University of Connecticut
Health Center
UCONN Medical Group
Comprehensive Spine Center

(Patient Identification)

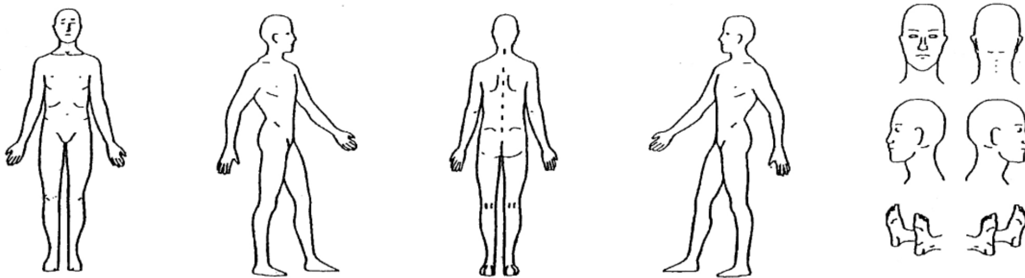
Physiatry New Patient Questionnaire/In-Take Form

NAME: ____________________ AGE: _____ SEX: M / F

Referring Physician: ___________ Primary Care Physician: _____________

1. Where is your major source of pain? ________________

Please indicate, on the diagram below, where your pain is located.



5. Is your pain constant? ❑ Yes ❑ No

6. Which best describes your pain currently: ❑ Sharp ❑ Stabbing ❑ Burning ❑ Dull ❑ Aching ❑ Throbbing ❑ Other _____________________

7. Are you experiencing any numbness? ❑ Yes ❑ No __________________

8. Are you experiencing any weakness? ❑ Yes ❑ No __________________

9. Are you experiencing any bladder problems? ❑ Yes ❑ No

10. What makes the pain worse?

❑ Cough/Sneeze	❑ Hot/Cold Weather	❑ Damp/Dry Weather
❑ Lifting >15lbs	❑ Bowel Movement	❑ Bending (Forward/Backward)
❑ Lying Down	❑ Exercise	❑ Standing
❑ Walking	❑ Sitting	❑ Other ___________________

10. Which of the following helps the pain?

❑ Lying Down	❑ Sitting	❑ Standing
❑ Walking	❑ Exercise	❑ Bending
❑ Shifting Positions	❑	❑ Other ___________________

11. When did your symptoms begin? __/__/__/

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12. How did your pain begin? (i.e. lifting injury, motor vehicle accident, etc.)
Onset: ❑ Sudden ❑ Gradual ❑ Recurrent
Where you injured at work? ❑ Yes ❑ No
Where you injured in a motor vehicle accident? ❑ Yes ❑ No

____

____

13. What do you believe is causing your pain? ______________________________

____

14. Have you had any prior surgery related to your symptoms? (i.e. discectomy, fusion, laminectomy)? ❑ Yes ❑ No If yes, how many operations? ____

If yes, also please complete the following:

Procedure	Date	Surgeon	Hospital	Outcome

15. Have you undergone any prior nerve blocks/pain procedures? ❑ Yes ❑ No

If yes, also please complete the following:

Procedure	Date	Physician	Hospital	Outcome

16. Have you had any diagnostic tests? ❑ Yes ❑ No

X Ray	Date	Findings
MRI		
CT Scan		
EMG		
Discogram		
Bone Scan		
Other:		

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17. Are you currently taking any medications for your symptoms? ❑ Yes ❑ No

Drug	Dose	Time of Day	Comments

18. Have you had any of the following treatments for your pain?

❑ Bed Rest ❑ Physical Therapy ❑ Back Corset / Brace
❑ Chiropractic ❑ Acupuncture ❑ Counseling
❑ Exercise Program ❑ Biofeedback ❑ Relaxation Therapy
❑ Trigger Point Injections ❑ Massage Therapy ❑ TENS

19. Please rate your pain on the scale below:

	No Pain	Mild	Discomforting			Distressing			Horrible		Excruciating
Worse Level	0	1	2	3	4	5	6	7	8	9	10
Best Level	0	1	2	3	4	5	6	7	8	9	10
Current Level	0	1	2	3	4	5	6	7	8	9	10

20. What is your occupation? _______________

What is your working status? ❑ Full Time/Full Duty ❑ Part Time/Part Duty
❑ Unemployed ❑ Retired ❑ Student

