Pikes Peak Spine & Joint
3604 Galley Rd. Suite 202
719-602-3394

New Patient Questionnaire

Personal Information

Patient Name: ____ **Male / Female**

Date of birth: ____ / ____ / _____ **Age**: _______ **Primary Language**: _______________________

Phone number: ___________________ Cell/ Home **E-mail**: _______________________________

Home address: ____

1. Who is your primary physician? ____

2. Do you have special needs in any of the following areas?
   - Reading
   - Vision
   - Hearing
   - Mobility (e.g., wheelchair, walker)
   - Communication (e.g., need for a translator)

3. What is/was your occupation? _________________________________
   - Full-time
   - Part-time
   - At home/homemaker
   - Disabled
   - Retired
   - Looking
   - Student, school: _________________________

   Present place of work: __________________________________

4. What is the highest grade in school you completed? ____________________________________

5. Do you smoke?
   ___ Not at all ___ less than ½ pack per day ___ ½ - 1 pack per day ___ 1-2 packs per day
   ___ 2 or more packs per day ___ Cigars ___ Marijuana use ___ Vape
   ___ In the past. How many years ago did you quit? ______________

6. Do you drink alcohol?
   ___ No ___ In the past ___ Yes, how many drinks per week? _________

7. Do you, or have you ever used recreational drugs?
   ___ No ___ Yes, please describe: _______________________________________

8. Do you get regular exercise?
   ___ No ___ Yes, what kind of exercise? _________________________________
   How often? ____

9. List any hobbies or leisure activities: ____

10. Have you ever had psychological or psychiatric treatment? Yes / No

11. Are you married?
    ___ Single ___ Long-term partner ___ Married ___ Divorced/Separated ___ Widowed

12. Do you live with:
    ___ Alone ___ Husband/wife ___ Children ___ Husband/wife & children
    ___ Other relatives ___ Friend(s)/roommates ___ Other: _____________________

Allergies
List medication allergies and the type of reaction you had. ☐ **I have no drug allergies.**

____________________________________ ____________________________________

____________________________________ ____________________________________

Medications
List with doses. Include contraceptives, vitamins, supplements, etc. Attach a list if needed.

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

Your Medical Conditions (check all that apply)

___ Allergies
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Blood transfusion
___ Cancer
___ Clotting disorder
___ Congestive heart failure
___ Depression
___ Diabetes mellitus
___ Emphysema/COPD
___ Gastroesophageal reflux disease (GERD)
___ Glaucoma
___ Heart murmur
___ HIV/AIDS
___ High cholesterol
___ Hypertension/ high blood pressure
___ Kidney disease
___ Myocardial infarction
___ Nerve/muscle disease
___ Osteoporosis
___ Seizures
___ Sickle cell anemia
___ Substance abuse
___ Thyroid disease
___ Tuberculosis

Surgical History (check all that apply)

___ Appendectomy
___ Brain surgery
___ Breast surgery
___ CABG
___ Cholecystectomy
___ Colon surgery
___ Tonsillectomy
___ Appendectomy
___ Thyroid surgery
___ Lung surgery
___ C-section
___ Eye surgery
___ Fracture surgery
___ Hernia repair
___ Hysterectomy
___ Joint surgery
___ Bunionectomy
___ Varicose vein surgery
___ Prostate surgery
___ Weight reduction surgery
___ Small intestine surgery
___ Tubal ligation
___ Valve replacement
___ Vasectomy
___ Vascular surgery
___ Cardiac stent
___ Bladder surgery
___ **Spine surgery**
Specify: ______________________

Family History (check all that apply)

	Substance abuse	Spine problems	Diabetes	Heart attack	High blood pressure	Cancer	Kidney disease	Mental illness	Other
Mother									
Father									
Sister									
Brother									
Daughter									
Son									

Gynecological and Obstetric History

How many times have you been pregnant? _______ Live births? _____ Miscarriages? _____
Do you use contraception? No / Yes, what kind? ____________________________________
Any chance that you could be pregnant? No / Yes, estimated date of delivery: ________________________

Other Health Issues

1. Do you feel unsafe, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter? No / Yes, describe: ____

2. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed or when you have lost all interest or pleasure in things that you usually care about or enjoyed? No / Yes, describe:
____

