

## New Patient Questionnaire

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

EVALUATION TYPE: **NEW PATIENT APPOINTMENT**

CHIEF COMPLAINT: \_\_\_\_\_

HPI: **SEE MEDICAL HISTORY**

### Myelopathy Screening

Difficulty w/ balance: YES NO      Difficulty walking/climbing stairs: YES NO      Difficulty w/ dark: YES NO  
Difficulty w/ coins: YES NO      Difficulty w/ buttons: YES NO      Difficulty stopping/starting urination: YES NO  
Urinary urgency/frequency: YES NO      Frequently drops objects: YES NO      Changes in bowel: YES NO  
Groin numbness: YES NO      Burning on soles of feet: YES NO      Cramping in arms/legs: YES NO

### Neck Symptoms

Neck Pain Scale 1-10: \_\_\_\_\_

LOCATION: (whole neck) (upper neck) (mid neck) (lower neck) (both sides) (right side) (left side)  
(with headaches) (across **both** shoulders) (across **right** shoulder) (across **left** shoulder)

DESCRIPTION: (electrical) (sharp) (aching) (cramping) (throbbing) \_\_\_\_\_

HOW OFTEN: (constant **AND**: sometimes better/worse) (comes and goes) (every day) (\_\_\_\_ days/week)

MADE BETTER BY: (changing activity) (changing positions) (looking up) (looking down) (applying heat)

(applying ice) \_\_\_\_\_ medications to include: \_\_\_\_\_

MADE WORSE BY: (activity) (computer work) (driving) (looking up) (looking down) (overhead activity)

(housework) (turning your head to the: right left) \_\_\_\_\_

SLEEP DISTURBANCE: (none) (every night) (\_\_\_\_ nights per week)

TIME OF DAY INCREASED: (not related to time of day) (more related to activity) (morning) (evening)

(worse in the morning, better at mid-day and worse again in the evening)

## Right Arm Symptoms

**PAIN** Right Arm Pain Scale 1-10: \_\_\_\_\_

LOCATION: (entire arm) (shoulder) (trapezius) (entire upper arm) (entire elbow) (entire forearm) (all fingers)  
 Upper arm: (front) (back) (inside-between arm and body) (outside)  
 Elbow: (front) (back) (inside-between arm and body) (outside)  
 Forearm: (top) (bottom) (thumb side) (small finger side)  
 Hand: (wrist) (entire hand) (back of hand) (palm side)  
 Fingers: (all fingers) (thumb) (index) (middle) (ring) (small)

DESCRIPTION: (electrical) (sharp) (aching) (cramping) (throbbing) \_\_\_\_\_

HOW OFTEN: (constant **AND**: sometimes better/worse) (comes and goes) (every day) (\_\_\_\_ days/week)

MADE BETTER BY: (activity modification) (changing positions) (limiting use of arm) (applying heat) (applying ice)

\_\_\_\_\_ medications to include: \_\_\_\_\_

MADE WORSE BY: (activity) (computer work) (driving) (using arm) (overhead activity) (housework)

(turning your head to the: right left) \_\_\_\_\_

SLEEP DISTURBANCE: (none) (every night) (\_\_\_\_ nights per week)

TIME OF DAY INCREASED: (not related to time of day) (more related to activity) (morning) (evening)

(worse in the morning, better at mid-day and worse again in the evening)

## NUMBNESS/TINGLING

LOCATION: (entire arm) (shoulder) (trapezius) (entire upper arm) (entire elbow) (entire forearm) (all fingers)  
 Upper arm: (front) (back) (inside-between arm and body) (outside)  
 Elbow: (front) (back) (inside-between arm and body) (outside)  
 Forearm: (top) (bottom) (thumb side) (small finger side)  
 Hand: (wrist) (entire hand) (back of hand) (palm side)  
 Fingers: (all fingers) (thumb) (index) (middle) (ring) (small)

HOW OFTEN: (constant **AND**: sometimes better/worse) (comes and goes) (every day) (\_\_\_\_ days/week)

MADE BETTER BY: (nothing) (shaking your arm) (changing positions) (massage) \_\_\_\_\_

