New Patient Questionnaire with ODI and NDI

Demographics

Name: _____ DOB: _____ Age: _____
Social Security #: _____ Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Cell Phone: _____ Email: _____
Emergency Contact: _____ Relationship to Insured: _____
Phone Number: _____
Insurance Type: _____ Insurance Company Name: _____
Insurance ID #: _____
Employment Status (Circle one): Full Time Part Time Disabled Retired Unemployed

Care Information

Pharmacy: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Referring Physician (if different from PCP): _____
Specialty: _____ Address: _____
City: _____ State: _____ Zip: _____
Primary Care Physician (PCP): _____
Address: _____ City: _____
State: _____ Zip: _____
Other Physician (if requesting report): _____
Address: _____ City: _____
State: _____ Zip: _____

Present Illness

1. What is the reason for your visit today? _____
2. What symptoms are you currently experiencing? _____
_____
3. How long have you had these symptoms? _____
4. How often do the symptoms occur? _____
5. How severe are the symptoms on a scale of 0 (no pain) to 10 (worst imaginable)?
0 1 2 3 4 5 6 7 8 9 1 0
6. Does anything make the problem better? Yes No Explain _____
_____
7. Does anything make the problem worse? Yes No Explain _____
_____
8. Have you had previous treatment for the problem? Yes (please circle below) No
PT Injections Pain Management Chiropractic Acupuncture Previous Surgery
other _____
9. Is this a Worker's Compensation Case? Yes No Case/insurance info: _____
_____
10. Is this a result of a Motor Vehicle Accident? Yes No Case/Insurance info: _____
_____
11. Is this a Medical Malpractice case? Yes No Case/Insurance info: _____
_____

Over

Past Medical History

Please carefully check the medical problem or major illness you have or have had. Please include approximate dates.

Medical Problem	Date
Cardiovascular:	
☐ Arrhythmia/A-fib	
☐ Congestive heart failure	
☐ Coronary artery disease	
☐ High cholesterol	
☐ Hypertension (high blood pressure)	
☐ Lower extremity edema	
☐ Mitral/ Aortic valve disease	
☐ Myocardial Infarction (heart attack)	
☐ Stroke/CVA/TIA	
Endocrine	
☐ Diabetes	
☐ Hyper/Hypothyroidism	
Ear-Nose-Throat	
☐ Hearing loss	
Eyes	
☐ Glaucoma	
Gastrointestinal	
☐ Diverticulitis	
☐ Gastritis (stomach inflammation)	
☐ GERD (acid reflux)	
☐ Irritable bowel syndrome	
☐ Peptic ulcer disease	
Hematological	
☐ Anemia	
☐ Bleeding Disorder	
☐ DVT/Pulm. Embolism	
Immunological	
☐ Arthritis	
☐ HIV/AIDS	
Kidney	
☐ Kidney disease	
☐ Kidney stones	
Liver	
☐ Hepatitis/Liver disease	
Musculoskeletal	
☐ Back pain	
☐ Herniated invertebral disk	
☐ Myopathy (muscular disease)	
☐ Neck pain	
☐ Osteoporosis (bone disease)	
☐ Scoliosis (curvature of the spine)	
☐ Spine disorder	
☐ Spine tumor	
☐ Stenosis (cervical/lumar) (narrowing)	
Neurological	
☐ Alzheimer's disease	
☐ Carpal tunnel	
☐ Carotid stenosis	
☐ Epilepsy/seizure	
☐ Hydrocephalus (congenital)/normal pressure hydrocephalus	
☐ Intracranial aneurysm	
☐ Migraine/Headaches	
☐ Multiple sclerosis	
☐ Neuropathy (nerve damage)	
☐ Parkinson's (movement disorder)	
☐ Pseudomeningocele (CSF leak)	
☐ Pseudotumor cerebri (false brain tumor)	
☐ Shunt infection/Malfunction	
☐ Sinus thrombosis	
Psychological	
☐ ADD/ADHD	
☐ Anxiety	
☐ Depression	
Respiratory	
☐ Asthma, COPD (lung disease)	
☐ Pneumonia	
☐ Sleep apnea	
Urinary	
☐ Self-catheterization (urinary)	
Other	
☐ Cancer (Type:)	
☐ Chronic Pain	
☐ Lyme Disease	
☐ Other:	
☐ Other:	
☐ Other:	

Over

Past Surgical History

Please list all surgeries in lifetime, including name and date.

Surgery	Date	Surgery	Date

Diagnostic Imaging (circle all that apply)

X-Ray CT MRI EMG

Do you take Aspirin, any medicines that contain Aspirin, Ibuprofen, Advil, or Motrin? Yes No

If yes, please list last date taken: _____

Do you take any blood thinners such as Plavix, Coumadin, Lovenox or others? Yes No

If yes, please list last date taken: _____

Over

Family History

If you have any relatives, including children, with serious medical conditions (such as asthma, high blood pressure, heart attacks, kidney problems, diabetes, seizures, strokes, cancers, etc.) please list below.

