



**The Austin Diagnostic Clinic  
Physical Medicine and Rehabilitation  
New Patient Questionnaire Form**

Please complete ALL QUESTIONS on ALL of the attached forms.

Name \_\_\_\_\_ DOB \_\_\_\_\_  
Occupation \_\_\_\_\_

1) What is your main complaint? \_\_\_\_\_

2) To the best of your knowledge, What caused your symptoms?  
\_\_\_\_\_

3) How long ago did your symptoms begin? \_\_\_\_\_

4) Is your pain getting (please circle the one that applies):  
Worse or Better or Plateaued

- 5) Is your pain:
- |                                    |                                       |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aching    | <input type="checkbox"/> Stinging     |
| <input type="checkbox"/> Soreness  | <input type="checkbox"/> Electrical   |
| <input type="checkbox"/> Cramping  | <input type="checkbox"/> Stabbing     |
| <input type="checkbox"/> Tingling  | <input type="checkbox"/> Numbness     |
| <input type="checkbox"/> Radiating | <input type="checkbox"/> Excruciating |
| <input type="checkbox"/> Burning   | <input type="checkbox"/> Coldness     |
| <input type="checkbox"/> Tightness | <input type="checkbox"/> Heaviness    |
| <input type="checkbox"/> Dullness  | <input type="checkbox"/> Sharpness    |
| <input type="checkbox"/> Constant  | <input type="checkbox"/> Spasm-like   |

6. Does your pain radiate? Yes or No Where does it radiate? \_\_\_\_\_

7) What is your percentage of neck pain to arm pain? \_\_\_\_:\_\_\_\_ (example50:50,60:40)  
What is your percentage of back pain to leg pain? \_\_\_\_:\_\_\_\_(example50:50,60:40)

8) *What position/activity makes the pain worse better? Mark an X.*

	Worse	Better	Comments
<i>Bending</i>			
<i>Coughing/sneezing</i>			
<i>General Activity</i>			
<i>Home Remedies</i>			
<i>Lying Down</i>			
<i>Sitting</i>			
<i>Standing</i>			
<i>Walking</i>			
<i>OTHER:</i>			

9) How long can you stand before your pain comes on: \_\_\_\_minutes.

10) How long can you walk before your pain comes on:  
0-50ft\_\_\_\_ 50-200ft\_\_\_\_ 200-500ft\_\_\_\_ 500+ft\_\_\_\_ ½ mile+\_\_\_\_

11) Do you have any weakness? YES NO (If yes, please explain)

---

12) Do you have any numbness? YES NO (If yes, please specify where)

---

13) Do you have any bowel or bladder problems? YES NO (If yes, please explain)

---

14) Have you ever been treated for drug or alcohol addiction? YES NO (If yes, please explain)\_\_\_\_\_

15) Do you suffer from sleep disturbance? Getting to sleep or Staying asleep?

---

**Please check any of the following treatments you have had for this problem:**

	<i>Approx. Dates/Details</i>	<i>Improved Pain</i>	
		<i>YES</i>	<i>NO</i>
<input type="checkbox"/> <i>Pain Clinic</i>			
<input type="checkbox"/> <i>Nerve Blocks/Epidurals</i>			
<input type="checkbox"/> <i>Tens Unit</i>			
<input type="checkbox"/> <i>Physical Therapy</i>			
<input type="checkbox"/> <i>Acupuncture</i>			
<input type="checkbox"/> <i>Chiropractor</i>			
<input type="checkbox"/> <i>Message Therapy</i>			
<input type="checkbox"/> <i>Medications</i>			
<input type="checkbox"/> <i>Other</i>			

**Please indicate which diagnostic procedures (tests) ou have had for this pain problem:**

	<i>Body Part</i>	<i>Date</i>	<i>Where</i>
<input type="checkbox"/> <i>MRI</i>			
<input type="checkbox"/> <i>CT Scan</i>			
<input type="checkbox"/> <i>X-ray</i>			
<input type="checkbox"/> <i>EMG/NCS</i>			
<input type="checkbox"/> <i>Other</i>			

Please list other physicians you have seen for this problem:

---



---



---

Family Physician: \_\_\_\_\_

Please list past or current medical problems:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney Problem	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Depression/ Anxiety	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Current Infection	<input type="checkbox"/> Arthritis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Other

**Family History:**

Describe current health, age cause of death, illness:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Siblings: \_\_\_\_\_

**PAST SURGERIES:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**List All Current Medications as follows**

Name	Dose ( milligrams)	How often	How long

**SOCIAL HISTORY**

Do you smoke? Y or N ? How much \_\_\_\_\_

Do you drink alcohol? Y or N? How much? \_\_\_\_\_ How often? \_\_\_\_\_

Drug /Substance abuse? Y or N ? Specify \_\_\_\_\_

**WORK STATUS**

\_\_\_ Full Duty \_\_\_ Light Duty \_\_\_ Off Duty per Physician \_\_\_ Unemployed \_\_\_ Retired