What job category is your work in? ❑ Sedentary ❑ Light ❑ Medium ❑ Heavy

21. Are you involved in personal injury litigation because of your pain? ❑ Yes ❑ No

22. PAST MEDICAL HISTORY

Please list medical conditions you currently have or have previously experienced below:	List all of the medications you are taking for these:

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23. Have you had any prior surgeries not related to your symptoms? ❑ Yes ❑ No

If yes, also please complete the following:

Procedure	Date	Surgeon	Hospital	Outcome

24. Allergies: ______________________________

25. SOCIAL HISTORY
Do you smoke? Y N Packs per day? ____ How many years? ____
Do you drink alcohol? Y N
Do you use recreational drugs? Y N
Marital Status: ❑ Married ❑ Divorced ❑ Widowed ❑ Single
How many children? ____

26. Do you have any of the following symptoms? (circle all that apply)

General:	Fevers, chills, skin rash, headaches night sweats
Head:	seizure, head injuries
Eyes:	decreased vision, double vision, cataracts, glaucoma
Ears:	decreased, ringing, dizziness, infection
Nose:	nasal congestion, sneezing, hay fever, nose bleeds
Mouth/Throat:	sore throat, sore tongue, hoarseness, stiff neck, neck mass
Breast:	breast mass, breast pain, discoloration
Respiratory:	cough, shortness of breath, wheezing, asthma, emphysema
Cardiovascular:	chest pain, palpitations, abnormal EKG, high blood pressure, heart failure, heart murmur, leg edema, arrhythmias
Gastrointestinal:	heartburn, nausea, vomiting, rectal bleeding, constipation, diarrhea, dark stools, abdominal pain
Urinary:	frequent urination, pain/burning with urination, hesitancy, inflection, stones
Musculoskeletal:	muscle/joint pain, joint stiffness, arthritis, gout, limitation of joint movement
Neurologic:	fainting, numbness, tingling, weakness, paralysis, tremor
Hematologic:	easy bruising, easy bleeding, anemia, anemia, Coumadin, prior blood transfusions
Endocrine:	heat/cold intolerance, diabetes, hyperthyroid, hypothyroid
Psychological:	anxiety, depression, suicidal thoughts/attempts, schizophrenia

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This questionnaire has been designed to give your caregiver information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the one box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but please mark only the box which most closely describes your current condition.

Pain Intensity
☐ I can tolerate the pain I have without having to use pain medication.
☐ The pain is bad but I can manage without having to take pain medication.
☐ Pain medication provides me complete relief from pain.
☐ Pain medication provides me with moderate relief from pain.
☐ Pain medication provides me with little relief from pain.
☐ Pain medication has no affect on my pain.

Personal Care (Washing, Dressing etc.)
☐ I can take care of myself normally without causing increased pain.
☐ I can take care of myself normally but it increases my pain.
☐ It is painful to take care of myself and I am slow and careful.
☐ I need help but I am able to manage most of my personal care
☐ I need help every day in most aspects of my care.
☐ I do not get dressed, wash with difficulty and stay in bed.

Lifting
☐ I can lift heavy weights without increased pain.
☐ I can lift heavy weights but it causes increased pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. on a table).
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I can not lift or carry anything at all.

Walking
☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than 1 mile.
☐ Pain prevents me from walking more than ½ mile
☐ Pain prevents me from walking more than ¼ mile.
☐ I can only walk with crutches or a cane.
☐ I am in bed most of the time and have to crawl to the toilet.

Sitting
☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting for more than 1 hour.
☐ Pain prevents me from sitting for more than ½ hour.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ Pain prevents me from sitting at all.

Standing
☐ I can stand as long as I want without increased pain.
☐ I can stand as long as I want but increases my pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than ½ hour.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Sleeping
☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using pain medication.
☐ Even when I take pain medication, I sleep less than 6 hours.
☐ Even when I take pain medication, I sleep less than 4 hours.
☐ Evens when I take pain medication, I sleep less than 2 hours.
☐ Pain prevents me from sleeping at all.

Social Life
☐ My social life is normal and does not increase my pain.
☐ My social life is normal, but it increases my level of pain.
☐ Pain prevents me from participating in more energetic activities (ex. sports, dancing etc.)
☐ Pain prevents me from going out very often.
☐ Pain has restricted my social life to my home.
☐ I have hardly any social life because of my pain.

Traveling
☐ I can travel anywhere without increased pain.
☐ I can travel anywhere but it increases my pain.
☐ My pain restricts travel over 2 hours.
☐ My pain restricts my travel over 1 hour.
☐ My pain restricts my travel to short necessary journeys under ½ hour.
☐ My pain prevents all travel except for visits to the doctor/therapist or hospital.

