Harrington
HOSPITAL
Total Local Care

HARRINGTON PHYSICIAN SERVICES, INC.
WWW.HARRINGTONHOSPTIAL.ORG
HPS SPECIALTY SERVICES
94 SOUTH STREET
SOUTHBRIDGE, MA 01550

New Patient Questionnaire

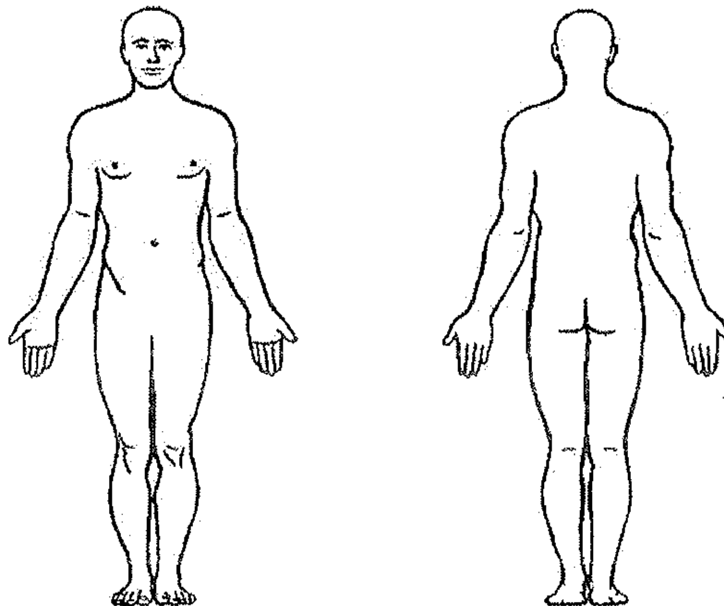
Your name: ______________________ Date of Birth: ______________ Age: ________

Referring Physician: ______________________ Primary Care Physician: ______________________

Chief Complaint (Area of pain): ____

Does this pain radiate? Where? ____

Use this diagram to indicate the area of your pain.



When did this pain begin? ____

What caused it? ____

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Check all of the following qualities that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp ☐ Cramping ☐ Numbness

☐ Spasming ☐ Throbbing ☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness

Other: ____

When is your pain at its worst?

☐ Mornings ☐Daytime ☐ Evenings ☐ Middle of the night ☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Comes and goes

If "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now__________ On your best days __________ On your worst days __________

State the effect each of the following has on your pain level (increases, decreases, no difference)

	No Change	Improves Pain	Worsens Pain
Bending Backward			
Bending Forward			
Changes in Weather			
Stairs			
Coughing/Sneezing			
Driving			
Lifting Objects			
Tilting head up			
Tilting head down			
Rising from chair			
Sitting			
Standing			
Walking			

Any other factors worsen or affect your pain that are not mentioned above?

____

How do you control your flare ups of pain? What helps?

____

Please circle any associated symptoms:

Numbness/Tingling Where? ______________________

Weakness in the arm/leg Balance Problems Loss of bladder control

Loss of bowel control Joint Swelling/Stiffness

Rate how pain has interfered with the following activities (on a scale of 0-10. 0= does not interfere, 10= interferes completely):

General Activity ______ Mood ______ Walking Ability ______ Sleep ______

Work Outside the Home ______ Relationships ______ Work Inside the Home ______

Enjoyment of Life ______ Sexual Relations ______

Are there things that you wish you could do, if only you felt better? Please list any goals, large or small, that you would like to work toward:

____

____

____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/Psychologist ☐ Chiropractor

☐ Orthopedic Surgeon ☐ Rheumatologist ☐ Internist ☐ Physical Therapist ☐ Neurologist

☐ Other (Examples: nutritionist, dietician, hypnotist, support groups, etc.)

Mark all of the following treatments that you have used for pain relief:

	No Change	Improved Pain	Worsened Pain
Spine or other surgery			
Physical Therapy (when? How long?)			
Osteopathic Manipulation			
Chiropractic Care			
Psychological Therapy			
Use of a Brace			
Acupuncture			
Heat/Ice			
Massage Therapy			

Medications			
TENS Unit			
Other (specify below)			

Mark all of the following interventional pain treatments that you have used for pain relief:

	No change	Improved Pain	Worsened Pain
Epidural Steroid injections			
Joint injections			
Medial Branch Blocks/Facet injections			
Nerve Blocks (type?)			
Radiofrequency Nerve Ablation			
Spinal Cord Stimulation			
Trigger Point injections			
Vertebroplasty/Kyphoplasty			
Intercostal Nerve Blocks			
Other			

Check the pain medications that you have used to treat your pain currently or in the past and note whether the medication was **helpful or not helpful**, as well as the doses you took.
Medication generic name (BRAND NAME)
Opioids

