



College Park
Family Care
Center, P.A.

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NEW PATIENT INFORMATION

Please help us to help you by answering the following questions as accurately as possible

NAME: _____ **DOB:** _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR ILLNESS

REFERRING DOCTOR? _____

PRIMARY DOCTOR? _____

DURATION: How long have you had the pain (weeks, months, years)? _____
Please include date pain started _____

FREQUENCY: How many days a week do you have pain? _____

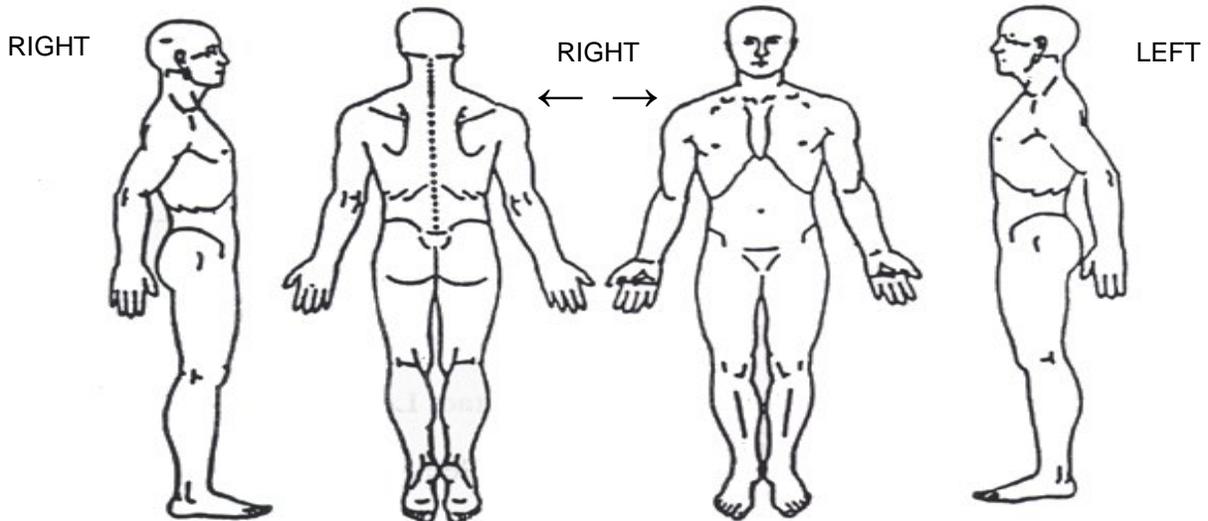
ONSET: Did the pain start _____ suddenly or _____ gradually?

MODIFYING FACTORS: Was there an accident or incident that first caused the pain? ____ No
____ Yes, please describe _____

TIMING: Is the pain _____ constant or does it _____ come and go?

QUALITY: How would you describe the pain ___ burning ___ stabbing ___ aching
___ Other, please describe _____

SEVERITY: Please rate your pain with "0"=no pain and "10"=pain requiring **immediate** ER visit
How severe is the pain at its **best** (circle one)? 0 1 2 3 4 5 6 7 8 9 10
How severe is the pain at its **worst** (circle one)? 0 1 2 3 4 5 6 7 8 9 10
At what level of pain do you need medication (circle one)? 0 1 2 3 4 5 6 7 8 9 10
What pain medication have you been taking and for how long? _____



MODIFYING FACTORS:

What (if anything) makes the pain **better**? _____
What (if anything) makes the pain **worse**? (sneezing, coughing, walking, sitting too long, carrying something heavy in one arm, crossing your legs, sleeping) _____

ASSOCIATED SIGN/SYMPTOMS: Does the pain ever travel down:

Right arm _____ Right leg _____
Left arm _____ Left leg _____

Is the pain worse in your: ___ Arm ___ Leg ___ Back ___ Neck ___ Other

Do you have numbness or funny feeling in your: ___ Right arm ___ Left arm ___ Right leg
___ Left leg ___ Other

Do you have any weakness in your extremities?

Right arm _____ Right leg _____ Other _____
Left arm _____ Left leg _____

How far down the arm does the pain go?

_____ Just to the top of the shoulder? ___ Left ___ Right
_____ Just to the shoulder? ___ Left ___ Right
_____ Just into the back of the shoulder? ___ Left ___ Right
_____ Just to the elbow? ___ Left ___ Right
_____ Just to the forearm? ___ Left ___ Right
_____ Into the hands but not the fingers? ___ Left ___ Right
_____ Into all of the fingers? ___ Left ___ Right
_____ Into the thumb and medial fingers? ___ Left ___ Right
_____ Into the middle fingers? ___ Left ___ Right
_____ Into the 4th and 5th fingers? ___ Left ___ Right

How far down the leg does the pain go?

_____ Just into the buttocks ___ Left ___ Right
_____ Just into the hip ___ Left ___ Right
_____ Into the groin ___ Left ___ Right
_____ Along the outside of the thigh just to the knee ___ Left ___ Right
_____ Across the front of the thigh ___ Left ___ Right
_____ To the knee, but NEVER below the knee on the ___ Left ___ Right
_____ To the lower leg, but NEVER into the foot ___ Left ___ Right
_____ Down the back, into the calf ___ Left ___ Right
_____ Down into the big toe ___ Left ___ Right
_____ Down into the little toe ___ Left ___ Right
_____ Into all of the toes ___ Left ___ Right

1. List tests that have been performed (I.e. MRI, CAT scan, myelogram, x-ray, EMG, etc.)

2. Circle any treatments you have tried before to treat your pain:

Physical Therapy Chiropractor Massage Therapy Ice Heat TENS Unit Other

If yes to Physical Therapy, what type of treatment did you have and where were you treated?

