

**New Patient Questionnaire:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Education Level: \_\_\_\_\_ Retired: Yes / No If yes, date: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Children: Son(s) \_\_\_\_\_ Daughter(s) \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other Treating Physicians: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Rel: \_\_\_\_\_ Phone: \_\_\_\_\_

**If your pain is the result of Accident/Fall/Injury, please fill out the following 3 questions:**

1) How and when did you hurt yourself?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Who first treated you and where?

\_\_\_\_\_  
\_\_\_\_\_

3) Who has treated you and what has been done since the injury occurred?

\_\_\_\_\_  
\_\_\_\_\_

**Are you currently working?** Yes / No (circle one) If no, last date worked? \_\_\_\_\_

Job Duties:

\_\_\_\_\_  
\_\_\_\_\_

**Is this a Work Comp injury:** Yes / No (circle one) **Date of Injury:** \_\_\_\_\_

**Disability Status:** \_\_\_\_\_Temporarily Disabled \_\_\_\_\_Permanently Disabled **From what date?** \_\_\_\_\_

Attorney (if applicable): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please list any other work related injuries or past accidents (car):

\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

**Tobacco Use:** Yes / No (circle one)

Packs per day: \_\_\_\_\_

Years smoked: \_\_\_\_\_

**Alcohol Use:** Yes / No (circle one)

How many drinks: \_\_\_\_\_

How often: \_\_\_\_\_

**Illicit Drug Use:** Yes / No (circle one)

Type of drugs: \_\_\_\_\_

How often: \_\_\_\_\_

**Exercise Level:** Yes / No (circle one)

What type: \_\_\_\_\_

How often: \_\_\_\_\_

**Past Medical History:** (circle all that apply)

AIDS/HIV

ALCOHOLISM

ALZHEIMERS

ANEMIA

ARTHRITIS

ASTHMA

BLEEDING PROBLEMS

BLOOD CLOTS

BREAST CANCER

CANCER: \_\_\_\_\_

CERVICAL CANCER

COLON CANCER

CONSTIPATION

COPD

DEPRESSION

DIABETES TYPE I

DIABETES TYPE II

DIVERTICULITIS

DIZZY/FAINTING

DRUG ABUSE

ERECTILE DYSF.

FIBROMYALGIA

GLAUCOMA

GOUT

HEART ATTACK

HEART DISEASE

HEPATITIS

HIGH BLOOD PRES.

HYPOGLYCEMIA

HYPERGLYCEMIA

HYPERTHYROIDISM

HYPOTHYROIDISM

IRREG. MENSES

KIDNEY DISEASE

KIDNEY STONES

LEUKEMIA

LUNG CANCER

LUNG PROBLEMS

OSTEOARTHRITIS.

PREGNANCY

PROSTATE PROB

SEIZURES

TUBERCULOSIS

ULCERS

OTHER: \_\_\_\_\_

**Review of Systems:** Do you have any of the following? (circle all that apply)

CHEST PAIN

EASY BRUISING

SHORTNESS OF BREATH

ABDOMINAL PAIN

ANKLE SWELLING

COUGH

HEADACHES

PROBLEMS WITH BOWEL MOVEMENTS

PROBLEMS WITH URINATION

ANY OTHER CONCERNS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Pain Management:** (circle all that apply)

ACCUPUNCTURE  
CHIROPRACTOR  
DISCOGRAM  
EPIDURAL  
FACET INJECTION  
HEAT TREATMENT  
ICE TREATMENT

IDET/NUCLEOPLASTY  
MASSAGE THERAPY  
OCCIPITAL NERVE BLOCK  
PHYSICAL THERAPY  
PUMP TRIAL  
RFTC (RADIOFREQUENCY)  
SCS TRIAL

SCS IMPLANT  
SYMPATHETIC BLOCK  
TENS UNIT  
TRIGGER POINT  
OTHER: \_\_\_\_\_  
\_\_\_\_\_

**Family History:** Circle (M) for Mother and (F) for Father

Mother: Living / Deceased Age: \_\_\_\_\_ Father: Living / Deceased Age: \_\_\_\_\_