1. tramadol (ULTRAM, ULTRAM ER)
2. tapentadol (NUCYNTA)
3. hydrocodone (VICODIN, NORCO)
4. oxcycodone (PERCOCET, ROXICET)
5. meperidine (DEMEROL)
6. hydromorphone (DILAUDID)
7. morphine IR (MSIR)
8. fentanyl (ACTIQ, FENTORA)
9. codeine (TYLENOL #3, #4)
10. oxycodone (OXYCONTIN)
11. morphine (MS CONTIN, KADIAN, AVINZA, ORAMORPH)
12. methadone (DOLOPHINE)
13. fentanyl patch (DURAGESIC)
14. oxmorphone (OPANA ER)
15. levorphanol (LEVODROMORAN)
16. buprenorphine (BUTRANS)
17. buprenophine/naloxone (SUBOXONE)

Anticonvulsants

1. gabapentin (NEURONTIN)
2. pregabalin (LYRICA)

3. carbamazepine (TEGRETOL)
4. topiramate (TOPAMAX)
5. levetiracetam (KEPPRA)
6. oxcarbazepine (TRILEPTAL)

Benzodiazepines
1. diazepam (VALIUM)
2. alprazolam (XANAX)
3. lorazepam (ATIVAN)
4. clonazepam (KLONOPIN)
5. chlordiazepoxide (LIBRIUM)

Muscle Relaxants
1. cyclobenzaprine (FLEXERIL)
2. carisoprodol (SOMA)
3. metaxalone (SKELAXIN)
4. methocarbamol (ROBAXIN)
5. tizanidine (ZANAFLEX)
6. orphenadrine (NORFLEX)
7. baclofen

Tricyclic Antidepressants
1. amitriptyline (ELAVIL)
2. nortriptyline (PAMELOR)
3. desipramine (NORPRAMIN)
4. imipramine (TOFRANIL)
5. trazodone

SNRI
1. duloxetine (CYMBALTA)
2. venlafaxine (EFFEXOR)
3. milnacipran (SAVELLA)

Topicals
1. Lidoderm patch
2. Flector/Pennsaid patch
3. Topical creams

Migraine
1. ergotamine (CAFERGOT, DHE45)
2. MIDRIN
3. naratriptan (AMERGE)
4. frovatriptan (FROVA)
5. sumatriptan (IMITREX)
6. rizatriptan (MAXALT)
7. FIORICET

Sleep Aids
1. diphenhydramine (NYTOL, BENADRYL, SOMINEX)
2. temazepam (RESTORIL)
3. triazolam (HALCION)
4. zaleplon (SONATA)
5. zolpidem (AMBIEN)
6. Other: ________________

Stimulants
1. modafinil (PROVIGIL)
2. amphetamine (ADDERALL)
3. methylphenidate (RITALIN, CONCERTA)
4. atmoxetine (STRATTERA)

Anti-inflammatories
1. ibuprofen (MOTRIN)
2. naproxen (ALEVE, NAPROSYN, ANAPROX)

3. meloxicam (MOBIC)
4. nabumetome
5. celecoxib (Celebrex)
6. diclofenac
7. aspirin
8. Other: ____________________

Mark all of the following tests that you have related to your current pain complaints:

☐ MRI of the: ____ Date: ______________

☐ X-Ray of the: ____ Date: ______________

☐ CT Scan of the: ____ Date: ______________

☐ EMG/NCV study of the: ______________________________________ Date: ______________

Circle the following conditions/diseases that you have been treated for in the past:

Musculoskeletal/Rheumatologic

Bursitis	Carpal Tunnel	Fibromyalgia	Osteoarthritis	Osteoporosis
Rheumatoid Arthritis	Chronic Joint Pain	Lyme Disease	Other:	

Respiratory

Asthma	Bronchitis/Pneumonia	Emphysema	COPD	Sleep Apnea

HEENT/Neurological

Headaches	Migraines	Head Injury	Glaucoma	Seizures
Strokes	Multiple Sclerosis	Neuropathy	Other:	

Psychiatric

Depression	Anxiety	Schizophrenia	Bipolar Disorder	Other:

Urological

Chronic Kidney Disease	Kidney Stones	Urinary Incontinence	Dialysis	Other:

Gastrointestinal

Acid Reflux	Gastrointestinal bleeding	Stomach Ulcers	Constipation	Hepatitis
Cirrhosis	Liver Disease	Other:		

Cardiovascular/Hematologic

Anemia	Heart Attack	Coronary Artery Disease	High Blood Pressure	Peripheral Vascular Disease
Heart Valve Disorder	Blood Clots	Bleeding Disorders	High Cholesterol	Other:

General Medical

Diabetes	Hypothyroidism	Hyperthyroidism	Cancer	HIV
Endometriosis	Dysmenorrhea	Other:		

