UNC HOSPITALS

Place Sticker Here

New Patient Questionnaire

General Medical Information:

What is your main problem? Low Back Pain Neck Pain Leg Pain Arm Pain Other _____

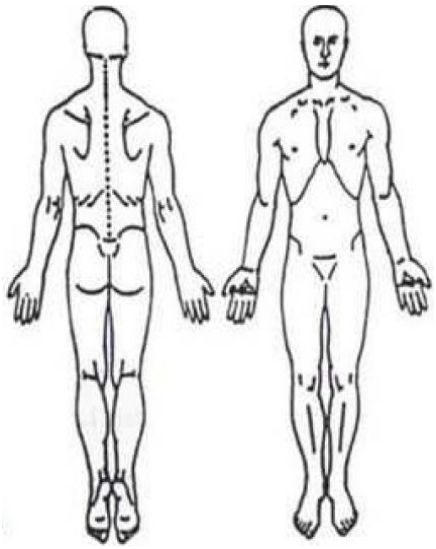
Primary Care Physician **and** Referring Doctor Name: _____

On a scale of 0-10, how would you rate your pain? _____

Please describe your current complaint:

1. **How did your problem start?** **Date of Onset:** _____
   Gradually Suddenly Accident/Injury Other _____
2. **What type of pain/symptoms?**
   Numbness Weakness Tingling Stiffness Swelling Other _____
3. **Have you experienced any loss of bowel or bladder control?**
   Yes No
4. **What worsens your problem?**
   Exercise Sitting/Lying Down Standing Walking Stairs Other _____
5. **How often do you have pain?**
   Getting Better Constant Intermittant Getting Worse No Pain Other _____
6. **What helps your pain?**
   Pain Medication Massage Heat Ice Nothing Other _____
7. **What are you unable to do because of your pain?**
   Sit Stand/Walk Cook/Clean Shop Work Hobbies Other _____
8. **Have you had any of the following treatment for your current problem?**
   Physical Therapy Medication Injections Surgery Chiropractic Treatments
9. **Have you had any of the following tests for your current problem within the last 7 years?**
   MRI X-Rays CT Scan Other: _____ **Did you bring them with you?** Yes No
10. **Will your visit involve Workman's Compensation?**
    Yes No
11. **If this is the result of an accident/injury, are you involved in a lawsuit or have a lawyer?**
    Yes No
12. **Are you currently working?** Full Time Part Time Not Working Retired

Please identify CURRENT painful areas in your body by **MARKING** appropriate areas:



Please tell us more about the pain areas/weakness/numbness you are having:

_____

_____

_____

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