MADE WORSE BY: (nothing) (computer work) (driving) (holding a telephone) \_\_\_\_\_

SLEEP DISTURBANCE: (none) (every night) (\_\_\_\_ nights per week)

## WEAKNESS

NONE YES: Entire Arm Grip

## Left Arm Symptoms

**PAIN**                      **Left Arm Pain Scale 1-10:** \_\_\_\_\_

LOCATION: (entire arm) (shoulder) (trapezius) (entire upper arm) (entire elbow) (entire forearm) (all fingers)  
 Upper arm: (front) (back) (inside-between arm and body) (outside)  
 Elbow: (front) (back) (inside-between arm and body) (outside)  
 Forearm: (top) (bottom) (thumb side) (small finger side)  
 Hand: (wrist) (entire hand) (back of hand) (palm side)  
 Fingers: (all fingers) (thumb) (index) (middle) (ring) (small)

DESCRIPTION: (electrical) (sharp) (aching) (cramping) (throbbing) \_\_\_\_\_

HOW OFTEN: (constant **AND:** sometimes better/worse) (comes and goes) (every day) (\_\_\_\_ days/week)

MADE BETTER BY: (activity modification) (changing positions) (limiting use of arm) (applying heat) (applying ice)

\_\_\_\_\_ medication to include: \_\_\_\_\_

MADE WORSE BY: (activity) (computer work) (driving) (using arm) (overhead activity) (housework)

(turning your head to the: right left) \_\_\_\_\_

SLEEP DISTURBANCE: (none) (every night) ( \_\_\_\_\_ nights per week)

TIME OF DAY INCREASED: (not related to time of day) (more related to activity) (morning) (evening)

(worse in the morning, better at mid-day and worse again in the evening)

## NUMBNESS/TINGLING

LOCATION: (entire arm) (shoulder) (trapezius) (entire upper arm) (entire elbow) (entire forearm) (all fingers)  
 Upper arm: (front) (back) (inside-between arm and body) (outside)  
 Elbow: (front) (back) (inside-between arm and body) (outside)  
 Forearm: (top) (bottom) (thumb side) (small finger side)  
 Hand: (wrist) (entire hand) (back of hand) (palm side)  
 Fingers: (all fingers) (thumb) (index) (middle) (ring) (small)

HOW OFTEN: (constant **AND:** sometimes better/worse) (comes and goes) (every day) (\_\_\_\_ days/week)

MADE BETTER BY: (nothing) (shaking your arm) (changing positions) (massage) \_\_\_\_\_

MADE WORSE BY: (nothing) (computer work) (driving) (holding a telephone) \_\_\_\_\_

SLEEP DISTURBANCE: (none) (every night) ( \_\_\_\_\_ nights per week)

## WEAKNESS

NONE                      YES: Entire Arm    Grip

## Mid Back Symptoms (Between Shoulder Blades to Bottom of Ribs)

Mid Back Pain Scale 1-10: \_\_\_\_\_

LOCATION: (entire mid back) (upper mid back) (middle-mid back) (lower mid back)

(right side) (left side) (both sides) (right shoulder blade) (left shoulder blade)

DESCRIPTION: (pulling) (burning) (catching) (stabbing) (aching) (electrical) \_\_\_\_\_

HOW OFTEN: (constant **AND**: sometimes better/worse) (comes and goes) (every day) (\_\_\_\_ days/week)

MADE BETTER BY: (changing activity) (changing positions) (applying heat) (applying ice) (stretching)

\_\_\_\_\_ medication to include: \_\_\_\_\_

MADE WORSE BY: (activity) (computer work) (twisting) (bending forward) (lifting) \_\_\_\_\_

SLEEP DISTURBANCE: (none) (every night) (\_\_\_\_ nights per week)

TIME OF DAY INCREASED: (not related to time of day) (more related to activity) (morning) (evening)

(worse in the morning, better at mid-day and worse again in the evening)

## Low Back Symptoms (Below Ribs)

Low Back Pain Scale 1-10: \_\_\_\_\_

LOCATION: (entire low back) (upper low back) (mid-low back) (lower low back) (right side) (left side)