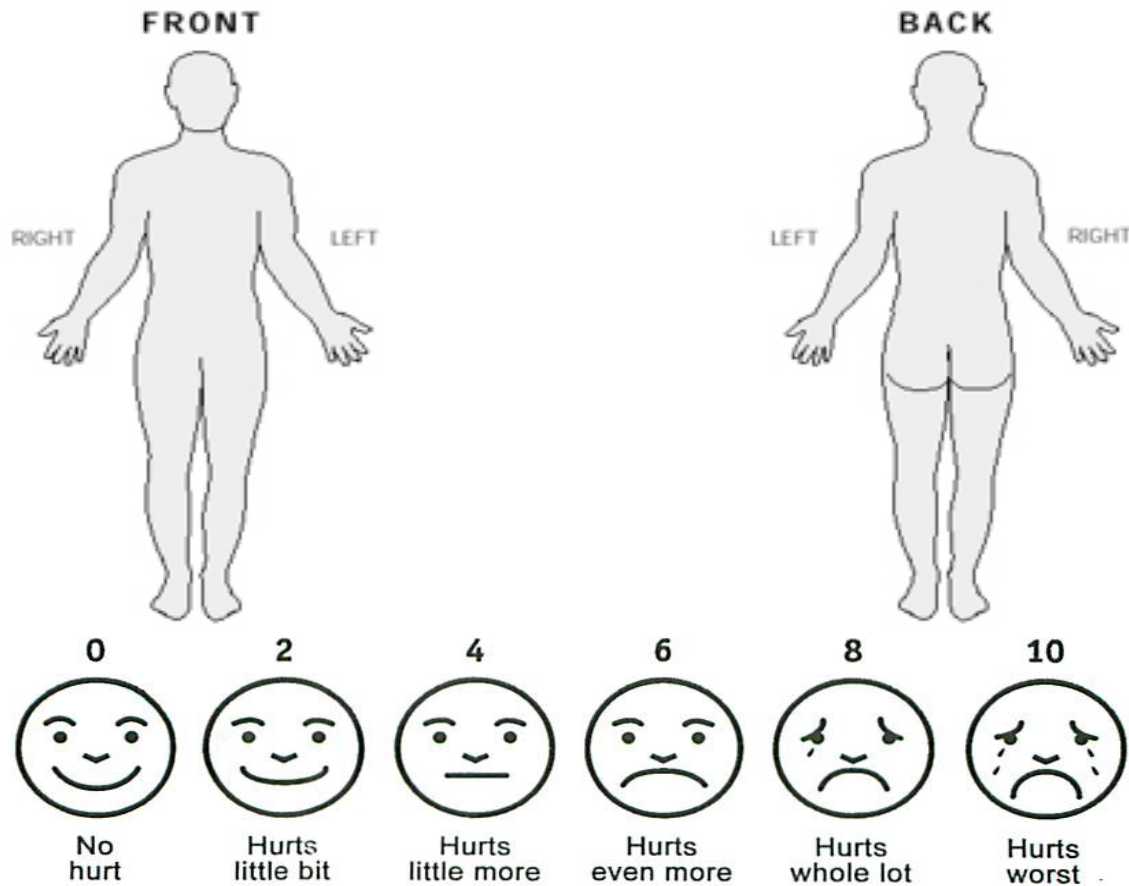
If not working, how long have you been off work? \_\_\_\_\_

**REVIEW OF SYSTEMS Check if you have experienced any of the following**

<i>General</i>	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	
<i>HEENT</i>	<input type="checkbox"/> Headache	<input type="checkbox"/> Enlarged Lymph Nodes	
<i>Cardiovascular</i>	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Palpitations	
<i>Pulmonary</i>	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath	
<i>Gastrointestinal</i>	<input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Bowel Incontinence
<i>Genitourinary</i>	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Urine Incontinence	
<i>Musculoskeletal</i>	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Joint pain	
<i>Psych</i>	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sleep disturbance
<i>Neuro</i>	<input type="checkbox"/> Weakness	<input type="checkbox"/> Numbness	
<i>Endocrine</i>	<input type="checkbox"/> Unexplained weight loss/gain	<input type="checkbox"/> Heat/Cold Intolerance	

Using the symbols below, please draw in the location of your symptoms on the diagrams

X = Burning      0 = Numbness      / = Aching      + = pins and needles



Circle the degree of the pain. **With medication and without.**

0 meaning no pain and 10 being the worst pain you have ever experienced in your life.