

**New Patient Assessment**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Visit Date: \_\_\_\_\_

**Please answer all questions using your own words. Some examples have been given.**

What would you like to discuss with the Dr. today? \_\_\_\_\_

\_\_\_\_\_

What are your current symptoms? (Example: back pain, headaches) \_\_\_\_\_

\_\_\_\_\_

Is it Constant or intermittent? (Circle one) What date did these symptoms begin? \_\_\_\_\_

How often do your symptoms occur? (example: daily, weekly) \_\_\_\_\_

What words would you use to describe how your pain feels? (example: dull, sharp, burning) \_\_\_\_\_

\_\_\_\_\_

How did your symptoms begin? (example: a fall, bending, lifting) \_\_\_\_\_

What makes your symptoms worse? (example: activity, just lying in bed, stress) \_\_\_\_\_

\_\_\_\_\_

What relieves your symptoms? (example: exercise, rest, medication) \_\_\_\_\_

Are you **right**-handed or **left**-handed? (Circle one)

Have you had any previous surgery(s) for this problem? \_\_\_\_\_

If so, what surgery(s) have you had? \_\_\_\_\_

\_\_\_\_\_

By Which Physician(s)? \_\_\_\_\_

\_\_\_\_\_

At which Hospital(s)? \_\_\_\_\_

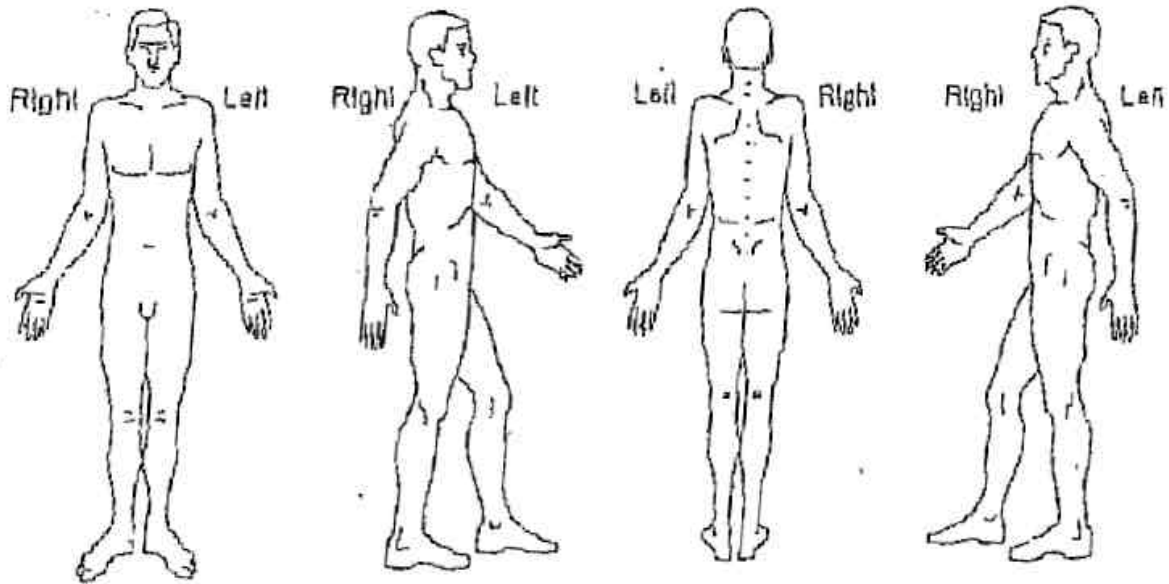
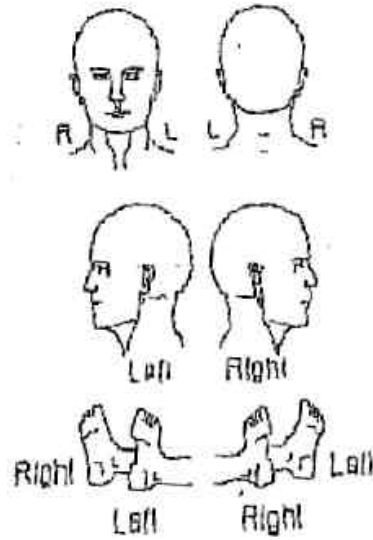
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Approximately what date(s) did you have the surgery(s)? \_\_\_\_\_

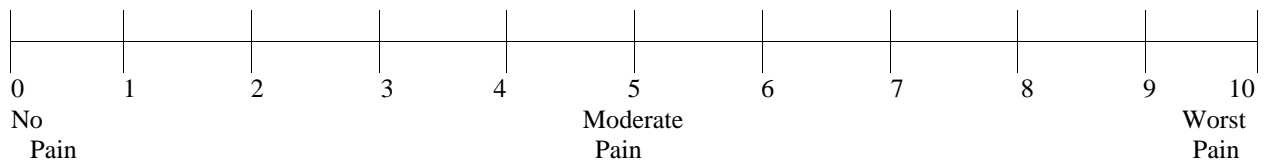
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On the diagram, **Color** the areas where your pain is located. *Please refer to the COLOR key.*

**Color Key:**  
**Blue**.....Pain  
**Yellow**...Numbness or tingling  
**Red**.....Burning  
**Green**.....Cramping



**Please rate your usual pain level**



**Please rate your pain level during today's visit**

