NEW PATIENT QUESTIONNAIRE **Translator:**
For Dr. Kenly

Dear Patient: Please complete this questionnaire for your appointment. Thank you.

Today's Date: ________________________

Your Name:__________________________ Date of Birth:___________ Age:________

Street Address:____

City:_____________________________ State:_______________ Zip:______________

Primary Physician's Name & Address (if known) :______________________________________

____

Referring Physician's Name & Address (if known):______________________________________

____

Preferred Pharmacy:____________________________________Phone#:___________________

Questions About Your Current Problem:

Where is your pain? ____

When did your current pain problem begin? _____________________________________

How did it happen?

____

____

Generally speaking, are your symptoms getting better, worse or the same**?** ______________

□ yes □ no Are you working currently? If so full time or part time?

If not working why not? ____

□ yes □ no Do you believe this problem is caused by your work?

□ yes □ no Are you out of work because of this problem? If yes, since what date?____________

Job Title (current):____

Employer / Company Name:____________________________Address:____________________________

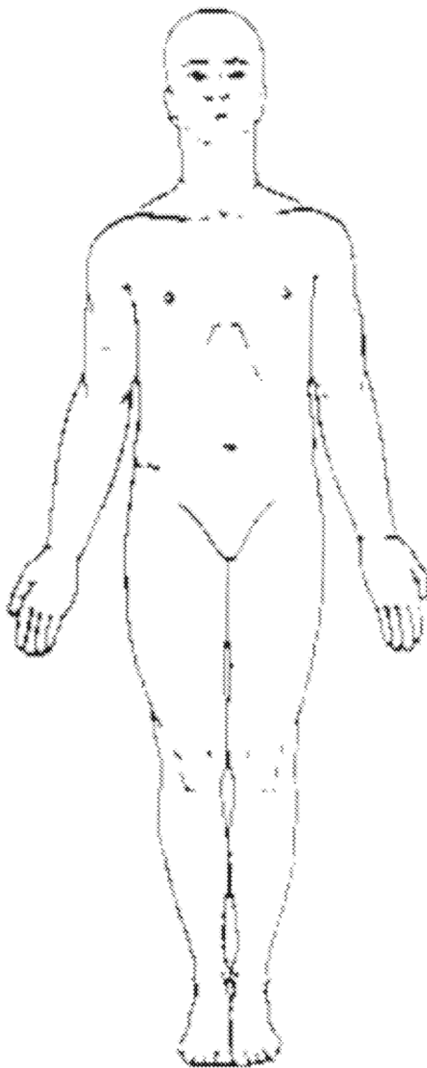
Length of employment: Years____________ Months_________________________

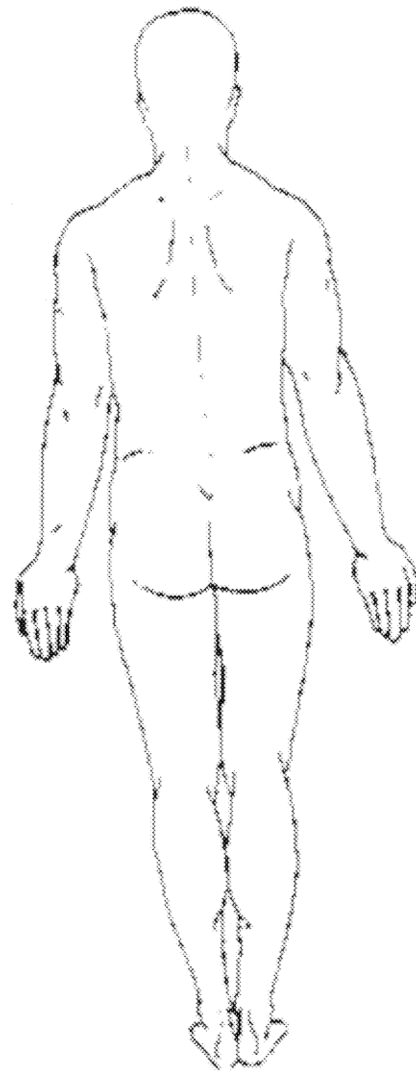
Where is your pain located?

Mark the areas on the body where you feel the described sensations using the following symbols. Include all affected areas. **<u>If multiple areas, *please circle* which area is the worst</u>:**

oooooo	**Pins & Needles**
xxxxxx	**Burning Pain**
///////////	**Stabbing Pain**
vvvvvv	**Aching Pain**
● ● ● ●●	**Numbness**

FRONT **BACK**





Use the following scale to indicate the severity of your pain on average on a scale of 0-10:

None	Annoying		Uncomfortable		Dreadful		Horrible		Agonizing	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No pain	**Mild Pain**		**Moderate Pain**		**Severe Pain**		**Very Severe Pain**		**Worst Possible Pain**	

Now, circle the number between 0 and 10 to indicate your level of pain ***over the past week***:

Worst this week (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Best this week (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Average this week (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Describe the quality of your pain (aching, throbbing, burning, stabbing, shooting, etc):

____

What makes your pain worse?____

What makes your pain better?____

The worst position for the pain is: □ Sitting □ Standing □ Walking □Other:____________

Please check (√) all treatments you have received for this problem and if they were helpful:

	√ if you've tried	**Did it help? Y/N**	**For how long?**
Physical Therapy			
Massage			
Heating Packs			
Ice			
TENS Unit			
Traction			
Medications			
Acupuncture			
Chiropractor			
Epidural Injection			
Other injection			
Ultrasound			
Other			

For the current pain problem, have you undergone any of the following:

□ yes □ no **MRI** **if yes, when? ________________**
□ yes □ no **EMG ("Nerve test")** **if yes, when? ________________**
□ yes □ no **CT Scan ("Cat Scan")** **if yes, when? ________________**
□ yes □ no **Discogram** **if yes, when? ________________**

Please list all the medications you **currently** take for **any reason** (including non-prescription drugs).

Drug Name	Dose	How Often	**For Pain meds only, Does it help?**
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know

Please list all known allergies:____

Medical Health History: Have you ever suffered from any of the following?

Please check appropriate answer:

□ yes □ no Tumors or Cancer? If yes, what type?
□ yes □ no any infection in the last year? If yes, what**?**_____
□ yes □ no Epilepsy/Seizures?
□ yes □ no Treated for headaches?
□ yes □ no Head injury with loss of consciousness?
□ yes □ no thyroid problem
□ yes □ no Treated for a psychiatric disorder?
□ yes □ no Circulatory problems?
□ yes □ no Do you have a history of stroke?
□ yes □ no Heart problem? If yes, describe:
□ yes □ no Currently do you have high blood pressure?
□ yes □ no Do you have high cholesterol? If yes, what is it?
□ yes □ no Are you diabetic? If yes, are you insulin dependent? □ yes □ no
□ yes □ no History of respiratory disorders? (Asthma, Emphysema)
□ yes □ no Intestinal disorder?

□ yes □ no Gastrointestinal reflux? (GERD)
□ yes □ no AIDS or related diseases (HIV positive)?
□ yes □ no Hepatitis?
□ yes □ no Any disease of the nerves or muscles? If so, what _______________
□ yes □ no Arthritis? What type____
□ yes □ no Gout?
□ yes □ no Any injuries to other bones or joints?
□ yes □ no Do you have any other health problems not mentioned above?
If yes, please explain:

Please list all prior surgeries and dates if known:

____
____
____
____

Review of Systems:

Check all that apply: □ None apply

□ **Fever or chills**	□ **Bowel incontinence**	□ **urinary incontinence**	□ Frequent urination
□ Frequent Constipation	□ bleeding with bowel movements		□ Burning on urination
□ Swollen ankles	□ Hot or cold spells	□ Frequent rash	□ Difficulty starting urination
□ Loss of hearing	□ Calf cramps w/walking	□ Frequent headaches	□ Bleeding with urination
□ Ear pain	□ Poor appetite	□ Blackouts	□ Frequent diarrhea
□ Hoarseness	□ Tooth ache	□ Seizures	□ Recent wt. change
□ Stomach pain	□ Gum trouble	□ Heart or chest pain	□ Shortness of breath
□ Ulcers	□ Difficulty swallowing	□ Nausea or vomiting	

Other: ____

How well are you sleeping?
____

Family History:

Has any family member had any of the following? Please check (√) each that apply
□ yes □ no Any blood relatives who have had a heart attack before age 55?
□ yes □ no Disabling back pain?
□ yes □ no Arthritis?
□ yes □ no Muscle or nerve disease? If so, what____
□ yes □ no Cancers? If so, what type____
□ yes □ no Any other disease which might affect your treatment? Please list:______________________

Social History:

How much alcohol do you usually drink ?
□ None □ 1 to 2 drinks per week □ 3 to 5 drinks per day
□ 1 to 2 drinks per day □ more than 5 drinks per day

□ yes □ no Have you been treated for drug or alcohol abuse?
□ yes □ no Do you use street drugs?
□ yes □ no Have you been a cigarette smoker in the past 5 years?
□ yes □ no Currently, do you smoke? If yes, how much per day _______________

Your Approximate Weight : _______________ **Your Approximate Height**: ____________________