3. In the past year, have you had any major life changes or stresses that you feel have impacted your overall health? No / Yes, describe: ____
____

Review of systems: (circle any that apply)

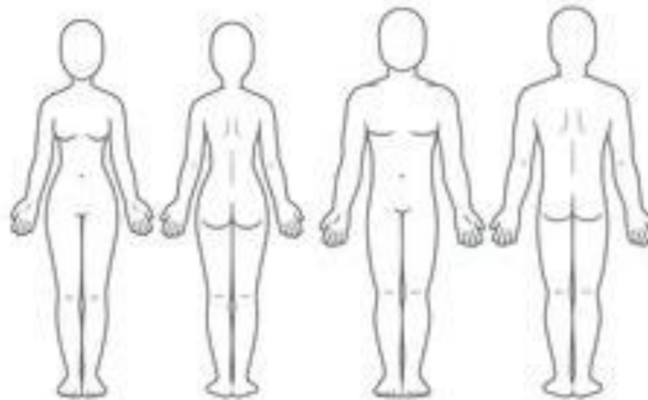
Fever
Weight loss/gain
Fatigue
Blurred vision
Double vision
Peripheral edema
Chest pain
Shortness of breath
Cough
Loss of control of bowel function
Constipation
Change in appetite
Loss of control of bladder function
Burning with urination
Blood in urine
Joint swelling
Joint stiffness
Muscle spasms
Rashes
Loss of hair
Itching
Headaches
Numbness
Tremors
Mood changes
Trouble sleeping
Memory changes
Excessive thirst
Excessive sweating
Bleeding/bruising problems

Pain Questionnaire

1. Where is your pain **located**? (Circle all that apply)

Low back	Right buttock	Right shoulder
Middle back	Left thigh	Left arm
Upper back	Right thigh	Right arm
Neck	Left calf	Left hand/wrist
Chest	Right calf	Right hand/wrist
Abdomen	Left ankle/foot	Head
Groin	Right ankle/foot	Face
Left buttock	Left shoulder	Other: ____________

2. Please indicate on the diagrams below where your pain occurs by **shading** the painful areas.



3. Use the following rating scale to indicate how severe your pain is at its worst, at its least severe, and as it usually is. (circle the appropriate number).

At its **WORST**	No pain	0	1	2	3	4	5	6	7	8	9	10	Unbearable Pain
At its **LEAST** severe	No pain	0	1	2	3	4	5	6	7	8	9	10	Unbearable Pain
As it **USUALLY** is	No pain	0	1	2	3	4	5	6	7	8	9	10	Unbearable Pain
Your pain **NOW**	No pain	0	1	2	3	4	5	6	7	8	9	10	Unbearable Pain

4. Would you **describe** your pain as: (circle all that apply)

Burning	Sharp	Aching
Shooting	Dull	Throbbing

Other: _________________

5. Does your pain **travel** anywhere? (e.g., down your leg/arm) No / Yes
   If yes, where? ____

6. Which statement **best** describes your pain? (Circle the appropriate letter A - H)

   A. Always present, always the same intensity.

   B. Always present, the intensity varies.

   C. Usually present, but have short periods without pain.

D. Often present, but have pain free periods lasting for one to several hours.

E. Often present, but I am pain free for most of the day.

F. Occasionally present, have pain once to several times a day lasting a few minutes to one hour

G. Occasionally present for brief periods, a few seconds to a few minutes.

H. Rarely present, have pain every few days or weeks.

7. What **time** of day is your pain at its worst? (Check all that apply)

___ Morning on arising
___ Later in the morning
___ Afternoon
___ Evening
___ Bedtime
___ Night (during usual sleep hours)
___ Pain is always the same
___ Pain varies

8. Do you have: (circle all that apply)

Numbness
Tingling
Weakness
Coldness
Increased swelling
Muscle spasm, tightness
Skin discoloration
Bowel or bladder trouble

9. Do any of the following make your pain **worse**? (circle all that apply)

Coughing/sneezing
Standing
Lying down
Sitting
Walking
Physical activity
Sexual activity
Other: _______________

10. Do any of the following make your pain **better**? (circle all that apply)

Relaxation
Heat
Lying down
Sexual activity
Sitting
Walking
Standing
Medications
Alcoholic drinks
Nothing makes me feel better
Other: __________________

11. Does your pain interrupt your **sleep**? (circle all that apply)

Not at all
Once per night
2 times per night
3 times per night
More than 3 times per night

12. When did you first notice the pain? Month __________ Day__________ Year__________

13. Have you ever been **hospitalized** for you pain? Yes / No

If yes, please list: Hospital Date admitted What was done?