Employment/Homemaking
☐ My normal homemaking/job activities do not cause pain.
☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
☐ Pain prevents me from doing anything but light duties.
☐ Pan prevents me from doing even light duties.
☐ Pain prevents me from performing any job or homemaking chores. ***END OF PATIENT SECTION***

Patient Signature/Responsible Party ____________________________________ Date_________Time _____________

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CERVICAL

	MAXIMUM (°)		PAINFUL (NO, YES)	
FLEXION				
EXTENSION				
SIDE ROTATION	R	L	R	L
ROTATION	R	L	R	L

	SHOULDER	ELBOW
RIGHT		
LEFT		

NEUROLOGICAL

		MOTOR (GRADE 1-5)		SENSORY	(PIN - PRICK)	
		RIGHT	LEFT		RIGHT	LEFT
C-5	BICEPS					
C-6	PRONATOR					
C-7	TRICEPS					
C-8	INTRINSIC					
T-1	ADM					

REFLEXES	BICEPS	BRACHIORADIALIS	TRICEPS
RIGHT			
LEFT			

THORACIC SPINE

	MAXIMUM (°)	PAINFUL (NO, YES)
ROTATION RIGHT		
ROTATION LEFT		

DEFORMITY

LUMBAR

	MAXIMUM (°)		PAINFUL (NO, YES)	
FLEXION				
EXTENSION				
SIDE EXTENSION	R	L	R	L

	HIP	KNEE
RIGHT		
LEFT		

ROOT TENSION SIGNS	STRAIGHT LEG RAISE (°)	PAIN (BACK,IPS,CONTRA)	QUALIFYING SIGNS
RIGHT			
LEFT			

	FEMORAL STRETCH
RIGHT	
LEFT	

NEUROLOGICAL

		MOTOR (GRADE 1-5)			SENSORY (PIN-PRICK)	
		RIGHT	LEFT		RIGHT	LEFT
L-3	QUAD					
L-4	DORSI					
L-5	EHI					
S-1	EVERT					

REFLEXES	PATELLA	ACHILLES	BABINSKI
RIGHT			
LEFT			

WADDELL (Y/N) REACT: SUP TEND: DIS SLR: SIMUL ROT: GLOBAL:
SKIN/VASCULAR: POSTURE: GAIT:
PALPATION:

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HIP BRIEF

RIGHT	LEFT
Extension (Thomas Test):	Extension (Thomas Test):
Flexion:	Flexion:
Abduction:	Abduction:
IR @ 90 deg:	IR @ 90 deg:
ER @ 90 deg:	ER @ 90 deg:
Tenderness: psoas / troch / pub symph / ish / add	Tenderness: psoas / troch / pub symph / ish / add
Clicking: Positive / Negative	Clicking: Positive / Negative
Impingement: Positive / Negative	Impingement: Positive / Negative
FABER: Positive / Negative	FABER: Positive / Negative
Log Roll: Positive / Negative	Log Roll: Positive / Negative
Heel Strike: Positive / Negative	Heel Strike: Positive / Negative
Ober's Test: Positive / Negative	Ober's Test: Positive / Negative
Hip Flexors: / 5	Hip Flexors: / 5
Hip abductors: / 5	Hip abductors: / 5
Hip adductors: / 5	Hip adductors: / 5

SHOULDER BRIEF

RIGHT	LEFT
Tenderness: SC /AC / Bicipital Groove	Tenderness: SC /AC / Bicipital Groove
Flexion:	Flexion:
Abduction:	Abduction:
ER @ neutral:	ER @ neutral:
IR @ neutral:	IR @ neutral:
O'Brien: Positive / Negative	O'Brien: Positive / Negative
Speed: Positive / Negative	Speed: Positive / Negative
Impingement: Positive / Negative	Impingement: Positive / Negative
Apprehension: Positive / Negative	Apprehension: Positive / Negative
Relocation: Positive / Negative	Relocation: Positive / Negative
Post Instability: Positive / Negative	Post Instability: Positive / Negative
Supraspinatus: / 5	Supraspinatus: / 5
Infraspinatus: / 5	Infraspinatus: / 5
Belly Press: Positive / Negative	Belly Press: Positive / Negative
LiftOff: Positive / Negative	LiftOff: Positive / Negative

RADIOLOGIC REVIEW: (X-RAY/MRI)

IMPRESSION:

PLAN:

Provider's Signature: ____________________
Date / Time: ________________