UT Physicians

PM&R Clinic New Patient Questionnaire

Name _____ **Date (MM/DD/YYYY)** _____

Pain History

Where is the location of **primary** pain (the reason you are here today)?

_____

How long have you had your primary pain?

_____

Is your primary pain the result of an injury?

◯ Yes
◯ No

If Yes, please specify initiating event

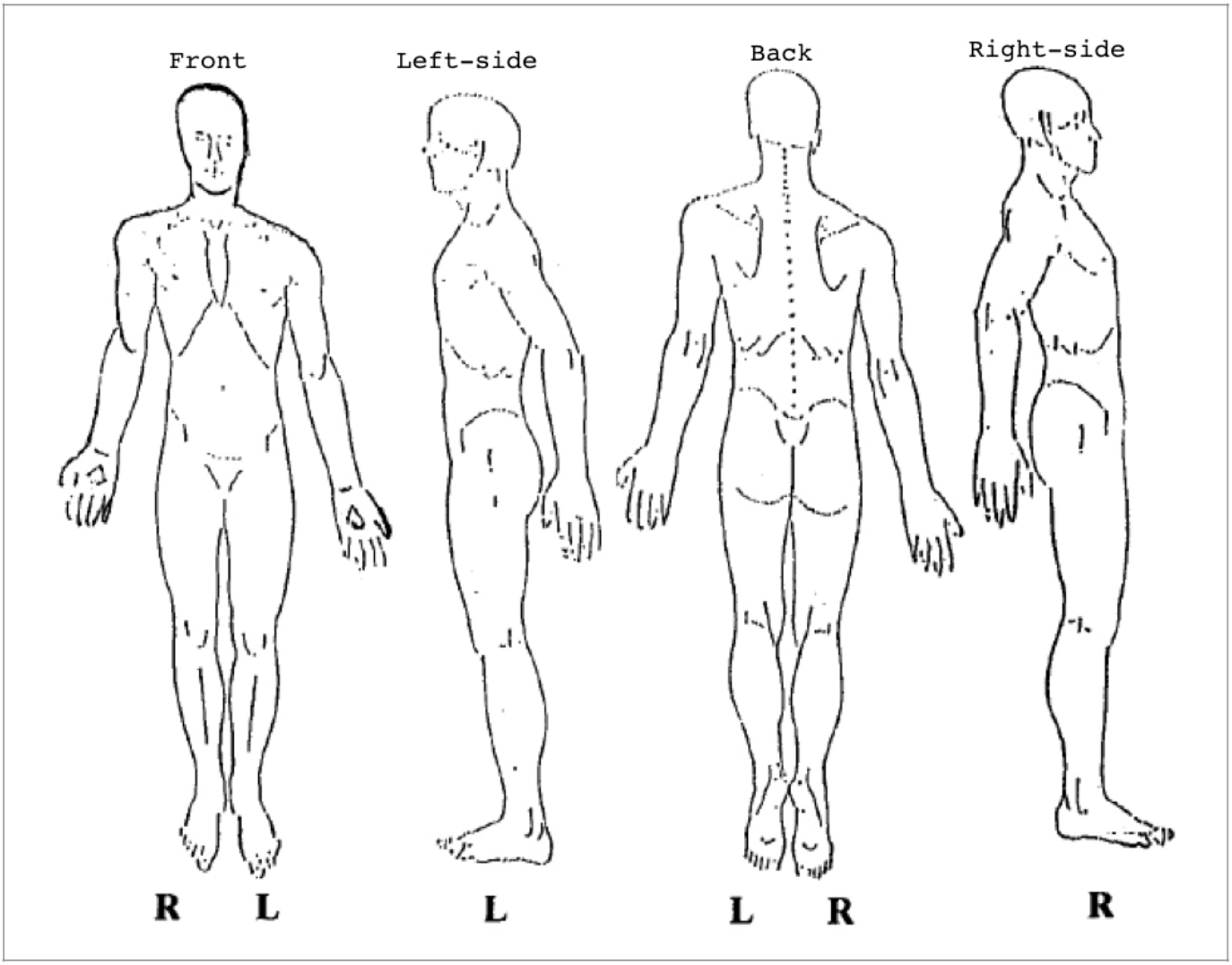
_____

Pain Location

Only for your primary area of pain:

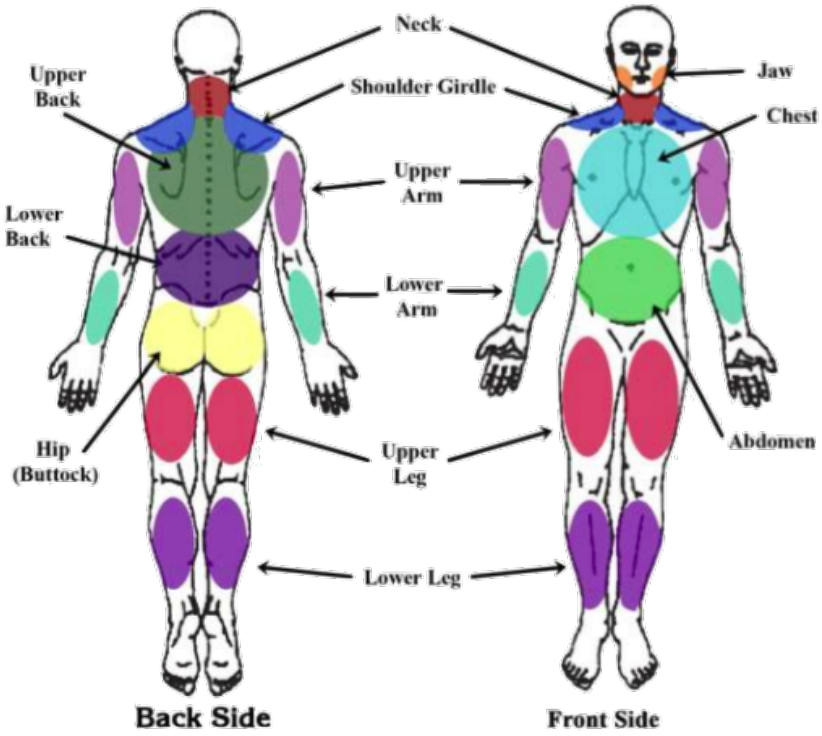
Choose the symbol(s) shown below that best describes the pain you are having (e.g. Δ Δ Δ means an aching type of pain), and draw the location of your pain on the body map

Aching: Δ Δ Δ | Numbness = = = | Pins & Needles 000 | Burning XXX | Stabbing or Sharp /// | Other . . .



If you have more than one area pain, please mark all of the affected body regions below. If you do not have any other pain besides your primary area, mark none.

- ☐ Head
- ☐ Neck
- ☐ Left Jaw
- ☐ Right Jaw
- ☐ Left Shoulder Girdle
- ☐ Right Shoulder Girdle
- ☐ Left Upper Arm
- ☐ Right Upper Arm
- ☐ Left Lower Arm
- ☐ Right Lower Arm
- ☐ Chest
- ☐ Upper Back
- ☐ Lower Back
- ☐ Left Hip (buttock)
- ☐ Right Hip (buttock)
- ☐ Left Upper Leg
- ☐ Right Upper Leg
- ☐ Left Lower Leg
- ☐ Right Lower Leg
- ☐ Abdomen
- ☐ None



Pain Intensity

Please rate your **pain intensity, for your primary pain,** by marking the number that best describes your pain. 0 = no pain, 10 = most severe pain

	0	1	2	3	4	5	6	7	8	9	10
Worst pain this past week	○	○	○	○	○	○	○	○	○	○	○
Least amount pain this past week	○	○	○	○	○	○	○	○	○	○	○
Average pain this past week	○	○	○	○	○	○	○	○	○	○	○
Current pain severity	○	○	○	○	○	○	○	○	○	○	○

Pain Relief

In the last week, how much relief have pain treatments and/or medications provided? Please mark the one percentage that most shows how much **relief** (reduction in pain severity and/or frequency) you have received. 0% means no relief at all, 100% means complete relief.

