CSN- NEW PATIENT INFORMATION QUESTIONAIRE

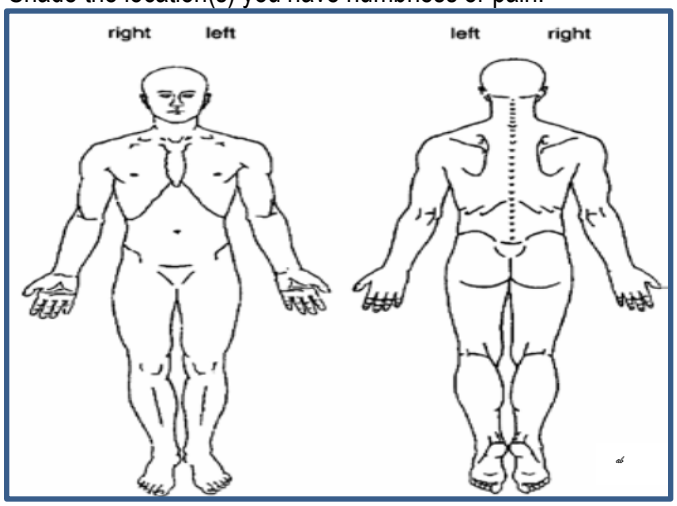
Last Name	First Name	Middle Name	Male/Female	Date of Birth
_____	_____	_____	_____	_____

Referring Physician
Physician's Name:_____
Practice Name:_____

Family Physician
Physician's Name:_____
Practice Name:_____

When did your pain/numbness begin?_____
Was there an inciting event?_____
Has the pain/numbness changed?_____

Shade the location(s) you have numbness or pain:



Circle the words below that describe your pain:

Burning	Aching	Sharp	Constant
Electric	Throbbing	Stabbing	Occasional
Prickling	Dull	Shooting	Frequent
Numbing	Cramping	Stinging	Rare

Circle the number that describes your average pain

|----------|----------|----------|

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

Anything make it **better**? (heat, cold, lying down Sitting, walking, coughing) **Worse**? (heat, cold, lying down sitting, walking, coughing

Circle activities affected by your pain. (sleep, leisure, Household chores, work/school, social interaction, Sexual activity) Explain_____
_____

List all prior treating physicians:_____
_____

Circle all prior medications used:

Tramadol	Hydrocodone	Percocet	Dilaudid
Oxycodone	Oxycontin	Morphine	MS Contin
Duragesic	Methadone	Tapentadol	Opana
Exalgo	Neurontin	Lyrica	topamax
Effexor	Cymbalta	Mobic	Celebrex

List adverse reactions to above:_____
_____
_____

List Physical Therapy location/dates:_____
_____
_____

Circle previous treatments you have had for pain:

Acupuncture	Biofeedback	Brace
Chiropractor	Epidural	Exercise
Physical therapy	Facet block	Hypnosis
Massage	Nerve block	Psychotherapy
Surgery	TENS	Trigger points

_____
HR:____ BP:____ RR:____ Sat___ Wt____ T____

Provider Notes:

Provider Signature:_____ **Date:**_____

Headache Assessment:

1. How long have you had headaches: _____
2. How many days per month are you headache FREE: _____
3. How many headache days do you have per month: _____
4. How many hours per day do your headaches last: _____
5. Over the past 3 months has the frequency changed:

More often	Less Often	No change

6. What symptoms do you normally have with your headaches:

Moderate Pain	Severe Pain	Sensitivity to light
Sensitivity to sound	Nausea	Pain on one side
Vomiting	Vision changes	

7. How many days per month do you have one of the above symptoms:

0-4	5-9	10-14	15+

8. On a scale of 1-10, 1 being mild, rate your typical headache: _____

9. Do you experience any symptoms prior to developing a headache, describe:_____

_____

10. Do you have any triggers: _____

11. Days last month you missed work/school due to headache:

0	1-2	3-4	5+

2. Days last month you cancelled plans due to headache:

0	1-2	3-4	5+

13. Times last year you went to the emergency room due to headache:

0	1-2	3-4	5+

14. Circle below if you have tried this medication or treatment and it was not effective in the past

Amitriptyline	Elavil	Nortriptyline	Pamelor
Effexor	Venlafaxine	Depakote	Divalproex
Topamax	Topiramate	Valpric acid	Gabapentin
Metoprolol	Propranolol	Verapamil	Botox
Occipital block	Tylenol	NSAIDS	Ibuprofen
Naproxen	Sumatriptan	Imitrex	Zolmitriptan
Zomig	Rizatriptan	Maxalt	Oxycodone
Percocet	Hydrocodone	Vicodin	Ubrevly

Circle the number to describe your average daily function

|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
0 1 2 3 4 5 6 7 8 9 10
In Bed — Hi Function

Family History

Please circle any of the following that run in your family:

Similar Pain	Arthritis	Cancer
Lupus	Depression	Stroke
Heart Disease	Diabetes	Bleeding D/O
Substance Abuse	Other:	

Patient Signature: _____

Date:_____ **Time:**_____

Provider Signature:_____ **Date:**_____

Review of Systems

Circle all past/present signs or symptoms

Constitutional

Change in Appetite	Chills	Sweating
Fever	Fatigue	Weight Change

HENT

Facial Swelling	Neck pain	Neck stiffness
Ear discharge	Hearing loss	Ear Pain
Congestion	Sinus Pressure	Sore Throat

Eyes

Eye Pain	Eye Redness	Photophobia
Visual disturbance		

Respiratory

Apnea	Chest tightness	Cough
Shortness of breath	Wheezing	

Cardiovascular

Chest pain	Pacemaker	Palpitations
Anticoagulation	Hypertension	Cardiac Stent

Gastrointestinal

Abdominal Pain	Diarrhea	Nausea/vomiting
Ulcers	Constipation	Rectal Pain

Endocrine

Heat intolerance	Cold Intolerance	Increased urination
High glucose	Thyroid disease	

GU

Difficulty urinating	Hesitancy	Flank pain
Frequency	Urgency	Incontinence

Musculoskeletal

Arthralgia	Back Pain	Gait Disturbance
Joint Swelling	Myalgia	Fibromyalgia

Skin

Color Changes	Rash	Pallor
Wounds	Pain to light touch	Swelling

Allergy/Immune

Tape allergies	Food allergies	immunocompromised

Neuro

Headache	Lightheadedness	Numbness
Seizures	Dizziness	Weakness
Tremors	Speech Changes	Confusion

Hematologic

Anticoagulation Coumadin/plavix	HIV	Bleeding disorder

Psychiatric

Agitation	Suicidal thoughts	Confusion
Dec. Concentration	Sleep disturbance	Hallucinations
Substance abuse	Nervous	Depression

Specific Question/Concern:_____

_____

_____

_____