(upper buttocks) (bands across top of the buttocks) (SI joint: right left) (tailbone)

DESCRIPTION: (pulling) (burning) (stabbing) (spasms) (electrical) (sharp) (aching) \_\_\_\_\_

HOW OFTEN: (constant **AND**: sometimes better/worse) (comes and goes) (every day) (\_\_\_\_ days/week)

MADE BETTER BY: (changing activity) (changing positions) (bending over) (applying heat) (applying ice)

\_\_\_\_\_ medications to include: \_\_\_\_\_

MADE WORSE BY: (activity) (sitting) (standing) (bending over) (twisting) (walking) \_\_\_\_\_

SLEEP DISTURBANCE: (none) (every night) (\_\_\_\_ nights per week)

TIME OF DAY INCREASED: (not related to time of day) (more related to activity) (morning) (evening)

(worse in the morning, better at mid-day and worse again in the evening)

## Right Leg Symptoms

**PAIN** Right leg pain scale 1-10: \_\_\_\_\_

LOCATION: (entire leg-like a stocking) (hip) (buttock) (groin) (testicle) (knee down-like a stocking)  
 Thigh: (entire thigh) (front) (back) (inside-between legs) (outside)  
 Knee: (entire knee) (front) (back) (inside-between legs) (outside)  
 Lower leg: (entire lower leg) (front) (back) (inside-between legs) (outside)  
 Ankle: (entire ankle) (inside) (outside) (heel)  
 Foot: (entire foot) (inside) (outside) (top) (bottom)  
 Toes: (all toes) (big toe) (second) (middle) (fourth) (small)

DESCRIPTION: (pulling) (burning) (stabbing) (spasms) (electrical) (sharp) (aching) \_\_\_\_\_

HOW OFTEN: (constant **AND**: sometimes better/worse) (comes and goes) (every day) (\_\_\_\_ days/week)

MADE BETTER BY: (changing activity) (changing positions) (limiting use of leg) (applying heat) (applying ice)

\_\_\_\_\_ medications to include: \_\_\_\_\_

MADE WORSE BY: (walking) (sitting) (standing) (bending over) (twisting) (lying on side: right left)

SLEEP DISTURBANCE: (none) (every night) (\_\_\_\_ nights per week)

TIME OF DAY INCREASED: (not related to time of day) (more related to activity) (morning) (evening)

(worse in the morning, better at mid-day and worse again in the evening)

### NUMBNESS/TINGLING

LOCATION: (entire leg-like a stocking) (hip) (buttock) (groin) (testicle) (knee down-like a stocking)  
 Thigh: (entire thigh) (front) (back) (inside-between legs) (outside)  
 Knee: (entire knee) (front) (back) (inside-between legs) (outside)  
 Lower leg: (entire lower leg) (front) (back) (inside-between legs) (outside)  
 Ankle: (entire ankle) (inside) (outside) (heel)  
 Foot: (entire foot) (inside) (outside) (top) (bottom)  
 Toes: (all toes) (big toe) (second) (middle) (fourth) (small)

HOW OFTEN: (constant **AND**: sometimes better/worse) (comes and goes) (every day) (\_\_\_\_ days/week)

MADE BETTER BY: (changing positions) (limiting use of leg) (walking) \_\_\_\_\_

MADE WORSE BY: (nothing) (walking) (sitting) (standing) (lifting) (lying on side: right left)

SLEEP DISTURBANCE: (none) (every night) (\_\_\_\_ nights per week)

**WEAKNESS:** NONE All Activities Up Stairs Down Stairs Uneven Surfaces

## Left Leg Symptoms

**PAIN**                    **Left Leg Pain Scale 1-10:** \_\_\_\_\_

LOCATION: (entire leg-like a stocking) (hip) (buttock) (groin) (testicle) (knee down-like a stocking)  
 Thigh: (entire thigh) (front) (back) (inside-between legs) (outside)  
 Knee: (entire knee) (front) (back) (inside-between legs) (outside)  
 Lower leg: (entire lower leg) (front) (back) (inside-between legs) (outside)  
 Ankle: (entire ankle) (inside) (outside) (heel)  
 Foot: (entire foot) (inside) (outside) (top) (bottom)  
 Toes: (all toes) (big toe) (second) (middle) (fourth) (small)