- |                     |                           |
|---------------------|---------------------------|
| M / F - AIDS/HIV    | M / F - DIABETES          |
| M / F - ALCOHOLISM  | M / F - DRUG ABUSE        |
| M / F - ALZHEIMERS  | M / F - GOUT              |
| M / F - ANEMIA      | M / F - HEART DISEASE     |
| M / F - ARTHRITIS   | M / F - HODGKIN'S DISEASE |
| M / F - ASTHMA      | M / F - HYPERTENSION      |
| M / F - CA BREAST   | M / F - KIDNEY DISEASE    |
| M / F - CA BONE     | M / F - LIVER DISEASE     |
| M / F - CA CERVICAL | M / F - MIGRAINS          |
| M / F - CA COLON    | M / F - MUSCLE DISEASE    |
| M / F - CA LIVER    | M / F - OBESITY           |
| M / F - CA LUNG     | M / F - OSTEOPOROSIS      |
| M / F - CA OVARIAN  | M / F - OSTEOARTHRTIS     |
| M / F - CA PROSTATE | M / F - PARKINSON'S       |
| M / F - CA UTERINE  | M / F - SEIZURES          |
| M / F - COLITIS     | M / F - ULCERS            |
| M / F - DEPRESSION  |                           |

**Surgical History:** (include dates, at least the year of surgery)

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**Are you allergic to any medications?**(What reaction did you experience?)

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**Current Medications:**

**Dose:**

**Frequency:**

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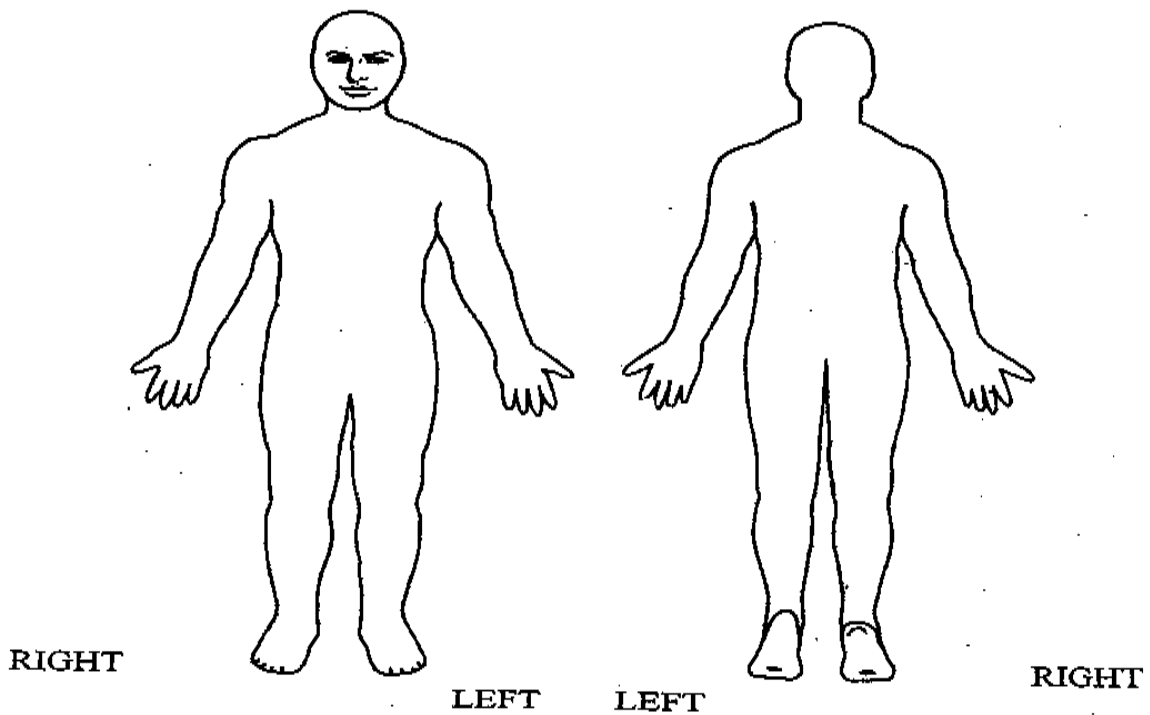
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**Pain History:**

Where is your pain located? (indicate on illustration)

Which area gives you the most pain?

Which side is worse?



**Pain Location:** (If you only have 1 location of pain, use section 1. If you have 3 pains use sections 1-3)

**1. Site of Pain:** \_\_\_\_\_ Increased / Decreased / Unchanged (circle one)

Pain Level Today: (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm	Throbbing
Burning	Dull	Sharp	Tightness	Weakness
Coldness	Hot	Shooting	Tingling	

**2. Site of Pain:** \_\_\_\_\_ Increased / Decreased / Unchanged (circle one)

Pain Level Today: (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm	Throbbing
Burning	Dull	Sharp	Tightness	Weakness
Coldness	Hot	Shooting	Tingling	

**3. Site of Pain:** \_\_\_\_\_ Increased / Decreased / Unchanged (circle one)

Pain Level Today: (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm	Throbbing
Burning	Dull	Sharp	Tightness	Weakness
Coldness	Hot	Shooting	Tingling	

