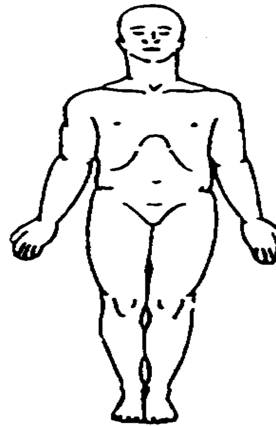
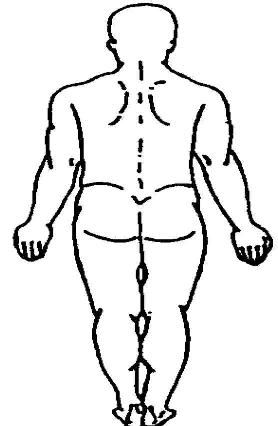
1206D-1065

WHERE IS THE PAIN? Draw the location of your pain by shading on the diagram to the right: >>>>>>>>>





Primary Care Provider:
____
____

REFERRAL: Doctor that sent you to clinic with address: ________________________________
____
____

CHIEF COMPLAINT (Check): ☐ Neck Pain ☐ Upper Back Pain ☐ Low Back Pain
☐ Hip/Pelvis Pain ☐ Right upper extremity pain ☐ Left upper extremity pain
☐ Right lower extremity pain ☐ Left lower extremity pain

HISTORY OF PRESENT ILLNESS:

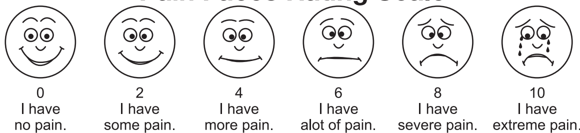
How long have you noticed pain? ______Days ______Weeks ______Months _____Years

The pain is described as: ☐ Constant ☐ Intermittent ☐ Unchanged ☐ Worse ☐ Better

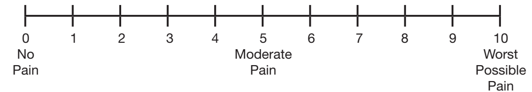
Rate your USUAL pain? ______/10 (0 = none, 10 = severe pain)

How severe is the pain? _______/10 (0 = none, 10 = severe pain)

Pain Faces Rating Scale



0-10 Numerical Pain Intensity Scale



Circle all that apply: ☐ Burning ☐ Sharp-shooting ☐ Tingling ☐ Numbness ☐ Pinprick
☐ Stabbing ☐ Tightness ☐ Spasms ☐ Dull ☐ Ache ☐ Deep-pressure

Was there any injury/event that caused your pain? ☐ No ☐ Yes (please describe below):
____
____

What makes pain worse?____
What makes pain better?____
How does the pain limit you?____

Have you had surgery on your back / neck? ☐ No ☐ Yes

Previous Evaluations: Check all that apply ☐ x-ray ☐ MRI ☐ CT ☐ EMG/NCS ☐ Bone scan

Check treatment tried for pain in the past: Check all that apply
☐ Physical Therapy ☐ TENS ☐ Heating pad ☐ Ice ☐ Chiropractor ☐ Exercise
☐ Epidural steroids ☐ Surgery ☐ Massage ☐ Medications ☐ Acupuncture ☐ Injections

PATIENT ID

Please list other MEDICAL problems:

☐ Diabetes ☐ Arthritis ☐ Osteoporosis ☐ Heart Disease ☐ Depression
☐ High blood pressure ☐ Cancer: ☐ Fibromyalgia ☐ DVT or PE ☐ Other

List all Medications you take regularly (include non-prescription med): ☐ See Attached List

Name & Dose	How Often	Name & Dose	How Often

Allergies: ☐ No ☐ Yes If yes, please list medication and reaction to it below:

Medication	Reaction	Medication	Reaction

Do you have Iodine, Contrast dye or Shellfish Allergy? ☐ Yes ☐ No ☐ Unknown
Do you take blood thinning medication? ☐ Yes ☐ No
Do you have any bleeding disorders? ☐ Yes ☐ No

Please list prior SURGERIES and approximate dates:

____ ______/______/______
____ ______/______/______
____ ______/______/______

FAMILY HISTORY:
Arthritis ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Bone disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No

SOCIAL HISTORY
How did/do you make a living?________________________
Alcohol use ☐ No ☐ Yes
Smoker ☐ No ☐ Yes
Recreational Substance ☐ No ☐ Yes

Mother: age ____ years ☐ healthy ☐ deceased due to:________________________________
Father: age ____ years ☐ healthy ☐ deceased due to:________________________________

PATIENT ID

REVIEW OF SYSTEMS: Please fill out CURRENT symptoms only. Check if None or Normal ☐

Skin ☐ Normal	Neurological ☐ Normal	Eyes ☐ Normal	Lymph Nodes ☐
☐ skin rash	☐ Headaches	☐ visual loss	☐ enlargement
☐ easy bruising/bleeding	☐ Incontinence	☐ color blindness	☐ pain
☐ abnormal hair loss	☐ seizures	☐ glaucoma	
	☐ paralysis	☐ glasses / contacts	

Ears/Nose ☐ Normal	Genitourinary ☐ Normal	Bone/ joint/ muscles ☐ None	Respiratory system ☐ Normal
☐ deafness	☐ blood in urine	☐ dislocation	☐ breath shortness
☐ vertigo/dizziness	☐ impotence	☐ fracture	☐ cough
☐ hoarseness	☐ painful urination	☐ muscle wasting	☐ asthma/bronchitis
☐ sinusitis	☐ kidney stones	☐ muscle pain	☐ tuberculosis
☐ post nasal drip	☐ venereal disease	☐ muscle weakness	☐ pneumonia

Mental status ☐ Normal	Blood System ☐ Normal	Endocrine ☐ Normal	Cardiovascular ☐ Normal
☐ Hallucinations	☐ anemia	☐ abnormal growth	☐ palpitations
☐ anxiety	☐ bleeding	☐ goiter	☐ chest pains
☐ depression	☐ bruising	☐ heat/cold intolerance	☐ leg swelling
☐ sleep disturbances	☐ blood thinners	☐ increase thirst	☐ arrhythmia

Constitutional ☐ Normal	Allergies ☐ Normal	Gastrointestinal ☐ Normal	General ☐ Normal
☐ fever / chills	☐ dermatitis	☐ appetite changes	☐ poor sleep
☐ weight loss	☐ hay fever	☐ jaundice	☐ poor energy
☐ nausea	☐ migraine	☐ hemorrhoids	☐ eat too much / little
☐ vomiting	☐ sensitivity to pollen	☐ irritable bowels	☐ unhappy

OFFICE USE ONLY

EMG:	RUE	LUE	RLE	LLE

Past Treatment: ____________________

Injections: ____________________

Medications: ____________________

Therapy: ____________________

Imaging: ____________________

X____________________ ____________ ____________

REVIEWING PROVIDER SIGNATURE **DATE** **TIME**

NEW PATIENT QUESTIONNAIRE
DR. CHRISTOPHER ORNELAS

PATIENT ID