DESCRIPTION: (pulling) (burning) (stabbing) (spasms) (electrical) (sharp) (aching) \_\_\_\_\_

HOW OFTEN: (constant **AND:** sometimes better/worse) (comes and goes) (every day) (\_\_\_\_ days/week)

MADE BETTER BY: (changing activity) (changing positions) (limiting use of leg) (applying heat) (applying ice)

\_\_\_\_\_ medications to include: \_\_\_\_\_

MADE WORSE BY: (walking) (sitting) (standing) (bending over) (twisting) (lying on side: right left)

\_\_\_\_\_

SLEEP DISTURBANCE: (none) (every night) ( \_\_\_\_\_ nights per week)

TIME OF DAY INCREASED: (not related to time of day) (more related to activity) (morning) (evening)

(worse in the morning, better at mid-day and worse again in the evening)

### NUMBNESS/TINGLING

LOCATION: (entire leg-like a stocking) (hip) (buttock) (groin) (testicle) (knee down-like a stocking)  
 Thigh: (entire thigh) (front) (back) (inside-between legs) (outside)  
 Knee: (entire knee) (front) (back) (inside-between legs) (outside)  
 Lower leg: (entire lower leg) (front) (back) (inside-between legs) (outside)  
 Ankle: (entire ankle) (inside) (outside) (heel)  
 Foot: (entire foot) (inside) (outside) (top) (bottom)  
 Toes: (all toes) (big toe) (second) (middle) (fourth) (small)

HOW OFTEN: (constant **AND:** sometimes better/worse) (comes and goes) (every day) (\_\_\_\_ days/week)

MADE BETTER BY: (changing positions) (limiting use of leg) (walking) \_\_\_\_\_

MADE WORSE BY: (nothing) (walking) (sitting) (standing) (lifting) (lying on side: right left)

\_\_\_\_\_

SLEEP DISTURBANCE: (none) (every night) ( \_\_\_\_\_ nights per week)

**WEAKNESS:**    NONE    All Activities    Up Stairs    Down Stairs    Uneven Surfaces

## Review of Systems

**Constitutional:** Fever Night Sweats Weight gain (\_\_\_\_ lbs) Weight loss (\_\_\_\_ lbs)

Exercise intolerance Sedation Lethargy

**Eyes:** Dry eyes Irritation Vision changes

**Ears:** Difficulty hearing Ear pain

**Nose:** Frequent nosebleeds Nose problems Sinus problems

**Mouth/Throat:** Sore throat Bleeding gums Snoring Dry mouth Oral abnormalities

Mouth ulcer Teeth abnormalities Mouth breathing

**Cardiovascular:** Chest pain on exertion Arm pain on exertion SOB w/ walking SOB w/ lying down

Palpitations Known heart murmur Light-headed on standing

**Respiratory:** Cough Wheezing SOB Coughing up blood Sleep apnea

**Gastrointestinal:** Abdominal pain Nausea Vomiting Constipation Change in appetite

Black/tarry stools Frequent diarrhea Vomiting blood Dyspepsia GERD

**Genitourinary:** Urinary loss of control Difficulty urinating Increased urinary frequency

Hematuria Incomplete Emptying

**Musculoskeletal:** Muscle aches Muscle weakness Arthralgias/joint pain

Back pain Swelling in the extremities

**Skin:** Abnormal mole Jaundice Rash Itching Dry skin Growths/lesions Laceration

**Neurologic:** Loss of consciousness Weakness Numbness Seizures Dizziness

Frequent or severe headaches Migraines Restless legs Tremor

**Psych:** Depression Sleep disturbances Feeling unsafe in relationship Restless sleep

Alcohol abuse Anxiety Hallucinations Suicidal thoughts

**Endocrine:** Fatigue Increased thirst Hair loss Increased hair growth Cold intolerance

**Hematologic/Lymphatic:** Swollen glands Easy bruising Excessive bleeding

**Allergy/Immunologic:** Runny nose Sinus pressure Itching Hives Frequent sneezing