WellStar North Fulton Hospital
Pain & Spine Center New Patient Questionnaire

Patient Name ____ Today's Date _____________________

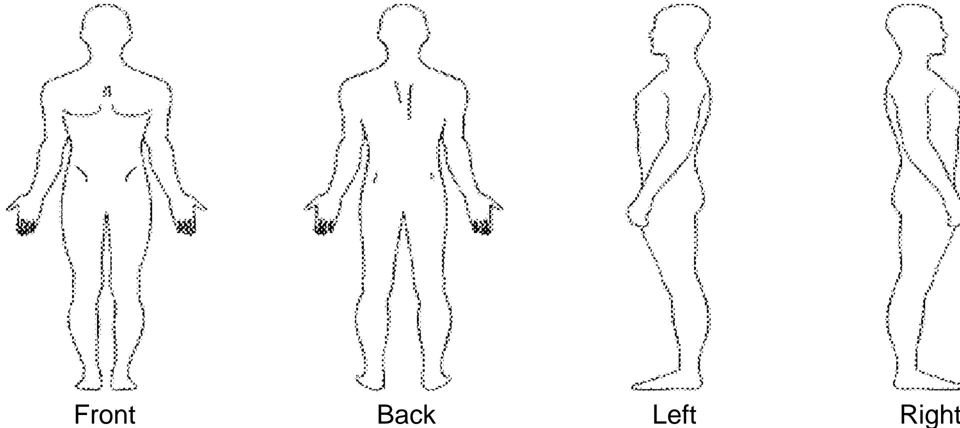
Birthdate _______________________________ Age ____________

Referring Doctor ____

Internist / Family Doctor ____

Chiropractor ____

On the diagram below, please indicate where you are experiencing pain right now.



Circle the level that your pain has been in the past few days

	No Pain									Severe (ER Visit)
Average	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Worst	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

PREVIOUS TREATMENTS

Since your pain began, circle the treatments below that you have tried. Circle Yes or No if the treatment helped and the date you tried the treatment.

TREATMENT	HELPED?	DATE	TREATMENT	HELPED?	DATE
Acupuncture	Yes / No		Ibuprofen / Motrin / Aleve	Yes / No	
Biofeedback	Yes / No		Ice packs	Yes / No	
Chiropractic	Yes / No		Massage	Yes / No	
Heating pad	Yes / No		Physical Therapy	Yes / No	
Injection: Epidural	Yes / No		Spinal Cord Stimulator	Yes / No	
Injection: Trigger point	Yes / No		TENS Unit	Yes / No	
Injection: Other	Yes / No		Traction	Yes / No	
Injection: Ablation / RFL	Yes / No		Other ___________________	Yes / No	

Over the last 2 weeks, how often have you been bothered by the following:

- Little interest in doing things
  r Not at all r Several days r More than half the days r Nearly every day
- Feeling down, depressed, or hopeless
  r Not at all r Several days r More than half the days r Nearly every day

Patient Name:____ Date of Birth: ________________________

Are you taking any BLOOD THINNERS? ○ Yes ○ No If Yes, please list: ______________________________

Allergy to contrast: ○ Yes ○ No **Allergy to steroids:** ○ Yes ○ No

REVIEW OF SYSTEMS Please circle any recent problems you have had.

