Highlands Neurology
& Pain Medicine
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New Patient Questionnaire

Thank you for arranging an appointment with UAB Neurology and Pain Medicine. Please COMPLETE this questionnaire before coming for your visit. It will become part of your pain clinic medical file. The form asks for information about your current pain-related problems and your past medical history. This form will give your doctor a better understanding of your problem, and will allow him or her to spend more time discussing pain management treatment plans with you.

Your Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Gender: ◯ Male ◯ Female

Handedness: ◯ Right ◯ Left

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

What doctor sent you to see us? Please include his or her mailing address and phone number.

_____

_____

_____

Who is your Primary Care Physician (family doctor)? Please include his or her mailing address and phone number.

_____

_____

_____

A. TELL US ABOUT YOUR PAIN PROBLEM (HISTORY OF PRESENT ILLNESS)

Do you have: ◯ Neck Pain ◯ Shoulder Pain ◯ Arm Pain ◯ Headaches ◯ Upper Back Pain ◯ Leg Pain ◯ Low Back Pain ◯ Pain All Over ◯ Other Pain Complaints:

_____

_____

_____

Date your pain began: _____

Was the onset of Pain: (Check One) ◯ Sudden ◯ Gradual

Can you tell what first caused your pain? ◯ No ◯ Yes
What?_____

_____

Please describe your pain problem in your own words (what you feel, where and when):

_____

_____

_____

Is your pain the result of a work-related injury? ◯ Yes ◯ No ◯ Unknown

Is it being covered under Worker Compensation? ◯ Yes ◯ No

Have you missed any work because of this problem? ◯ Yes ◯ No

If yes, how much? _____

B. DESCRIBE IN MORE DETAIL YOUR PAIN FOR US

Please rate the overall amount of pain you are experiencing today by circling a number between 0 and 10, with 0 being no pain and 10 being the worst pain imaginable.

0 1 2 3 4 5 6 7 8 9 10

Please also rate the worst that your pain gets on a bad day.

0 1 2 3 4 5 6 7 8 9 10

Please also rate the least pain you ever experience on a good day.

0 1 2 3 4 5 6 7 8 9 10

Check all of the boxes below that describe your pain:

◯ Constant ◯ Intermittent ◯ Deep ◯ Dull ◯ Sharp ◯ Pulsing ◯ Stiffness ◯ Aching
◯ Shooting ◯ Tender ◯ Pressure ◯ Cramping ◯ Burning ◯ Throbbing ◯ Stabbing
◯ Pressing ◯ Pulling ◯ Like a tight band ◯ Tingling ◯ Numbness ◯ Electric Shock

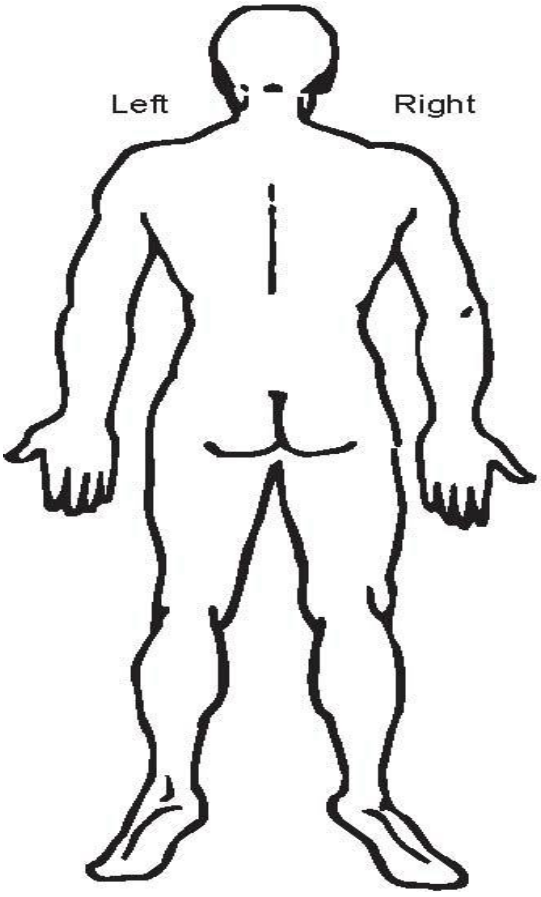
Do you experience any of the following symptoms?