3. List other Doctor who have treated you for this problem:

4. Have you previously had any injections/epidurals for your pain?

5. Have you been treated by other pain or sports medicine doctors in the past?

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT OTHER SYMPTOMS YOU MAY HAVE (REVIEW SYSTEM)

Do you have fevers on a regular basis (temperature of 101 degrees or more on a thermometer)?
___ No ___ Yes, details _____

Have you had any unintentional weight loss greater than 15 pounds? ___ No ___ Yes

Do you have **FREQUENT** lower leg cramping or pain when walking that goes away if you stop and rest? ___ No ___ Yes, details _____

Do you cough up bloody sputum? ___ No ___ Yes, details _____

Have you had any complete loss of bowel control (NOT diarrhea or constipation)?
___ No ___ Yes, details _____

Have you had any complete loss of bladder control (NOT loss of urine while coughing, sneezing, or straining)?
___ No ___ Yes, details _____

Does your pain or injury cause you to feel sad or depressed on a regular basis? ___ No ___ Yes
Details _____

Do you have problems with your blood clotting or have low platelets? ___ No ___ Yes
Details _____

In the past few months have you experienced any of the following symptoms or complaints?

Night Sweats	___ No ___ Yes	New rashes or blisters	___ No ___ Yes
Chest pain	___ No ___ Yes	Red swollen joints	___ No ___ Yes
Difficulty breathing	___ No ___ Yes	Numbness	___ No ___ Yes
Persistent Cough	___ No ___ Yes	Weakness	___ No ___ Yes
Constipation	___ No ___ Yes	Recurrent infections	___ No ___ Yes
Diarrhea	___ No ___ Yes	Nausea	___ No ___ Yes

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PAST MEDICAL HISTORY

Please list your past or present medical conditions:

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bleeding ulcers |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart disease or heart attack | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Aneurysm | Other Medical Problems |
| <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Hepatitis | _____ |
| <input type="checkbox"/> AIDS or HIV | _____ |
| <input type="checkbox"/> Cancer (if yes, what type) | _____ |
| _____ | _____ |
| <input type="checkbox"/> Gout | _____ |
| <input type="checkbox"/> Rheumatoid Arthritis | _____ |

Please list any BACK or NECK SURGERIES you have had:

- | | | | |
|----------|------------|----------|------------|
| 1. _____ | Date _____ | 3. _____ | Date _____ |
| 2. _____ | Date _____ | 4. _____ | Date _____ |

Please list any BACK or NECK INJECTIONS you have had:

- | | | | |
|----------|------------|----------|------------|
| 1. _____ | Date _____ | 3. _____ | Date _____ |
| 2. _____ | Date _____ | 4. _____ | Date _____ |

Please list any OTHER SURGERIES you have had:

- | | | | |
|----------|------------|----------|------------|
| 1. _____ | Date _____ | 3. _____ | Date _____ |
| 2. _____ | Date _____ | 4. _____ | Date _____ |

Are you allergic to any medications? No Yes, Please list

Please list ALL of the medications you currently take

<u>Medicine</u>	<u>Dose</u>	<u>How many time daily</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any of the following?

- | | | |
|---------------------|-----------------------------|------------------------------|
| Aspirin | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Plavix | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Warfarin (coumadin) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL HISTORY

Do you currently smoke? _____ No _____ Yes

If so, how many packs per day? _____

For how many years? _____

If you don't currently smoke, did you smoke in the past? _____ No _____ Yes

If yes, how long ago did you quit? _____

Before you quit, how many packs per day did you smoke? _____

Before you quit, how many years did you smoke? _____

Do you CURRENTLY drink alcohol? _____ No _____ Yes

If yes, how many days per week? _____

How many drinks do you have when you drink? _____

Do you CURRENTLY use any of the following recreational drugs?

Marijuana _____ No _____ Yes

Cocaine _____ No _____ Yes

Speed or amphetamines _____ No _____ Yes

Heroin/opium/morphine _____ No _____ Yes

Designer drugs (XTC, GNB, etc) _____ No _____ Yes

Other _____

Have you EVER used any of the following recreational drugs?

Marijuana _____ No _____ Yes, last time used _____

Cocaine _____ No _____ Yes, last time used _____

Speed or amphetamines _____ No _____ Yes, last time used _____

Heroin/opium/morphine _____ No _____ Yes, last time used _____

Designer drugs (XTC, GNB, etc) _____ No _____ Yes, last time used _____

Other _____ last time used _____

Are you CURRENTLY _____ Married _____ Single _____ Divorced

How many children do you have? _____

What are their ages? _____

Do you CURRENTLY work? _____ No _____ Yes, where? _____

What do you do? _____

For how long? _____

If you currently work, how would you describe your job satisfaction?

_____ I love my job.

_____ I like my job most of the time.

_____ I go to work because I have to.

_____ I usually dislike my job.

_____ I hate my job.

If you don't currently work, how long have you been out of work? _____

Are you presently receiving DISABILITY benefits? ____No ____Yes

Have you EVER filed a claim under worker's compensation? ____No ____Yes

Are you currently involved in ANY litigation due to your pain or injury? ____No ____Yes

Have you EVER been a victim of any of the following?

Emotional abuse ____No ____Yes, how long ago _____

Physical abuse ____No ____Yes, how long ago _____

Sexual abuse ____No ____Yes, how long ago _____

I understand that for my doctor to provide me with the best possible care, I must provide complete and accurate information about my medical history. I certify the information I have provided is true and correct.

Patient Signature

____/____/____
Date