

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

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: \_\_\_\_\_

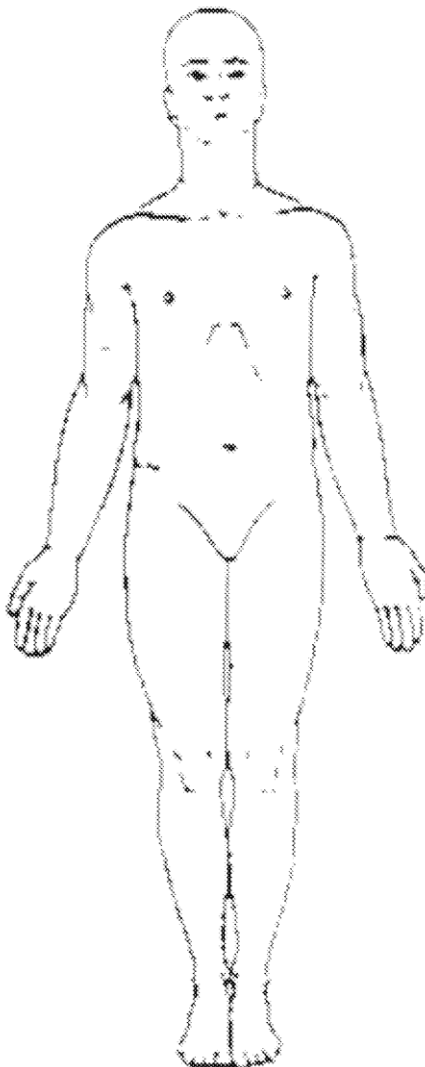
Length of employment: Years \_\_\_\_\_ Months \_\_\_\_\_

**Where is your pain located?**

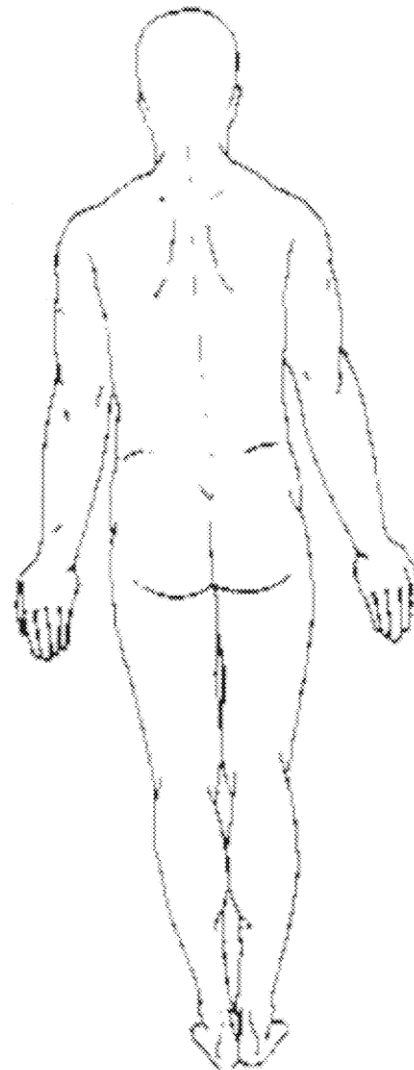
Mark the areas on the body where you feel the described sensations using the following symbols. Include all affected areas. **If multiple areas, please circle which area is the worst:**

- 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?		
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
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			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
			<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> 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:**

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**Review of Systems:**

Check all that apply:    None apply

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

Other: \_\_\_\_\_

How well are you sleeping?

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**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:** \_\_\_\_\_