◯ Numbness ◯ Tingling ◯ Weakness ◯ Clumsiness ◯ Falls ◯ Walking Problems ◯ Balance Problems ◯ Spasms ◯ Limited motion ◯ Bowel problems ◯ Bladder problems ◯ Sweating changes ◯ Temperature changes ◯ Skin color changes ◯ Hair/Nail growth changes

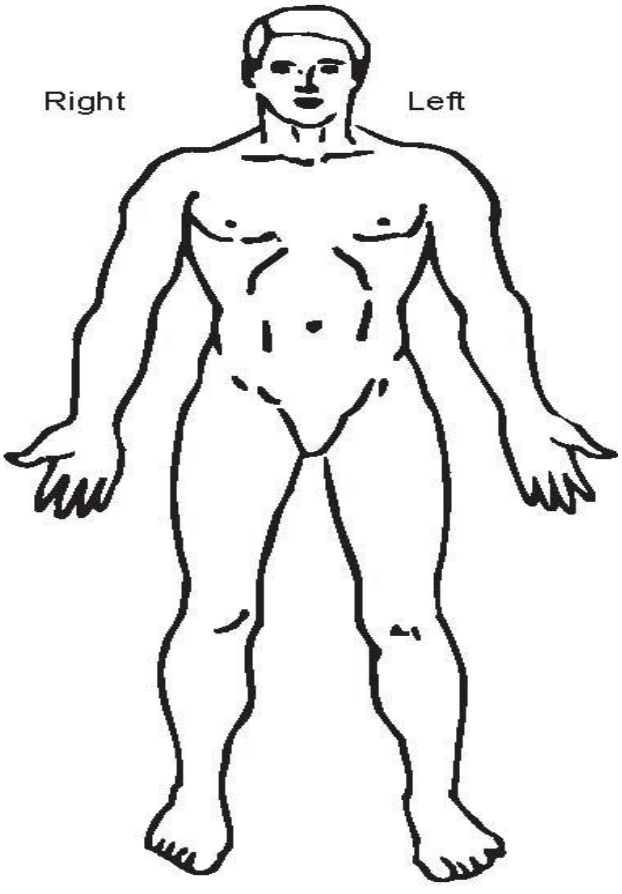
If you do experience any of the symptoms above, where and when?

_____
_____
_____

Back



Front



Which of the following activities affect your pain?

	Increases Pain	Decreases Pain	Neither
Getting out of bed	◯	◯	◯
Standing up	◯	◯	◯
Continuous standing	◯	◯	◯
Sitting	◯	◯	◯
Lying on your back/side	◯	◯	◯
Going down stairs	◯	◯	◯
Bending backwards	◯	◯	◯
Leaning forward	◯	◯	◯
Coughing/sneezing	◯	◯	◯
Lifting	◯	◯	◯
Twisting	◯	◯	◯
Straining	◯	◯	◯
Reaching over	◯	◯	◯
Looking up or sideways	◯	◯	◯
Washing/combing hair	◯	◯	◯
Long car rides	◯	◯	◯
Reading	◯	◯	◯
Computer work	◯	◯	◯
Exercising	◯	◯	◯
Walking	◯	◯	◯
Running	◯	◯	◯

What other activities affect your pain? _____

_____

What one activity most AGGRAVATES your pain? _____

What one activity most RELIEVES your pain? _____

C. TELL US ABOUT YOUR EVERYDAY FUNCTION

What parts of your life can you NOT do normally because of your pain?

_____

_____

_____

_____

For how long (IN MINUTES AND HOURS) can you continuously:

Sit: _____ Stand: _____ Walk: _____

Do you:	YES	NO		YES	NO
Sleep soundly	◯	◯	Wake up rested	◯	◯
Have trouble falling asleep	◯	◯	Wake up in the middle of the night	◯	◯
Feel fatigued much of the time	◯	◯	Take sleeping medication	◯	◯

How would you describe your emotional health (check all that applies to you)?

◯ Happy/Cheerful ◯ Optimistic ◯ Anxious ◯ Worried ◯ Angry ◯ Depressed ◯ Compulsive

◯ Uninterested ◯ Hopeless ◯ Frustrated ◯ Panicked

Have you ever or are you currently considering suicide? ◯ Yes ◯ No

If yes, do you have a plan on how to do so? ◯ Yes ◯ No

D. TELL US ABOUT YOUR PREVIOUS PAIN EVALUATION AND TREATMENT

What tests have been done to evaluate your current pain problems?

Test Date and Where? (What Clinic or Hospital)

◯ Plain X rays_____

◯ CT Scan (CAT Scan) _____

◯ MRI Scan _____

◯ Myelogram _____

◯ EMG/Nerve Conduction Studies _____

◯ Bone Scan _____

◯ Other_____

_____

_____

List ALL of the other physicians and pain clinics that have treated you in the past for your pain.

_____
_____
_____
_____
_____

Have you ever been dismissed by another Pain Clinic or Pain Physician? If so, who and why?

_____
_____
_____
_____
_____

Have you ever participated in a Methadone Clinic? If so, which one and when?

_____
_____
_____
_____
_____

Have you ever been charged or arrested for a drug related crime? If so, please provide the details.