Family Member	Age (or age at death)	Living = [L] or Deceased = [D]	Medical Condition(s)
Mother			
Father			
Sibling (Sister)			
Sibling (Brother)			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Child(ren)			

Social History

Gender: Male Female **Height:** ____feet ____inches **Weight:** ____lbs. **Birthplace:** _____

Education: High School Vocational School College Graduate Degree

Current Occupation: _____

Marital Status: Single Married Separated Divorced Widowed

Living Arrangement: Alone Roommate(s) Spouse Children Parent(s) Sibling(s)

Alcohol Use: Yes No Drinks/week: _____ Beer Wine Liquor # of years: _____

Tobacco Use: Yes No # Packs/day: _____ # of years: _____ Ready to quit? Yes No

Counseling given? Yes No *If Previous Smoker Year quit: _____ # Packs/day: _____

Substance Use: Yes No Type of Drug(s): _____

Amount Used/Week: _____

Over

Medication List*

Update and give a copy of this list to the patient with each outpatient visit. *Do not use abbreviations.*

☐ Patient taking no medications regularly and none in the past 72 hours.

Medications Nombre del medicamento (including over the counter and herbal medications)	**Dose** Dosis (ex: strength, #of pills or drops)	**Route** Ruta de medicación (ex: by mouth, inhaled, on skin)	**Frequency** Frequencia (how often)

Allergy Information

Drug Allergy

Drug Name	Reaction	Date

Food Allergy

Food	Reaction	Date

* *If you have questions about any of your medications, please contact the person who perscribed them.*

Reviewed by: _____ Date / Time: _____

(Name and credentials of health care provider)

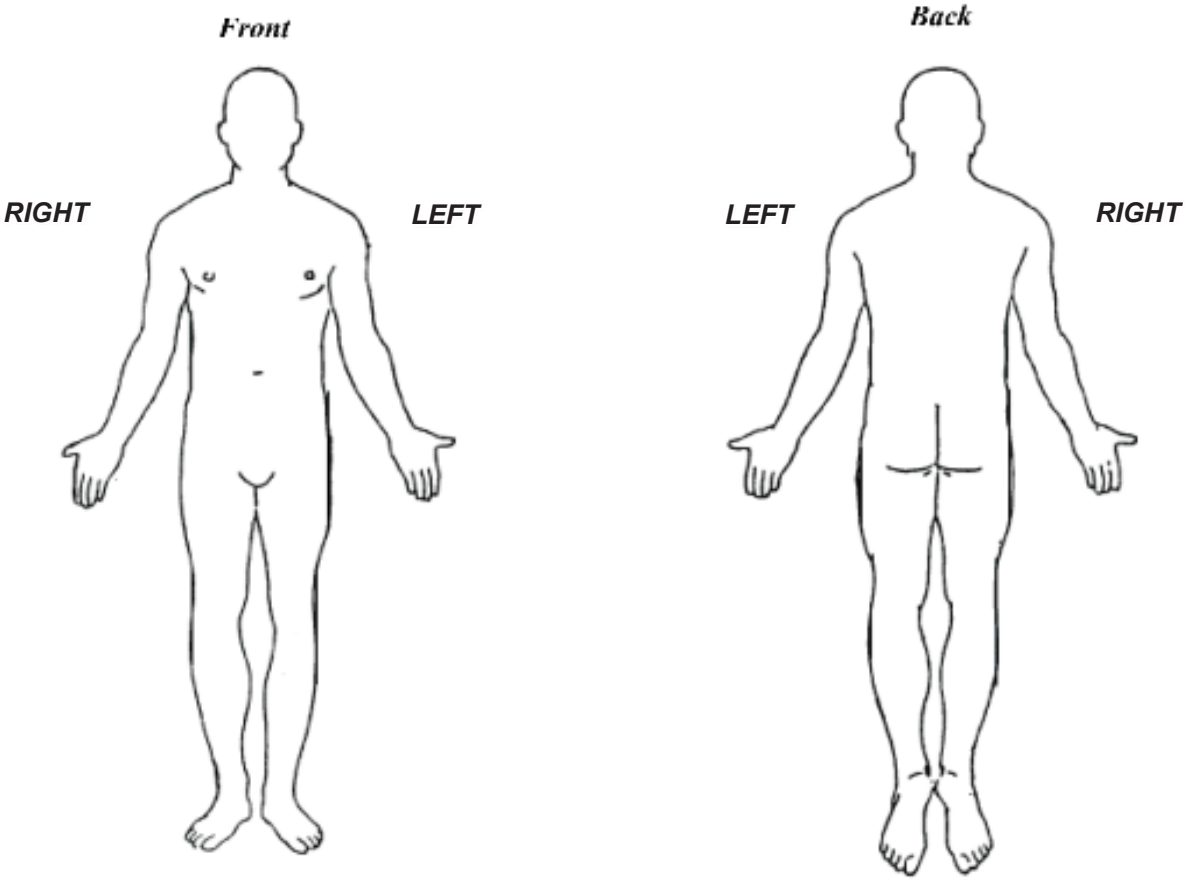
Over

Pain Drawing

Where is your pain now?

Mark the areas on your body where you feel the described discomfort using the appropriate symbols.

Ache ^^ Numbness **00** Pins & Needles **||** Burning **XX** Radiating Pain: **//**



Please rate your Back Pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Pain

Please rate your Leg Pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Pain

Please rate your Neck Pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Pain

Please rate your Arm Pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Pain

Over

Name: _____

Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday-life activities. In each section below, please carefully circle ONE number that describes your pain. Although you may consider that two of the statements in any one section relates to you, please circle only ONE number that most closely describes your current situation.

Section 1 – PAIN INTENSITY

0. I have no neck pain at this moment.
1. The pain is mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain severe at the moment.
5. The pain is the worst imaginable at the moment.

Section 2 – PERSONAL CARE

0. I can look after myself normally without causing extra neck pain.
1. I can look after myself normally, but it causes extra neck pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but can manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – LIFTING

0. I can lift heavy weights without extra neck pain.
1. I can lift heavy weights, but it gives extra neck pain.
2. Neck pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table.
3. Neck pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – WORK

0. I can do as much work as I want.
1. I can do only my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Section 5 – HEADACHES

0. I have no headaches at all.
1. I have slight headaches that come infrequently.
2. I have moderate headaches that come infrequently.
3. I have moderate headaches that come frequently.
4. I have severe headaches that come frequently.
5. I have headaches almost all of the time.

Section 6 – CONCENTRATION

0. I can concentrate fully without difficulty.
1. I can concentrate fully with slight difficulty.
2. I have a fair degree of difficulty concentrating.
3. I have a lot of difficulty concentrating.
4. I have a great deal of difficulty concentrating.
5. I cannot concentrate at all.

Section 7 – SLEEPING

0. I have no trouble sleeping.
1. My sleep is slightly disturbed for less than 1 hour
2. My sleep is mildly disturbed for less than 1-2 hours.
3. My sleep is moderately disturbed for up to 2-3 hours.
4. My sleep is greatly disturbed for up to 5 hours.
5. My sleep is completely disturbed for up to 5-7 hours.

Section 8 – DRIVING

0. I can drive my car without neck pain.
1. I can drive my car with only slight neck pain.
2. I can drive as long as I want with moderate neck pain.
3. I cannot drive as long as I want because of moderate neck pain.
4. I can hardly drive at all because of severe neck pain.
5. I cannot drive at all because of neck pain.

Neck Disability Index

Please circle ONE number in each section which most closely describes your problem.

Section 9 – READING

0. I can read as much as I want with no neck pain.
1. I can read as much as I want with slight neck pain.
2. I can read as much as I want with moderate neck pain.
3. I can't read as much as I want because of moderate neck pain.
4. I can't read as much as I want because of severe neck pain.
5. I cannot read at all.

Section 10 – RECREATION

0. I am able to engage in all recreational activities with no neck pain.
1. I am able to engage in all my recreational activities with some neck pain.
2. I am able to engage in most, but not all of my recreational activities because of pain in my neck.
3. I am able to engage in a few of my recreational activities because of neck pain.
4. I can hardly do recreational activities due to neck pain.
5. I cannot do any recreational activities due to neck pain.

Name: _____

Oswestry Low Back Pain Scale - Please Complete if You Have Back Pain

Please carefully circle ONE number in each section which most closely describes your problem.

Section 1 - PAIN INTENSITY

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – PERSONAL CARE

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain, I am unable to do some washing and dressing without help.
5. Because of the pain, I am unable to do any washing and dressing without help.

Section 3 – LIFTING

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – WALKING

0. I have no pain with walking.
1. I have some pain with walking, but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without in creasing pain.
5. I cannot walk at all without increasing pain.

Section 5 - SITTING

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 - STANDING

0. I can stand as long as I want without pain.
1. I have some pain with standing, but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes
5. I avoid standing because it increases pain immediately.

Section 7 – SLEEPING

0. I get no pain in bed.
1. I get pain in bed, but it does not prevent me from sleeping well.
2. Because of my pain, my normal night's sleep is reduced by less than ¼.
3. Because of my pain, my normal night's sleep is reduced by less than ½.
4. Because of my pain, my normal night's sleep is reduced by less than ¾.
5. Pain prevents me from sleeping at all.

Oswestry Low Back Pain Scale - Please Complete if You Have Back Pain

Please circle ONE number in each section which most closely describes your problem.

Section 8 - SOCIAL LIFE

0. My social life is normal and gives me no pain.
1. My social life is normal, but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I hardly have any social life because of the pain.

Section 9 - TRAVELING

0. I get no pain when traveling.
1. I get some pain when traveling, but it does not compel me to seek alternate forms of travel.
2. I get extra pain when traveling, but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling, which compels me to seek alternate forms of travel.
4. Pain restricts me to shorten necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 - CHANGING DEGREE OF PAIN

0. My pain is rapidly getting better.
1. My pain fluctuates, but is definitely getting better.
2. My pain seems to be getting better, but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Revised 07/28/22