Are you currently pregnant or trying to become pregnant? ____________________

Date of last menstrual period ______________ Method of Birth Control, if applicable__________________

SLEEP HISTORY

Do you snore? ____________________
Are you excessively tired during the day? ____________________
Have you been told that you stop breathing or gasp for breaths during sleep? ____________________
Do you have a history of hypertension? ____________________
Is your neck size > 17 in (male) or > 16 in (female)? ____________________

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 - No chance of falling asleep 1 - slight chance of falling asleep
2 - Moderate chance of falling asleep 4 - High chance of falling asleep

Situation	Chance of Falling Asleep
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (ex: meeting)	
Passenger in car for an hour without a break	
Lying down to rest in afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	

Please list any surgical procedures you have had done in the past including date:

1) ________________________________ Date? ______________
2) ________________________________ Date? ______________
3) ________________________________ Date? ______________
4) ________________________________ Date? ______________
5) ________________________________ Date? ______________

Are you currently taking any blood thinners or anticoagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other ____________

Please list ALL medications you are currently taking including vitamins. Attach additional sheet if required:

Medication Name	**Dose**	**Frequency**
1) ____________	________	________
2) ____________	________	________
3) ____________	________	________
4) ____________	________	________
5) ____________	________	________
6) ____________	________	________
7) ____________	________	________
8) ____________	________	________
9) ____________	________	________
10) ____________	________	________

Please list all medication allergies:

Medication Name	Allergic Reaction
1) ____________	____________
2) ____________	____________
3) ____________	____________
4) ____________	____________
5) ____________	____________

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐Arthritis ☐Cancer ☐Diabetes ☐Headaches/Migraines ☐High Blood Pressure ☐Kidney Problems ☐Liver Problems ☐Osteoporosis ☐Rheumatoid arthritis ☐Seizures ☐ Stroke/Seizure ☐Bleeding Disorders

Other Family Medical Problems:

____

Social History:

Occupation: ______________________ When was the last time you worked?____________________

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Who lives in your current household? ____

Marital Status (circle one): Single Married Domestic Partner Widowed Separated Divorced

Ages of children, if any: ____

Do you exercise (circle one)? No Rarely 1-2 /week 3-4/week 5 or more/week
What do you do for exercise? ____

	Yes	No
Do you have a family history of substance abuse (alcohol? Prescription drugs? Illegal Drugs?		
Do you have a personal history of substance abuse? (Alcohol? Prescription drugs? Illegal drugs?)		
Age between 16-45 years old		
History of preadolescent sexual abuse?		
Psychological disease? (ADD, ADHA, OCD, Bipolar, Schizophrenia, Depression)		

Alcohol Use:

☐ Beer ☐ Wine ☐ Liquor ☐Never ☐ History of alcoholism, not currently using

Number of drinks per week ____________________________

Tobacco Use:

☐ Current user ☐ Former user ☐ Never used

Packs per day? ______ How many years? ______ Quit Date: ______

Illegal Drug Use:

☐ Never ☐ Currently ☐ Formerly used illegal drugs (not currently using)

Have you ever abused prescription medications? ☐ Yes ☐ No

Mark the following symptoms that you currently experience:

Constitutional: ☐ Chills ☐Difficulty sleeping ☐ Easy bruising ☐ Night Sweats ☐Fatigue

☐ Fevers ☐ Insomnia ☐ Low sex drive ☐ Tremors ☐ Unexplained Weight Gain

☐ Weakness ☐ Unexplained Weight Loss

Eyes: ☐ Recent Visual changes

Ears/Nose/Throat/Neck: ☐ Dental Problems ☐ Earaches ☐ Hearing Problems

☐ Nosebleeds ☐ Sinus problems

Cardiovascular: ☐ Chest Pain ☐ Easy Bruising ☐ Blood Clots ☐ Fainting

☐ Palpitations ☐ Swelling in feet ☐ Shortness of breath during sleep

Respiratory: ☐ Cough ☐ Wheezing ☐ Shortness of breath

Gastrointestinal: ☐ Constipation ☐ Acid Reflux ☐Abdominal Cramps ☐ Diarrhea

☐ Nausea/Vomiting ☐ Hernia

Musculoskeletal: ☐ Back Pain ☐ Joint Pains ☐ Joint Stiffness ☐ Joint Swelling

☐ muscle spasms ☐ Neck Pain

Genitourinary/Nephrology: ☐ Flank Pain ☐ Blood in Urine ☐ Painful Urination

☐ Decreased Urine Flow/Frequency/Volume

Neurological: ☐ Dizziness ☐ Headaches ☐ Tremors ☐ Numbness/Tingling ☐ Seizures

Psychiatric: ☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems ☐ Suicidal Thoughts

☐ Suicidal Planning ☐ Thoughts of Harming Others