Constitutional: • Difficulty sleeping • Fever • Unexplained weight loss

Allergy / Immunology: • Congestion • Swollen lymph glands

Eyes: • Itching / redness • Vision changes

ENT: • Difficulty swallowing • Sore throat

Integumentary: • Hives • Itching • Skin wounds / lesions

Cardiovascular: • Chest pain • Palpitations • Swelling in legs or feet

Respiratory: • Cough • Shortness of breath at rest • Wheezing

Gastrointestinal: • Acid reflux • Constipation • Diarrhea

Genitourinary: • Difficulty urinating • Incontinence of urine

Musculoskeletal: • Joint Stiffness • Muscle spasms • Weakness

Neurological: • Dizziness • Tingling / numbness • Tremor

Psychiatric: • Anxiety • Depression • Loss of appetite • Suicidal Thoughts

Hematology: • Easy bruising • Prolonged bleeding

Other: ____

Do you have intranasal naloxone (Narcan) at home? ○ Yes ○ No

MEDICAL HISTORY

❑ Abnormal ECG	❑ Concussion	❑ Headaches	❑ Pancreatitis
❑ Alcoholism	❑ Conversion Disorder	❑ Hepatitis	❑ Psychosis
❑ Anemia	❑ COPD	❑ History of Blood Transfusion	❑ Pulmonary Artery Hypertension
❑ Aneurysm	❑ Coronary Artery Disease	❑ HIV/AIDS	❑ PVD
❑ Anxiety	❑ Deep Vein Thrombosis	❑ Hyperlipidemia	❑ Rheumatoid Arthritis
❑ A-V Malformation	❑ Depression	❑ Hypertension	❑ Schizophrenia
❑ Bipolar Disorder	❑ Diabetes Mellitus	❑ Kidney Disease	❑ Seizures
❑ Cancer	❑ Disc problem - Cervical	❑ Liver Disease	❑ Sickle Cell Anemia
❑ Carotid Disease	❑ Disc problem - Lumbar	❑ Low Back Pain	❑ Sleep Apnea
❑ CHF	❑ Disc problem - Thoracic	❑ Myocardial Infarction	❑ Stroke
❑ Cirrhosis	❑ Fatigue	❑ Neuropathy	❑ Substance Abuse
❑ Clotting Disorder	❑ Fibromyalgia	❑ Osteoarthritis	❑ TIA

Other Medical History: ____

____

____

Patient Name:____ Date of Birth: _________________________

SURGICAL HISTORY

Surgery	Date		Surgery	Date

SIGNIFICANT FAMILY HISTORY

Mother	
Father	
Siblings	

Do you drink alcohol? Yes / No Circle: Wine / Beer / Shots of Liquor How many per week? __________________

Do you use any recreational drugs? Yes / No Please list: ____

Tobacco use: Current / Former / Never Packs per day ________ Number of years ________ Quit Date __________

Smokeless Tobacco use: Current / Former / Never Quit Date __________

Have you traveled outside the United States in the past 21 days? Yes / No

If Yes, where? ______________________________

Common Opioid Misuse Measure (COMM)

Please answer ALL of the following questions if you are taking an Opioid or Narcotic.
Examples: Oxycodone, Hydrocodone, Oxycontin, Tramadol, Percocet, Lortab, Methadone

1. **In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?**
   0 = Never 1 = Seldom 2 = Sometimes 3 = Often
2. **In the past 30 days, how often have people complained that you have not completed necessary tasks?**
   0 = Never 1 = Seldom 2 = Sometimes 3 = Often
3. **In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications (i. e. another doctor, the emergency room, friends, street sources)?**
   0 = Never 1 = Seldom 2 = Sometimes 3 = Often
4. **In the past 30 days, how often have you taken your medications differently from how they were prescribed?**
   0 = Never 1 = Seldom 2 = Sometimes 3 = Often
5. **In the past 30 days, how often have you seriously thought about hurting yourself?**
   0 = Never 1 = Seldom 2 = Sometimes 3 = Often

Patient Name:____ Date of Birth: _________________________

Common Opioid Misuse Measure (COMM) continued

6. **In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?**
   0 = Never 1 = Seldom 2 = Sometimes 3 = Often
7. **In the past 30 days, how often have you been in an argument?**
   0 = Never 1 = Seldom 2 = Sometimes 3 = Often
8. **In the past 30 days, how often have you had trouble controlling your anger (e.g. road rage, screaming, etc.)?**
   0 = Never 1 = Seldom 2 = Sometimes 3 = Often
9. **In the past 30 days, how often have you needed to take pain medications belonging to someone else?**
   0 = Never 1 = Seldom 2 = Sometimes 3 = Often
10. **In the past 30 days, how often have you been worried about how you're handling your medications?**
    0 = Never 1 = Seldom 2 = Sometimes 3 = Often
11. **In the past 30 days, how often have others been worried about how you're handling your medications?**
    0 = Never 1 = Seldom 2 = Sometimes 3 = Often
12. **In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?**
    0 = Never 1 = Seldom 2 = Sometimes 3 = Often
13. **In the past 30 days, how often have you gotten angry with people?**
    0 = Never 1 = Seldom 2 = Sometimes 3 = Often
14. **In the past 30 days, how often have you had to take more of your medication than prescribed?**
    0 = Never 1 = Seldom 2 = Sometimes 3 = Often
15. **In the past 30 days, how often have you borrowed pain medication from someone else?**
    0 = Never 1 = Seldom 2 = Sometimes 3 = Often
16. **In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g. to help you sleep, improve your mood, or relieve stress)?**
    0 = Never 1 = Seldom 2 = Sometimes 3 = Often
17. **In the past 30 days, how often have you had to visit the Emergency Room?**
    0 = Never 1 = Seldom 2 = Sometimes 3 = Often

_______________________________________ ______________ ______________ AM / PM
Patient Signature Date Time

Reviewed by:

_______________________________________ ______________ ______________ AM / PM
Nurse Signature Date Time