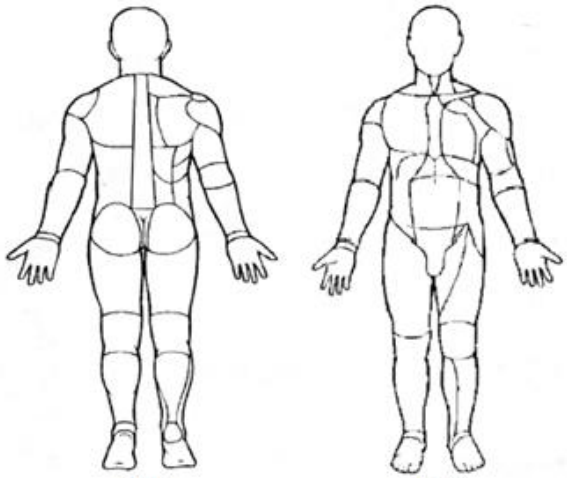
New Patient Assessment Form

Providence
St. Jude Heritage Medical Group

Place an "X" on the figure where your pain starts and show where it goes with an arrow:



Where is your pain? _____

When did it start? _____

Frequency of pain: Constant or Intermittent

Rate your pain on a scale from 0-10, with 10 being the worst imaginable pain and 0 being no pain:

Worst: _____

Best: _____

Average: _____

Description of pain: *(Circle all that apply)*

Sharp	Stabbing	Burning	Shooting	Dull	Deep
Aching	Throbbing	Tight	Pulling	Cramping	Heavy

What makes your pain worse? *(Circle all that apply)*

Bending	Sitting	Standing	Walking	Lying down	Lifting
Stairs	Coughing	Sneezing	Defecation	Sexual intercourse	

What makes your pain better? *(Circle all that apply)*

Heat	Ice	Rest	Sitting	Lying down	Massage
Exercise	TENS	Traction	Medication(s): _____		

Do you have any associated symptoms? *(Circle all that apply)*

Arm weakness	Leg weakness	Numbness/tingling	Bowel/bladder change
Dizziness	Incoordination	Insomnia	Depression
Nighttime pain	Night sweats	Unintentional weight loss	

LABEL

What have you tried previously? *(Circle all that apply)*

Physical Therapy	Chiropractic care	Acupuncture	Massage	Heat/ice
Cognitive Behavioral Therapy		Biofeedback	Other: _____	

What tests have you had for your pain? *(Circle all that apply)*

X-ray	CT scan	MRI	EMG/NCV	Myelogram

Have you had any injections or surgery for your pain? If yes, please describe.

_____

_____

Which of the following medications have you taken prior to your arrival here today?

- ☐ Tylenol®/acetaminophen
- ☐ Muscle relaxants/Flexaril®
- ☐ By mouth: Steroids/Medrol® dose pack
- ☐ Non-steroidal anti-inflammatory agents/NSAIDs/Motrin®/Ibuprofen®
- ☐ Amitriptyline®/Nortriptyline®/Prozac®/Cymbalta/Effexor
- ☐ Morphine/Methadone®/Percocet®/Norco
- ☐ Tegretol®/Neurontin®/Topamax®/Lyrica

Have you taken any of the following to treat your pain?

- ☐ Marijuana/CBD
- ☐ Xanax®
- ☐ Ativan®
- ☐ Valium®

Medications you take:

Medication	Dosage (mg)	How often?

Any allergies? _____ If yes, reaction(s): _____

Past Medical History: *(List all medical problems)*

_____

_____

Past Surgical History: *(List all surgeries and dates)*

_____

_____

Social History:

Occupation: _____

Tobacco Use: *(Type, frequency)* _____

Alcohol Use: If yes, type: _____ # Drinks per week: _____

Recreational Drug Use: *(Type, frequency)* _____

Family History:

Mother:	☐ Living	☐ Deceased	Age: _____	Health issues: _____
Father:	☐ Living	☐ Deceased	Age: _____	Health issues: _____
Brother(s):	☐ Living	☐ Deceased	Age(s): ____	Health issues: _____
Sister(s):	☐ Living	☐ Deceased	Age(s): ____	Health issues: _____

Review of Systems *(Check all that apply)*

Constitutional	**Cardiovascular**	**Genitourinary**	**Neurologic**
☐ Fever ☐ Weight loss ☐ Fatigue	☐ Chest pain ☐ Light headedness ☐ Palpitations ☐ Limb swelling ☐ Shortness of breath ☐ Fainting	☐ Incontinence ☐ Painful urination ☐ Blood in urine	☐ Weak arms/legs ☐ Numbness/tingling ☐ Headache ☐ Seizures ☐ Trouble concentrating ☐ Memory loss
EYES	**Respiratory**	**Musculoskeletal**	**Psychiatric**
☐ Blurry vision ☐ Double vision ☐ Loss of vision ☐ Eye pain ☐ Eye redness ☐ Eye dryness	☐ Trouble breathing ☐ Coughing blood ☐ Cough	☐ Back pain ☐ Neck pain ☐ Muscle pain ☐ Joint pain ☐ Muscle spasm ☐ Weakness	☐ Depression ☐ Suicidal thoughts ☐ Hallucinations
ENT	**Gastrointestinal**	**Skin**	**Hematologic**
☐ Trouble hearing ☐ Ringing ☐ Dizziness ☐ Imbalance ☐ Ear pain ☐ Ear discharge	☐ Abdominal pain ☐ Nausea/vomiting ☐ Diarrhea ☐ Constipation ☐ Bloody stools	☐ Rash/redness ☐ Sweating change ☐ Discoloration	☐ Night sweats ☐ Abnormal bleeding ☐ Easy bleeding
Endocrine ☐ Frequent urination ☐ Heat/cold intolerance ☐ Excessive thirst			

Person completing this form: _____ Relationship to patient: _____

Patient signature: _____ Date: _____

Reviewed by physician (Signature): _____

Date: _____

LABEL