications (Vicodin/Dilaudid)
- ☐ Prescription nerve medications (Lyrica/Cymbalta)
- ☐ Prescription topical agents (Voltaren gel/Liboderm patch)

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Previous conservative measures:

- ☐ Physical therapy
- ☐ Chiropractic treatment
- ☐ Cortisone injections
- ☐ Surgical intervention
- ☐ Activity moderation
- ☐ Bracing
- ☐ Massage
- ☐ Acupuncture

Current Medications: (if you run out of space, please add additional medications to the back of the page)

1. Name:__________________________ Frequency:________________________ Dose:_____________
2. Name:__________________________ Frequency:________________________ Dose:_____________
3. Name:__________________________ Frequency:________________________ Dose:_____________
4. Name:__________________________ Frequency:________________________ Dose:_____________
5. Name:__________________________ Frequency:________________________ Dose:_____________
6. Name:__________________________ Frequency:________________________ Dose:_____________
7. Name:__________________________ Frequency:________________________ Dose:_____________
8. Name:__________________________ Frequency:________________________ Dose:_____________

Allergies: (include allergies/side effects to medications or seafood)

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Past medical history: (please check any of the following conditions you have or have had)

- ☐ Headaches
- ☐ High blood pressure
- ☐ Gastrointestinal disease
- ☐ Fracture
- ☐ Stroke
- ☐ Arthritis
- ☐ TMJ
- ☐ Peripheral vascular disease
- ☐ Stomach ulcers
- ☐ Neurologic disorders
- ☐ Thyroid disease
- ☐ Cancer
- ☐ Heart attack
- ☐ Kidney disease
- ☐ Pinches nerves
- ☐ Lung disease/asthma
- ☐ Coronary artery disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Blood clots
- ☐ Diabetes
- ☐ Seizures
- ☐ HIV/AIDS

Please list any other past or present medical conditions you have:

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Please indicate any prior accidents or work injuries:

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Past surgical history:

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Family history: ☐none ☐unknown

Please list all medical conditions that are common in your family:

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Social History

Occupation: ____

Are you: ☐Full-time ☐Part-time ☐Retired ☐Not working

Marital status: ☐Single ☐Married ☐Widowed ☐Divorced

Tobacco use: ☐Yes ☐No **Former smoker:** ☐Yes ☐No

Alcohol use: ☐Yes ☐No

Do you have problems with drug or alcohol use or dependency? ☐Yes ☐No

Review of Systems

Problems you are experiencing at the present time

I am experiencing:

- ☐ Fever
- ☐ Constipation
- ☐ Sleep Disturbance
- ☐ Dry Eye
- ☐ Involuntary Urine Loss
- ☐ Depression
- ☐ Dry Mouth
- ☐ Poor Balance
- ☐ Anxiety
- ☐ Leg Swelling
- ☐ Dry Skin
- ☐ Weight Loss
- ☐ Shortness of Breath
- ☐ Joint Swelling
- ☐ Easy Bleeding
- ☐ Rash

Current Pharmacy

Name:____ **Phone:**______________________________

Address:____

Patient Signature

The above information is accurate to the best of my knowledge

____ ______________________________

Patient Signature Date