____

14. Have you had any of the following to evaluate your present pain? (check all that apply)

___ X-rays
___ MRI
___ CT
___ Myelogram
___ EMG
___ Other: ______________

Where was the imaging done? ____

What were the results? ____

15. Have you had **surgery** specifically for your pain? No / Yes, please list:

Procedure	Hospital/facility	Date	Physician
___________________________	________________________________	________________	_____________________________________
___________________________	________________________________	________________	_____________________________________

16. Have you had **physical therapy** for your pain? Yes / No

Site of therapy: ____ Date: ______________________________

17. Have you had **previous injections** (epidural steroid injections, nerve blocks) for relief of your symptoms? No / Yes

Name of physician who performed injections: ______________________________________

If yes, did the injections relieve your pain? Yes / No

If yes, how long did the relief last? ___ less than a day ___ a few days ___ a few weeks ___ more than 1 month

18. Have you had any of the following specifically for relief of your present pain? If yes, did it relieve your pain?

	Done	Pain Relief
Hypnosis	Yes / No	Yes / No
Hormonal therapy	Yes / No	Yes / No
Bio-feedback	Yes / No	Yes / No
TENS (elec. Stim)	Yes / No	Yes / No
Heat therapy	Yes / No	Yes / No
Bed rest	Yes / No	Yes / No
Traction	Yes / No	Yes / No
Psychiatric therapy	Yes / No	Yes / No

19. Since your pain began, has it: ___ Increased ___ Decreased ___ Stayed the same

20. Do you take medications for pain relief?

___ No
___ 1-2 times/day
___ 3-4 times/day
___ More than 5 times/day
___ less than once a week
___ several times a week

21. If you take medications for your pain, do you take it:

___ When needed for pain ___ Regularly by the clock

22. On average, do the medication you take:

__ Always take the pain away
__ Usually take the pain away
__ Provide little relief
__ Always make the pain less
__ Usually make the pain less
__ Do not take pain medications

Motor Vehicle Accident Questionnaire

Have you been involved in an auto accident within the last 2 years? ____ YES ____ NO

Do you still have an open case? ___ YES ___ NO

****If you answered yes to the above question, please fill out form in its entirety****

Date of Accident: ____

Was the accident your fault? ______ YES ______ NO

YOUR AUTO INSURANCE INFORMATION:

Company____

Adjuster Name ____

Adjuster Phone # ____

Adjuster Email ____

Claim # ____

PARTY WHO CAUSED ACCIDENT (3rd Party Information): (if known)

Company: ____

Adjuster Name ____

Adjuster Phone # ____

Adjuster Email ____

Claim # ____

ATTORNEY INFORMATION:

Attorney Name ____

Attorney Group ____

Attorney Phone # ____

Attorney Email ____

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Please explain in detail how the injury happened: ____

____

____

____

____

When did you start experiencing symptoms? _______________________________________

List the extent of your injuries as you know them: ____

____

Did you require emergent care? _____ YES _____ NO

Name of Hospital or Urgent Care Clinic: ____

Have you ever had any complaints involved in the same area(s) before? _____ YES ____ NO

Please describe: ____

____

Were the police notified? ____ YES _____ NO

Was an accident report prepared? _____ YES _____ NO

Accident report number? ____

I hereby authorize payment to be made directly to Pikes Peak Spine & Joint, for all benefits which may be payable under the claims related to the subject accident. I authorization utilization of this application or copies thereof for the purpose of processing claims with the insurance carrier and effecting payments, and further acknowledge that this does not in any way relieve me of payment liability and that I will remain financially responsible to Pikes Peak Spine & Joint for any and all services I receive at this office as it relates to the subject accident. Our office will not accept your case if we do not believe your condition will respond satisfactorily to care and/or if you erroneously report the causation of injuries. We cannot bill your health insurance for treatment related to the auto accident.

____ _________________________

Patient Signature Date Signed