_____
_____
_____
_____
_____

Has addiction or substance abuse (including alcohol abuse) ever been a problem for you? If so, please provide the details.

_____
_____
_____
_____
_____

Have you ever obtained pain medications from any source other than a prescribing doctor? (ex: buying drugs from someone off of the street or taking someone else's medication)

_____
_____
_____
_____
_____

Please list all medications already used in an attempt to help with your chronic pain condition:

Which ones?	Helpful	No Help	Not Used
Anti-Inflammatory:_____	◯	◯	◯
_____	◯	◯	
Muscle Relaxants: _____	◯	◯	◯
_____	◯	◯	
Narcotic Pain Medications: _____	◯	◯	◯
_____	◯	◯	
Other Medications:_____	◯	◯	◯

Check all of the treatments below that you have already received for your pain. Then, next to each of those previous pain treatments, write **YES** if it HELPED you pain, **NO** if it made you WORSE, or **0** if it made no difference.

◯ Physical therapy_____ ◯ Heat _____ ◯ Ice _____

◯ Ultrasound_____ ◯ Traction_____ ◯ Braces/Splints_____

◯ Stretching exercises _____ ◯ Treadmill_____ ◯ Back School_____

◯ Work Hardening_____ ◯ Pool Therapy_____ ◯ Chiropractic_____

◯ TENS Unit_____ ◯ Acupuncture_____ ◯ Massage Therapy_____

◯ Epidural Blocks_____ ◯ SI Joint Block_____ ◯ Facet Block_____

◯ Nerve Block_____ ◯ Spinal Cord Stimulator_____ ◯ Implanted Pump_____

◯ Spinal Injections_____ ◯ Trigger Point Injections_____

◯ Other Treatments: _____

Please list your previous pain related surgeries:

Date Surgery Reason (Symptoms) Surgeon and Hospital

_____

_____

_____

Did your symptoms improve after your most recent pain related surgery? ◯ Yes ◯ No

If yes, which symptoms got better?

_____

_____

_____

Did you get worse after pain related surgery? ◯ Yes ◯ No

If yes, please explain.

_____

_____

_____

E. TELL US ABOUT YOUR PREVIOUS MEDICAL AND SURGICAL HISTORY

Please check the box if you have ever been treated for any of the following conditions:

◯Heart Failure	◯High Blood Pressure	◯Blood Clots	◯Heart Attack
◯Irregular Rhythm	◯Heart Murmur	◯Emphysema	◯Chronic Cough
◯Pneumonia	◯Asthma	◯Bronchitis	◯Thyroid Disease
◯Hepatitis	◯GERD	◯Liver Disease	◯Irritable Bowel
◯Crohn's Disease	◯GI Bleeding	◯Kidney Stones	◯Kidney Disease
◯Prostate Disease	◯Incontinence	◯Interstitial Cystitis	◯Bipolar
◯Fibromyalgia	◯Rheumatoid Arthritis	◯Osteoarthritis	◯Stroke
◯Multiple Sclerosis	◯Headaches/Migraines	◯Memory Disorder	◯Neuropathy
◯Seizures/Epilepsy	◯Depression	◯Anxiety Disorder	◯Nervous Breakdown
◯Diabetes	◯Glaucoma	◯Anemia	◯Bleeding Disorder
◯Autoimmune Disorder		◯Anti-coagulation (taking blood thinners)	

◯Cancer: What type?_____Date last treated: _____

Are you under a doctor's care for any other medical condition? ◯Yes ◯No

If yes, please explain: _____

_____

Please note all of the surgeries you have had in the past:

◯Spine-Neck	◯Spine-Lower Back	◯Brain	◯Heart	◯Pacemaker
◯Filter for Blood Clot	◯Angioplasty	◯Stent Lung	◯Gallbladder	◯Stomach
◯Appendix	◯Intestine	◯Hernia	◯Colon	◯Rectum
◯Hysterectomy	◯C-Section	◯Kidneys	◯Bladder	◯Urinary Tract
◯Prostate	◯Shoulders	◯Arms	◯Hands	◯Hips
◯Knees	◯Legs	◯Feet	◯Eyes	◯Ears
◯Nose	◯Throat	◯Other: _____		

Are you pregnant?: ◯Yes ◯No ◯No Not Possible

Date of last menstrual period: _____

F. TELL US ABOUT YOUR MEDICATIONS AND ALLERGIES

MEDICATIONS: Please list all the medications you are currently taking, with their doses and how often you take them per day. Please include "over the counter" drugs, birth control pills, and vitamins/supplements/herbals, and any medication you use only "as needed" rather than daily.

NAME OF DRUG:	DOSE:	HOW OFTEN

ALLERGIES: Please list any medications you cannot take because of allergies or other problems (side effects). Please tell us what reaction you had to each drug.

