Questionnaires

Saint Luke's Health System

New Patient Information Form (Spine and Pain)

Patient Information

Today's Date:_____ Your Name:_____ Date of Birth:_____ Age:___

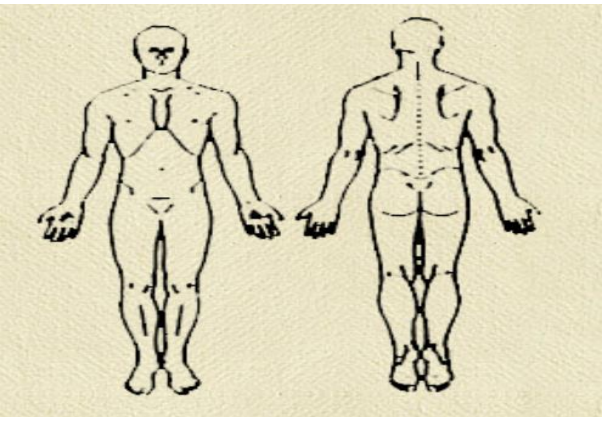
Referring Physician:_____ Primary Care Physician:_____ Your Email:_____

Current Problem

Chief Complaint (reason for your visit today)?_____

Please MARK the area(s) where you feel pain:

R L L R



What is your PAIN INTENSITY? (Please CIRCLE one):

0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Pain Imaginable*

Date of injury:_____

Dominant Hand: Left ☐ Right ☐ Both

Did injury occur from:

☐ Sports? If so, which sport(s)?

☐ Work? If so, list OWCP or L&I claim #:

☐ Motor vehicle accident? Is litigation involved?

☐ Other?

Please provide the details of how your injury occurred:

_____

_____

_____

Symptoms

Quality of Pain:	Other **Symptoms:**	**Status** of Symptoms:	**When** are symptoms most severe?	What makes symptoms **Worse**:	What makes symptoms **better**?
☐ Sharp	☐ Stiffness ☐ Bruising	☐ Worsening	☐ Morning	☐ Rest	☐ Rest
☐ Dull	☐ Instability ☐ Swelling	☐ Stable	☐ Afternoon	☐ Activity	☐ Activity
☐ Throbbing	☐ Catching ☐ Numbness	☐ Improving	☐ Evening	☐ Sleeping	☐ Ice
☐ Stabbing	☐ Popping ☐ Tingling	☐ Constant	☐ Consistent all day	☐ Kneeling	☐ Medication
☐ Aching	☐ Locking ☐ Weakness	☐ Occasional	☐ Interrupts sleep	☐ Other:	☐ Brace
☐ Heavy	☐ Other:	☐ Other:	☐ Other:		☐ Other:
☐ Burning					
☐ Other:					

Treatments

Have you:

Seen another physician for this injury? ☐ Yes ☐ No

If so, who did you see?_____ When:_____

Had surgery in the problem? ☐ Yes ☐ No

If so, what surgery?_____ When:_____

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Were the treatments you have tried helpful?		What treatments are you interested in receiving?	What studies have you had for this problem?
☐ Massage Therapy	☐ Yes ☐ No	☐ Physical Therapy	☐ X-Rays
☐ Physical Therapy	☐ Yes ☐ No	☐ Surgery	☐ MRI
☐ Chiropractic Therapy	☐ Yes ☐ No	☐ Bracing	☐ CT Scan
☐ Acupuncture	☐ Yes ☐ No	☐ Injection	☐ EMG (Nerve Study)
☐ Bracing	☐ Yes ☐ No	☐ Medication	☐ Bone Scan
☐ Injections	☐ Yes ☐ No	☐ Other:	☐ Ultrasound
☐ Medications	☐ Yes ☐ No		☐ Other:
☐ Other:	☐ Yes ☐ No		

Allergies

Are you allergic to LATEX: ☐ Yes ☐ No

Are you allergic to IODINE: ☐ Yes ☐ No

Are you allergic to FOODS: ☐ Yes ☐ No If yes, which foods?_____

Are you allergic to MEDICATIONS: ☐Yes ☐ No If yes, which medications? _____

Past Medical History

Have you ever been hospitalized? ☐ Yes ☐ No If yes, explain:_____

Please identify if you have previously suffered from:

☐ Depression/Anxiety ☐ Seizures ☐ High Blood Pressure ☐ High Cholesterol ☐ Arthritis ☐ MRSA
☐ Eating Disorder ☐ Vertigo ☐ Heart Disease/Attack ☐ Peptic Ulcer ☐ Osteoporosis ☐Other:_____
☐ HIV/AIDS ☐ Asthma ☐ Stroke ☐ Hepatitis/Liver Disease ☐ Cancer ☐ Sleep Apnea
☐ Bleeding Disorder ☐ Reflux (GERD) ☐ Diabetes ☐ Pulmonary Embolism ☐ Tuberculosis
☐ Deep Vein Thrombosis ☐ Kidney Disease ☐ Thyroid (☐ Hyper vs. ☐ Hypo)

Medications

Please list all of your current prescription medications, over-the-counter medications, and nutritional supplements:

Medication	Dose	Frequency

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Surgical History

Please list all surgeries you have had in the past, including complications (bleeding, infection, blood clots, anesthesia reaction, etc):

Surgery	Date	Surgeon	Complications

Family History

Please identify if any of your family members have had the following and who had it (example father, mother, grandparents):

☐ Anesthesia Problems	☐ Osteoporosis	☐ Diabetes	☐ Kidney Disorder
☐ Anxiety/Depression	☐ Bleeding/Clotting	☐ Heart Disease	☐ Stroke
☐ Arthritis	☐ Cancer	☐ High Blood Pressure	☐ Other:

Social History

Are you currently employed? ☐ Yes ☐ No

Occupation:_____ Employer:_____

Are you disabled from work? ☐ Yes ☐ No

If yes, when were you last able to work?_____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Number of Children:_____

Tobacco Use: ☐ Yes ☐ No

Amt per day:_____ Duration:_____ Quit Date:_____

Alcohol Use: ☐ Yes ☐ No

Amt per week:_____

Recreational Drugs: ☐ Yes ☐ No

History of drug/alcohol abuse? ☐ Yes ☐ No

What sports and physical activities do you participate in? _____

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Current Review of Systems – Check all that you are currently experiencing today

Constitutional
- ☐ Fatigue/Malaise
- ☐ Chills
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Increased Appetite
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Generalized Weakness

Eyes
- ☐ Double Vision
- ☐ Impaired Vision
- ☐ Vision Loss – left/right
- ☐ Eye Pain

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Sleep Disturbances due to Breathing Problems
- ☐ Wheezing

Skin
- ☐ Persistent Rash
- ☐ Persistent Itching
- ☐ Change in Pigmentation

HENT
- ☐ Congestion
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Tinnitus (ringing in ears)
- ☐ Neck Lumps or Masses

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Passing Out
- ☐ Swelling in Ankles
- ☐ Fluid in Lungs
- ☐ Shortness of Breath

Endocrine
- ☐ Increased Fatigue
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Intolerance to Heat
- ☐ Intolerance to Cold

Blood
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Bleeding from Gums
- ☐ Prolonged Bleeding

Musculoskeletal
- ☐ Joint Pain/Swelling
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Back Pain
- ☐ Leg Pain/Cramping
- ☐ Neck Pain
- ☐ Arm Pain/Cramping
- ☐ Stiffness
- ☐ Recent Fall

Gastrointestinal
- ☐ Nausea/Vomiting
- ☐ Diarrhea/Constipation
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Abdominal Bloating
- ☐ Indigestion
- ☐ Bowel Incontinence

Genitourinary
- ☐ Bladder Incontinence
- ☐ Difficulty Voiding
- ☐ Hesitancy
- ☐ Frequency/Urgency
- ☐ Painful Urination
- ☐ Pelvic Pain

Nervous System
- ☐ Tingling or Numbness
- ☐ Loss of Balance
- ☐ Tingling in Feet
- ☐ Tremors
- ☐ Difficulty Concentrating
- ☐ Vertigo

Psychiatric
- ☐ Stress
- ☐ Anxiety
- ☐ Depression
- ☐ Compulsive Behavior
- ☐ Excessive Anger
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Ideas
- ☐ Thoughts of Violence

Other symptoms not listed above:

_____

_____

_____

_____

Patient Signature:_____ Date:_____ Time:_____

Patient Label: