Lipson Pain Institute
RELIEVING PAIN • CHANGING LIVES

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New Patient Questionnaire

SO THAT WE MAY BETTER SERVE YOU, PLEASE COMPLETE THE FOLLOWING FORM AND BRING THE COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTEMNT OR SCAN AND FAX TO: 863-293-4410

GENERAL INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Age: _____ Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Street Address: _____

City: _____State: _____Zip:_____

Home Phone: _____-_____-_____ Business Phone: _____-_____-_____ Cell Phone _____-_____-_____

PROFESSIONAL REFERRAL INFORMATION

Referring Physician's Name: _____Phone: _____-_____-_____

Street Address: _____

City: _____State: _____Zip:_____

Referring Attorney's Name: _____Phone: _____-_____-_____

Street Address: _____

City: _____State: _____Zip:_____

Referring Insurance Company's Name: _____Phone: _____-_____-_____

Street Address: _____

City: _____State: _____Zip:_____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician's Name: _____Phone: _____-_____-_____

Street Address: _____

City: _____State: _____Zip:_____

INFORMATION ABOUT YOUR PAIN

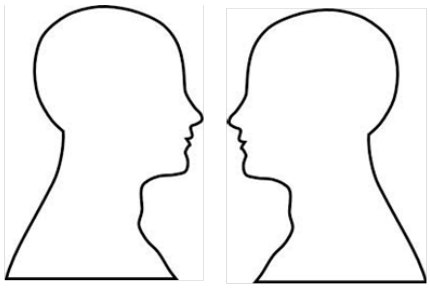
Please describe your major pain problem?

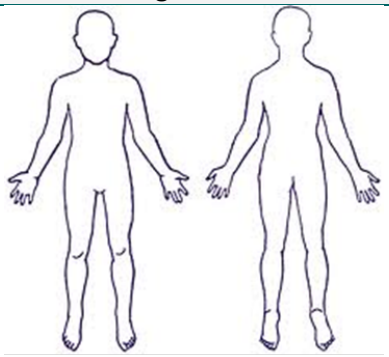
_____

_____

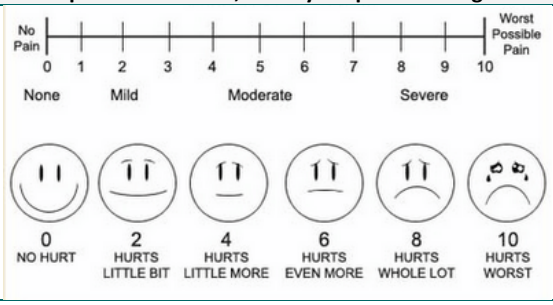
_____

Please shade in the areas where you feel pain on the drawings below.

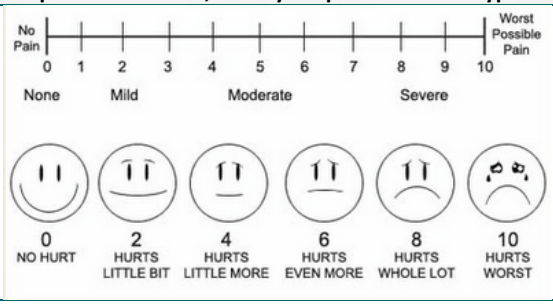




On the pain scale below, circle your pain level right now.



On the pain scale below, circle your pain level on a typical day.



How many months ago did your pain begin? _____

What events led to your present pain problem?

☐ Cancer ☐ Disease ☐ Operation ☐ Injury ☐ Other, Please Describe: _____

_____

_____

What was the date of your injury? _____/_____/_____

Do you have pain free intervals? ☐ YES ☐ NO If Yes, for how long? _____

CHECK ONE DESCRIPTION PER LINE TO DESCRIBE YOUR PAIN IN WORDS OF SEVERITY

Throbbing	___none	___mild	___moderate	___severe
Shooting	___none	___mild	___moderate	___severe
Stabbing	___none	___mild	___moderate	___severe
Sharp	___none	___mild	___moderate	___severe
Cramping	___none	___mild	___moderate	___severe
Gnawing	___none	___mild	___moderate	___severe
Hot-Burning	___none	___mild	___moderate	___severe
Aching	___none	___mild	___moderate	___severe
Heavy	___none	___mild	___moderate	___severe
Tender	___none	___mild	___moderate	___severe
Splitting	___none	___mild	___moderate	___severe
Tiring / Exhausting	___none	___mild	___moderate	___severe
Sickening	___none	___mild	___moderate	___severe
Fearful	___none	___mild	___moderate	___severe
Punishing / Cruel	___none	___mild	___moderate	___severe

WHAT FACTORS AGGRIVATE YOUR PAIN? PLEASE CHECK ALL THAT APPLY.

___Massage	**___Anxiety**	**___Cold**	**___Sex**	**___Lying Down**	**___Sitting**
___Walking	**___Coughing**	**___Heat**	**___Straining**	**___Standing**	**___Running**

What helps your pain?

_____
_____
_____

Which position is most comfortable for you?

_____
_____
_____

Describe your activities before your pain problems started:

_____
_____
_____

Describe your sleep pattern:

_____
_____
_____

Has your pain affected your mood?

_____
_____
_____

PREVIOUS EVALUATIONS OF YOUR PAIN

Please complete the following information regarding the doctors who have evaluated your pain problem:

Doctor #1

Doctor's Name: _____

Doctor's Specialty: _____

Year of Doctors Care: _____

Doctors Care:_____

List Treatments Performed by Doctor: _____

Doctor #2

Doctor's Name: _____

Doctor's Specialty: _____

Year of Doctors Care: _____

Doctors Care:_____

List Treatments Performed by Doctor: _____

Doctor #3

Doctor's Name: _____

Doctor's Specialty: _____

Year of Doctors Care: _____

Doctors Care:_____

List Treatments Performed by Doctor: _____

Doctor #4

Doctor's Name: _____

Doctor's Specialty: _____

Year of Doctors Care: _____

Doctors Care:_____

List Treatments Performed by Doctor: _____

SOCIAL HISTORY

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

Highest Level of Education: _____

Children: ☐ YES ☐ NO Number of Children: _____Ages:_____

Present Source of Financial Support:

☐ Personal Earnings ☐ Workman's Compensation ☐ Spouse Earnings

☐ Disability Payments ☐ Pensions ☐ Insurance

☐ None ☐ Other _____

Do You Work? ☐ YES ☐ NO If Yes, ☐ FULL TIME ☐ PART TIME

Occupation: _____

Do You Smoke? ☐ YES ☐ NO Do You Drink? ☐ YES ☐ NO

Are There Any Legal Actions Pending? If Yes, Please Explain: _____

_____

_____

PAST MEDICAL HISTORY

☐ Asthma / Breathing Problems
☐ Thyroid Problems
☐ Chronic Pain
☐ Liver Problems
☐ Bleeding Problems
☐ Diabetes
☐ High Blood Pressure
☐ Ulcer Disease
☐ Stroke
☐ Other
☐ Headaches
☐ Cancer
☐ Kidney Problems
☐ Hepetitis

PREVIOUS TREATMENTS FOR PAIN

MODALITIES	YES	NO	DATE	EFFECTIVENESS
Blocks/Injections				
TENS				
Biofeedback				
Counseling				
Pain Management				
Surgery				
Other				

SURGICAL HISTORY

Please List Any Surgeries Performed On You and the Dates They Were Performed.

Surgery	Date Performed	Surgeon	Outcome/ Results That MD/ARNP Should Know?

MEDICATIONS

Allergies:

Drug / Product	Allergic Reaction

Previous Medications:

Drug	Effectiveness	Side Effects

Current Medications:

Drug	Dosage	Purpose	Effectiveness	Prescribing Physician

PREVIOUS EXAMINATIONS

Studies / Tests	YES	NO	DATE	PHYSICIAN'S DISCOVERIES / Where Studies Were Completed?
X-Rays				
CAT Scans				
MRI				
EMG				
Nerve Construction Studies				
Myelogram				
Thermogram				

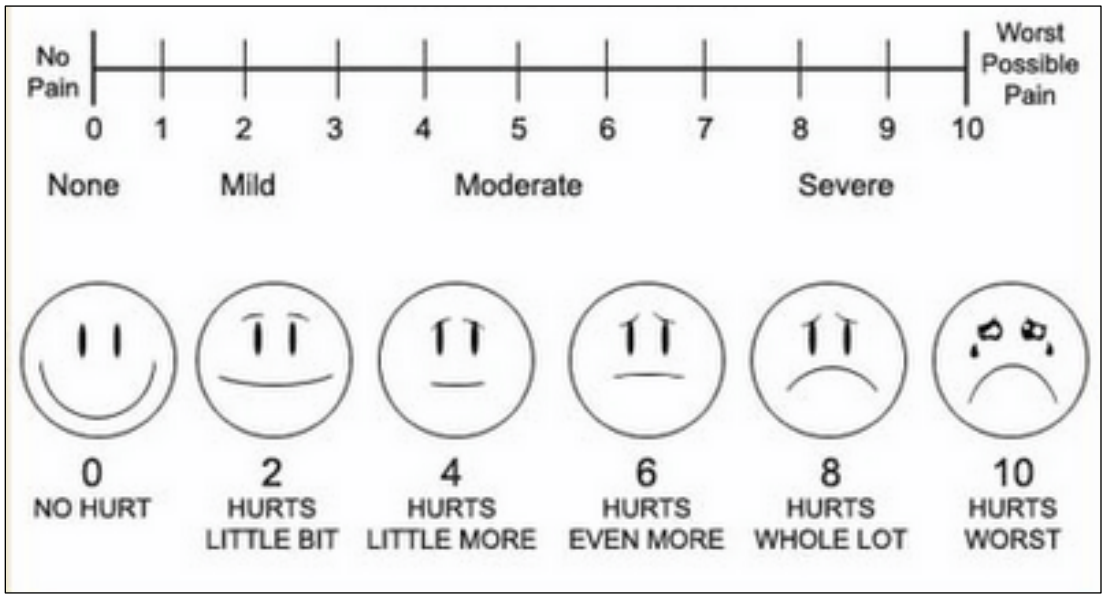
We request that all above medical records be brought to your first appointment, there is no need to bring the actual films only the report.

PHYSICAL STATUS

Current Height: _____ Current Weight: _____

VISUAL ANALOG SCALE

Use the chart below to indicate your current level of pain, circle the number that accurately describes your pain.



On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out one statement from each group that best describes the way you have been feeling this past week, including today. Circle the number beside the statement that you picked. If several statements in the group seem to apply well, circle each item. Be sure to read all of the statements within each group before making your choice.

1. 0 I do not feel sad.
   1 I feel sad
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad and unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated by things than I ever was.
    1 I am slightly more irritated now than usual.
    2 I am quite annoyed or irritated a good deal of the time.
    3 I feel irritated all the time.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions more than I used to.
    3 I can't make decisions at all anymore.

14. 0 I don't feel that I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel there are permanent changes in my appearance that make me look unattractive
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
    1 I have lost more than five pounds.
    2 I have lost more than ten pounds.
    3 I have lost more than fifteen pounds.

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems that I cannot think of anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I have almost no interest in sex.
    3 I have lost interest in sex completely.