NAME OF DRUG:	REACTION OR SIDE EFFECTS:

G. TELL US ABOUT YOUR LIFE (SOCIAL AND WORK HISTORY)

What is your present or previous occupation:

_____

Do you work: ◯ Full Time ◯ Part Time ◯ Light Duty or Limited Duty?

Explain:

_____

_____

_____

How long have /had you been at this job?_____

How much do/did you like it?_____

_____

Have you been off work because of your pain in the past? ◯ No ◯ Yes

If yes, how many times and for how long?

_____

_____

How many hours per day does your job require you to:

◯Sit ◯Stand ◯Walk

◯Bend/Stoop ◯Drive ◯Reach

◯Work at Computer ◯Work with Chemicals or Fumes

◯Use Power Tools Which ones?_____

◯Carry, Push, Pull How Heavy?_____

◯Lift How Heavy?_____

Please answer these questions if you are not working outside the home:

When did you last work, and why did you stop?

_____

_____

How do you spend your day?

_____

_____

What is your source of income?

_____

_____

Do you plan to: ◯ Return to your old job? ◯ Take a different job? ◯ Not return to work?

How far did you go in school? _____

Were you in the Military? ◯ Yes ◯ No

Are you: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Have you had any children? If so, how many and what are their ages?

_____

_____

Who lives at home with you now?

_____

_____

Do you currently: <u>If yes, how much and for how long? If no, did you in the past? If yes, how much and for how long?</u>

Smoke? ◯ Yes ◯ No _____ ◯ Yes ◯ No_____

Use Alcohol? ◯ Yes ◯ No _____ ◯ Yes ◯ No _____

Use Illegal Drugs ◯ Yes ◯ No _____ ◯ Yes ◯ No _____

Use Caffeine? ◯Yes ◯ No _____ ◯ Yes ◯ No _____

H. TELL US ABOUT YOUR FAMILY HISTORY

What illnesses run in your close family members (other than yourself)?

◯ Diabetes ◯ Kidney Stone ◯ Spine Disease ◯ Cancer ◯ Arthritis ◯ Bleeding Disorder

◯ Heart Disease ◯ Mental Illness ◯ High Blood Pressure ◯ Alcoholism ◯ Any other medical

conditions: _____

_____

_____

I. REVIEW OF SYMPTOMS

Please check off any of these current problems you have experienced:

CONSTITUTIONAL	EYE	EAR/THROAT	RESPIRATORY	HEART
□FEVER	□VISUAL CHANGE	□DECREASED HEARING	□SHORT OF BREATH	□CHEST PAIN
□CHILLS	□YELLOWING	□EAR PAIN	□COUGHING	□SKIPPING
□WEAKNESS	□DISCHARGE	□CONGESTION	□SPITTING UP	□SLOW
□FATIGUE	□BLURRING	□SORE THROAT	□COUGHING BLOOD	□FAST
□FATIGUE	□DOUBLE VISION		□WHEEZING	□SWOLLEN LEGS
□DECREASED ACTIVITY			□BLUE LIPS □HOLDING BREATH	□PASSING OUT

GI	GU	BLOOD	ENDOCRINE	IMMUNE
□NAUSEA	□PAIN ON URINATION	□EASY BRUISING	□EXCESSIVE THIRST	□FREQ FEVERS
□VOMITING	□BLOOD IN URINE	□EASY BLEEDING	□URINATE AT NIGHT	□FREQINFECTIONS
□DIARRHEA	□CHANGE IN URINATION	□SWOLLEN GLANDS	□COLD INTOLERANCE	□MALAISE
□CONSTIPATION	□DISCHARGE		□HEAT INTOLERANCE	
□HEARTBURN	□LESIONS		□EXCESS HUNGER	
□ABDOMINAL PAIN				
□VOMITING BLOOD				

MUSCULOSKELETAL	SKIN	NEUROLOGIC	PSYCHIATRIC	OTHER
□BACK PAIN	□RASH	□BALANCE PROBLEMS	□ANXIETY	□NO CHANGE
□JOINT PAIN	□SCRATCHES	□NUMBNESS	□MANIA	
□MUSCLE	□BREAKDOWN	□TINGLING	□SUICIDAL	
□CLAUDICATION	□BURNS	□HEADACHE	□DELUSIONAL	
□DECREASED MOTION	□DRYNESS		□HALLUCINATIONS	
□INJURY	□BRUISING			
	□LESIONS			
	□SCAR EASILY			

I have answered these questions to the best of my knowledge and I understand that failing to disclose the above information may result in termination from Dr. Bailey's care.

Patient Signature: _____Date: _____

Physician's Signature: _____Date: _____