	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
% of pain relief from medications and/or other pain treatments	○	○	○	○	○	○	○	○	○	○	○

Pain Alleviating and Aggravating factors

Things that make your pain **worse** (select all that apply)

- ☐ activity/exercise
- ☐ sitting
- ☐ standing
- ☐ laying down
- ☐ walking
- ☐ coughing
- ☐ bending backwards
- ☐ bending forwards
- ☐ weather
- ☐ Other _____

Things that make your pain **better** (select all that apply)

- ☐ activity
- ☐ sitting
- ☐ standing
- ☐ laying down
- ☐ walking
- ☐ coughing
- ☐ bending backwards
- ☐ bending forwards
- ☐ weather
- ☐ medications
- ☐ exercise
- ☐ Other _____

Pain Interference

Please mark the number that describes how much, during the past week, your pain has interfered with each of the following activities.
0 = does not interfere with activity, 10 = completely interferes with activity.

	0	1	2	3	4	5	6	7	8	9	10
General activity	○	○	○	○	○	○	○	○	○	○	○
Mood	○	○	○	○	○	○	○	○	○	○	○
Walking ability	○	○	○	○	○	○	○	○	○	○	○
Normal work	○	○	○	○	○	○	○	○	○	○	○
Relationships with other people	○	○	○	○	○	○	○	○	○	○	○
Sleep	○	○	○	○	○	○	○	○	○	○	○
Enjoyment of life	○	○	○	○	○	○	○	○	○	○	○

Review of Systems

Please indicate if you have any of the following symptoms for the past week by marking yes or no for each organ system. If you marked yes for an organ system, please indicate which symptoms you are having by circling the symptom.

	Yes	No
General: *fevers*, chills, weight loss, weight gain, *fatigue*, malaise, *loss of appetite*	◯	◯
Head, eyes, ears, nose and throat (HEENT): *headache*, *blurry vision*, double vision, seeing spots, floaters, *dry eyes*, cataracts, *hearing difficulty*, *ringing in the ears*, dizziness, nasal discharge, sore through, difficulty swallowing, *loss or change in taste*, *dry mouth*	◯	◯
Cardiovascular: *chest pain*, palpitations, abnormal heart rhythm, *dizziness*, spider veins, swelling in the extremities	◯	◯
Respiratory: *shortness of breath*, difficulty breathing, pneumonia, oxygen use, cough, *wheezing*, stridor	◯	◯
Gastrointestinal: *abdominal pain*, *nausea*, *vomiting*, *heartburn*, gastric ulcers, bloody stools, dark tarry stools, hemorrhoids, *irritable bowel syndrome*, *constipation*, *diarrhea*, bowel incontinence	◯	◯
Genitourinary: urgency, *frequency*, *painful urination*, blood in urine, difficulty starting urination, weak urinary stream, dribbling with urination, urinary incontinence, urinary tract infection, *bladder spasms*	◯	◯
Hematologic: history of cancer, anemia, *easy bruising*, easy bleeding, swollen lymph nodes, history of blood clots	◯	◯
Endocrine: thyroid disorder, heat/cold intolerance, excessive sweating, diabetes mellitus	◯	◯
Musculoskeletal: *muscle pain*, *muscle weakness*, loss of range of motion, swelling of joints	◯	◯
Neurologic: *seizures*, *numbness*, *tingling*, tremor, increased sensitivity to light touch, increased sensitivity to pain, *thinking or remembering problem*	◯	◯
Skin: *itching*, rashes, open wounds, skin ulcers, *hair loss*, discoloration of skin, *sun sensitivity*, *hives/welts*	◯	◯
Psychiatric: *nervousness*, *depression*, anxiety, mood disorder, bipolar, schizophrenia, hallucinations, memory loss, suicidal ideation, suicide attempts, *insomnia*	◯	◯

Associated Symptoms

For each item, indicate the severity of the associated symptom to your pain, over the past week, by marking the corresponding number.

	No Problem	Mild	Moderate	Severe
Fatigue	◯	◯	◯	◯
Trouble thinking or remembering	◯	◯	◯	◯
Waking up tired (unrefreshed)	◯	◯	◯	◯

Pain Management History

Please indicate if you have been evaluated by any of the following specialists for your current pain issue:

- ☐ Pain management
- ☐ Physical Medicine and Rehab
- ☐ Sports medicine
- ☐ Orthopedic surgery
- ☐ Neurosurgery
- ☐ Thoracic surgery
- ☐ Neurology
- ☐ Rheumatology
- ☐ Psychiatry
- ☐ Other _____

Please select any diagnostic testing you have received to evaluate your current pain problem:

- ☐ x-ray
- ☐ CT/CAT scan
- ☐ MRI
- ☐ myelogram
- ☐ ultrasound
- ☐ EMG/nerve testing
- ☐ Other _____

Non Interventional Treatments

Please mark all that apply and indicate how beneficial (in terms of providing pain relief) each technique was for your current problem.
If you have not been treated with non-interventional treatments, please mark "not applicable".