**4. Site of Pain:** \_\_\_\_\_ Increased / Decreased / Unchanged (circle one)

Pain Level Today: (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm	Throbbing
Burning	Dull	Sharp	Tightness	Weakness
Coldness	Hot	Shooting	Tingling	

**5. Site of Pain:** \_\_\_\_\_ Increased / Decreased / Unchanged (circle one)

Pain Level Today: (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm	Throbbing
Burning	Dull	Sharp	Tightness	Weakness
Coldness	Hot	Shooting	Tingling	

**Does your pain radiate to different parts of your body?** Yes / No (example: from low back into the leg)

**If Yes, where?** \_\_\_\_\_

**Pain Frequency:** (circle one) Constant Intermittent Occasional

**Pain is aggravated by:** (circle all that apply)

Bending Driving Lying Down Overhead Activity

Sitting Standing Walking Working Other: \_\_\_\_\_

**Pain is alleviated by what:** (example: heat, ice, meds, massage, nothing)

\_\_\_\_\_

**Daily Activities are limited by how many percent:** \_\_\_\_\_% (In increments of 10)

**Do you have difficulty sleeping?** Yes / No (circle one)

**Are you depressed?** Yes / No (circle one)

**Goals:** (circle all that apply)

Decrease medications Decrease pain Increase physical activities

Return to sports Return to work Return to school

**Is there anything else you would like the doctor to know?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have read the above Health History and have made any necessary changes to the information.

This information is correct to the best of my knowledge. \_\_\_\_\_

**Signature**

**Today's Date:** \_\_\_\_\_

TO OUR PATIENTS:

BECAUSE ALL OF OUR PAIN MANAGEMENT PROCEDURES ARE PERFORMED IN A SURGERY CENTER, YOU MAY BE REFERRED TO THE NEWPORT COAST SURGERY CENTER, LP. NEWPORT COAST SURGERY CENTER, LP IS A CALIFORNIA CORPORATION IN WHICH YOUR DOCTOR MAY HAVE A BENEFICIAL INTEREST.

WE FEEL THAT VERY QUALIFIED AND COMPETENT MEDICAL SERVICES AND PROCEDURES ARE PROVIDED BY THIS FACILITY. HOWEVER, YOU HAVE THE ABSOLUTE RIGHT TO USE AN ALTERNATIVE FACILITY OF YOUR CHOICE. YOU ARE NOT OBLIGATED TO USE THE FACILITY, AND WE WILL BE HAPPY TO DISCUSS OTHER FACILITIES WHICH PROVIDE THE SAME MEDICAL PROCEDURES AND SERVICES.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT AND THAT ANY QUESTIONS I HAVE CONCERNING THE ABOVE MATTER HAVE BEEN ANSWERED.

DATE: \_\_\_\_\_ PATIENT SIGNATURE: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL RECORDS INFORMATION:**

I HEREBY IRREVOCABLY ASSIGN THE INSURANCE BENEFIT PAYMENT, BOTH BASIC AND MAJOR MEDICAL, TO WHICH I AM ENTITLED DIRECTLY TO THE DOCTOR RENDERING SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THE INSURANCE COMPANY. A PHOTOSTAT OF THIS AUTHORIZATION IS ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL. I HEREBY AUTHORIZE THE DOCTOR RENDERING SERVICE TO RELEASE ANY INFORMATION REQUIRED, IN THE COURSE OF MY EXAMINATION OR TREATMENT.

DATE: \_\_\_\_\_ PATIENT SIGNATURE: \_\_\_\_\_

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**PLEASE DO NOT WRITE BELOW THIS LINE**

**C-SPINE**

**L-SPINE**

ROM: \_\_\_\_\_  
RANGE OF MOTION R: \_\_\_\_\_ L: \_\_\_\_\_  
SENSORY: \_\_\_\_\_  
REFLEX: \_\_\_\_\_  
MOTOR: \_\_\_\_\_  
PULSES: \_\_\_\_\_  
JAMAR: R: \_\_\_\_\_ L: \_\_\_\_\_

ROM: \_\_\_\_\_  
(EXT 30, LAT 35)  
SENSORY: \_\_\_\_\_  
REFLEX: \_\_\_\_\_  
MOTOR: \_\_\_\_\_  
PULSES: \_\_\_\_\_  
SLR: R: \_\_\_\_\_ L: \_\_\_\_\_

(SIT 90, SUPINE 60)  
(BAVINSKY, HOOVER, KERNIG)  
GAIT (NON-ANTALAGIC)  
SQUAT / HEEL/TOE WALKING

**CIRCUMFERENCE**

R      L

R      L

ARM (6") \_\_\_\_\_  
FOREARM (3") \_\_\_\_\_

THIGH (9") \_\_\_\_\_  
CALVES (4") \_\_\_\_\_