[PATIENT LABEL]

Aultman Pain Management

New Patient Questionnaire

Name:________________________________Birth Date:____/____/____Age:____❑Male ❑Female

Primary Care Physician/Family Physician Name:____

Please complete this entire form. Do not leave any blanks in the answer sections (use N/A if not applicable). When completed, sign and date and return to Aultman Pain Management.

1. Main reason for your visit:____
____
____

2. When did your pain start? ____

3. Is your pain related to an accident? ❑ YES ❑ NO Date of accident: ________

   Description of injury____
____

4. Is the pain related to a work injury? ❑ YES ❑ NO Date of injury ___________

   Description of injury____
____

5. Where is your pain located? PLEASE BE SPECIFIC:_______________________________
____
____
____
____

6. What makes your pain better? ____
____
____
____

7. What makes your pain worse? ____
____
____
____

PAST MEDICAL HISTORY

1. Please list all past **surgeries**:____
____
____

2. Please list any other **medical conditions:**___________________________________
____
____

[PATIENT LABEL]

PREVIOUS EVALUATION AND TREATMENT FOR YOUR CURRENT PROBLEM

1. Have you seen any other pain management clinics for your **current** problem? Please list below:

Name	Address	Date of First Visit	Date of Last Visit
1.			
2.			

2. Have you had any of these tests completed **for this condition**?

Test	Yes	No
Regular X-Rays		
Myelogram		
MRI		
CT Scan		
Bone Scan		
EMG/Nerve Conduction		
Blood Tests		

3. Have you had any of the following treatments **for this condition**? If YES, please indicate the effectiveness of the treatment received.

Treatment	Yes	No	Helpful	Not Helpful	Worse
Physical Therapy					
Traction					
Chiropractic Adjustment					
Acupuncture					
Epidural Injections					
Other Injections					
TENS Unit					
Medicines					
Pain/Stress Management					
Counseling for stress/depression/anger					
Surgery					
Spinal Cord Stimulator **Trial Date:___________** **Implanted Date:__________** **Type:___________**					
Intrathecal Pain Pump **Trial Date:___________** **Implanted Date:__________** **Type:___________**					

MEDICATIONS

1. List all of your current medications, dosage and how many times per day you take them:
   Include ALL prescribed, over-the-counter, vitamins and herbal medications, supplements.

****BRING ALL MEDICATIONS WITH YOU TO YOUR FIRST VISIT****

Medication	Dosage (mg)	How often per day

3. Do you use any of the following currently or in the past?

Substance	Currently Yes	Past Yes	Never	Type	Amount per Day
Alcohol					
Tobacco					
Marijuana					
Cocaine					
Heroin					
CBD Oil					
Medical Marijuana					
Opioid / Prescription Pain Medications					

[PATIENT LABEL]

6. Have you EVER been told you have a problem with alcohol or drug abuse? ❑ YES ❑ NO

   If YES, please check the abused substance: ❑ Alcohol ❑ Drug (Name/Type)____________

7. Have you ever participated in rehabilitation for substance abuse? ❑ YES ❑ NO

   If YES, please list the date(s) and location(s)____

____

8. Have you ever been convicted or charged with a drug or alcohol offense? ❑ YES ❑ NO

   If YES, please list____

Family History of Substance Abuse (Mother, Father, Grandparents, Siblings)			**Personal (Your) History of Substance Abuse**		
Alcohol	❑ **Yes**	❑ **No**	Alcohol	❑ **Yes**	❑ **No**
Illegal Drugs	❑ **Yes**	❑ **No**	Illegal Drugs	❑ **Yes**	❑ **No**
Prescription Drugs	❑ **Yes**	❑ **No**	Prescription Drugs	❑ **Yes**	❑ **No**
			Present Age		
			History of Preadolescent Sexual Abuse	❑ **Yes**	❑ **No**
			Psychologic Disease		
			Diagnosed ADHD, ADD, OCD	❑ **Yes**	❑ **No**

9. Are you or have you ever been enrolled in MAT – medically assisted treatment for drug overuse? ❑ YES ❑ NO

   Have you ever taken: ❑ Suboxone ❑ Subutex ❑ Vivitrol

10. Current/retired/former occupation:______________________ Date of last day worked:______

11. Are you currently receiving disability benefits? ❑ YES ❑ NO

This questionnaire will become part of medical record. Any false information or omissions may lead to termination of treatment from Aultman Pain Management. Complications and side effects due to falsifications or omissions are the responsibility of the patient.

I verify that the above information is accurate and complete.

____

Date **Patient Signature**