	Not Applicable	Much Worse	Worse	No Change	Better	Much Better
Acupuncture	○	○	○	○	○	○
Biofeedback	○	○	○	○	○	○
Bracing	○	○	○	○	○	○
Chiropractor	○	○	○	○	○	○
Physical therapy	○	○	○	○	○	○
TENS unit	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Interventional Procedures

Please mark all that apply and indicate how beneficial (in terms of providing pain relief) each technique was for your current problem.
If you have not been treated with a procedure, please mark "not applicable".

	Not Applicable	Much Worse	Worse	No Change	Better	Much Better
Epidural steroid injection	○	○	○	○	○	○
Facet injection/Medial branch block	○	○	○	○	○	○
Radiofrequency ablation of facet/medial branch	○	○	○	○	○	○
Sacroiliac joint injection	○	○	○	○	○	○
Surgery	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Pain Medication History

Please list any pain medications (include frequency and dosage) you have used (current or in the past) for your current problem. If no previous or current trial of pain medications, please write "none". Attach a separate page if necessary.

Other Medications:

Please list any and all medications you are taking (include doses and frequency - for example aspirin 81mg, one tablet daily). If not taking any medications (including over the counter supplements, vitamins and mineral supplements), please write "none". Attach a separate page if necessary.

Past Medical History

Please list any medical problems/diagnoses you have; include psychiatric diagnoses (such as depression, anxiety, schizophrenia, OCD, bipolar disorder, etc). If no past medical history or psychiatric history, please write "none". Attach a separate page if necessary.

Surgical History

Please list any surgical procedures you have had. If no past surgical history, please write "none". Attach a separate page if necessary.

Allergies

Please list your allergies (if none, write "none"):

Family History

Please list any medical problems that your immediate family members (mother, father, siblings, children) have. If no medical problems, please write none.

Social History

Do you currently smoke tobacco or use chewing tobacco? ◯ Never used ◯ Not currently/Quit ◯ Yes

If yes, how much tobacco do you smoke/chew? _____ If you quit, what year did you quit? _____

Do you drink alcohol? ◯ No ◯ Yes

If yes, how much alcohol do you drink (specify volume and frequency, for example 1 beer per day)? _____ If yes, has alcohol ever affected your family relationships, your ability to work, or resulted in DUI or other negative consequences? ◯ No ◯ Yes

Mark each box that applies:

Personal history of substance abuse
- ☐ none
- ☐ alcohol
- ☐ prescription drugs
- ☐ illegal drugs

Family history of substance abuse
- ☐ none
- ☐ alcohol
- ☐ prescription drugs
- ☐ illegal drugs

Do you have any thoughts of hurting or killing yourself or someone else? ◯ No ◯ Yes

Have you ever been physically or sexually abused? ◯ No ◯ Yes

Marital Status
- ◯ Married
- ◯ Never married
- ◯ Divorced/Separated
- ◯ Widowed

Who do you live with/who lives with you?
- ◯ Alone
- ◯ Spouse
- ◯ Young Children
- ◯ Adult children
- ◯ Significant other
- ◯ Roommate
- ◯ Other _____

What is your highest level of completed education?
- ◯ Graduate school
- ◯ College graduate
- ◯ Some college
- ◯ Vocational school
- ◯ High school graduate
- ◯ Some high school

Are you currently employed? ◯ Yes ◯ No

Current or most recent occupation _____ # hrs work/wk _____

Are you seeking compensation for your pain? ◯ Yes ◯ No

Are you currently receiving compensation for your current pain? ◯ Yes ◯ No

If you are currently receiving compensation for your pain, please indicated the type of compensation?

- ☐ Social Security Disability
- ☐ Worker's compensation
- ☐ Auto
- ☐ Other

Are there any stressors, current or in the past, that contribute to your pain?

- ○ No
- ○ Yes

Is there anything else you think we should know in order to assess your current pain problem?

How long did it take you to complete this form?

For clinic use only

Intake form reviewed ☐

Signature of reviewer

Date of review