**Dr. Jennifer Gargano New Patient Questionnaire**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Appointment Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please clearly mark your painful areas.** 

The location of my worst pain is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle** **Current** **Pain Score:** No pain = 0, Worst Pain Imaginable = 10

0 1 2 3 4 5 6 7 8 9 10

Over this past month, Your Best pain score: /10 Worst pain score: /10

When / how did your pain begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(month, year)

Was there an injury or accident?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your pain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle: Sharp, stabbing, aching, burning, lightening shock, electric, dull, sore, sensitive to light touch, tingling, constant, variable, punishing, terrifying

What increases my pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves my pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tried: Chiropractor \_\_\_\_\_Physical therapy \_\_\_\_\_Injections \_\_\_\_\_\_\_

Current Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_

**Current Medications:**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | # per day | Prescriber |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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**Any pain medications tried?**

**Medical Problems:**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Surgical Procedures and Dates:**

|  |  |
| --- | --- |
|  |  |
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|  |  |

**Allergies:** List Medications and reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Allergy to Latex, Contrast, or Shellfish? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a family history of any medical problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any family history of drug or alcohol addiction? Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Do you work? Yes/No/Disability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your job?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink Alcohol? Yes/No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoke Tobacco? Yes No How may packs per day? \_\_\_\_\_ How many years?\_\_\_\_\_\_

Are you using Recreational or Street Drugs: Yes No

Any history of drug or alcohol addiction or abuse? Yes No

If yes, was this treated and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been having any unusual symptoms? Please circle or check here if none\_\_\_\_\_\_\_\_\_\_

Fatigue, night sweats, weight loss or gain, headache, blurred vision, chest pain, racing heart beat, shortness of breath, heartburn, constipation, difficulty urinating, accidents of urine or stool, low back pain, joint pain, numbness or tingling, anxiety or depression, easy bleeding, rash

Have you been treated for mental health? Yes/No

What kind of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other concerns today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_ Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_