Weill Cornell Medicine
Center for Comprehensive Spine Care

Phone: (888) 922-2257 (888-WC-BACKS)
Please return this form to our office via fax. (646)-962-0640
***For Eric Elowitz, MD; Kai-Ming Fu, MD; and**
Ali A. Baaj, MD; please return forms to (646) 962-0119

Please note which department or physician you are requesting to see: _____

Neurosurgery Neurology Pain Management Physiatry/Rehab Medicine

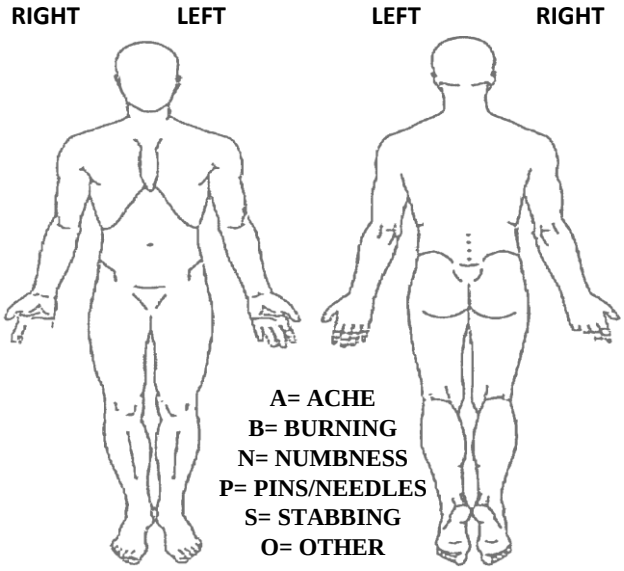
NEW PATIENT QUESTIONNAIRE

DATE: _____

Patient Name:_____ **Date of Birth**:_____/_____/_____ **Gender**: M or F
Phone Number: _____ **Address**:_____
Referred by _____ **Insurance Carrier/ ID or Policy #** _____
Reason for Visit: _____
Have you had a history of accident or injury? If **yes**, please explain and answer the next three questions:
_____

- Was the accident at work? Yes or No
- Are you using Workman's Compensation? Yes or No
- Are you currently involved in litigation? Yes or No

On the diagram below, please mark where you are feeling your symptoms with the appropriate letters.



Please note if other: _____

1. When did the pain begin? _____

Duration of Pain: _____

Overall the pain is:

Improved Worse Stable

2. Quality of Pain (check all that applies)?

☐ Sore	☐ Aching ☐ Burning	
☐ Sharp	☐ Dull	☐ Tender
☐ Stabbing	☐ Tingling	☐ Cramping
☐ Shooting	☐ Pulling	☐ Radiating
☐ Unsure	☐ Throbbing	

On a scale of 0 to 10, please circle your level of pain or discomfort
0 being none and 10 being unbearable for the following areas:

1. Neck Pain:	0	1	2	3	4	5	6	7	8	9	10
2. Left Shoulder Pain:	0	1	2	3	4	5	6	7	8	9	10
3. Right Shoulder Pain:	0	1	2	3	4	5	6	7	8	9	10
4. Left Arm Pain:	0	1	2	3	4	5	6	7	8	9	10
5. Right Arm Pain:	0	1	2	3	4	5	6	7	8	9	10
6. Back Pain:	0	1	2	3	4	5	6	7	8	9	10
7. Left Hip/Buttock Pain:	0	1	2	3	4	5	6	7	8	9	10
8. Right Hip/Buttock Pain:	0	1	2	3	4	5	6	7	8	9	10
9. Left Leg Pain:	0	1	2	3	4	5	6	7	8	9	10
10. Right Leg Pain:	0	1	2	3	4	5	6	7	8	9	10
11. Left Foot Pain:	0	1	2	3	4	5	6	7	8	9	10
12. Right Foot Pain:	0	1	2	3	4	5	6	7	8	9	10

If you are <u>not experiencing pain</u> as a symptom, please skip Questions 1-7.

3. What makes the pain better (check all that applies)?

☐ Heat	☐ Cold	☐ Bend Forward
☐ Bend Back	☐ Change Position ☐ Sitting	
☐ Standing	☐ Walking	☐ Twisting
☐ Movement	☐ Change in weather	☐ Lying Supine
☐ Rest	☐ Valsalva	☐ Coughing/Sneezing
☐ Nothing	☐ Sex	☐ N/A

4. What makes the pain worse (check all that applies)?

☐ Heat	☐ Cold	☐ Bend Forward
☐ Bend Back	☐ Change Position ☐ Sitting	
☐ Standing	☐ Walking	☐ Twisting
☐ Movement	☐ Change in weather	☐ Lying Supine
☐ Rest	☐ Valsalva	☐ Coughing/Sneezing
☐ Nothing	☐ Sex	☐ N/A

5. Pain interferes with:

☐ Sleep	☐ Appetite	☐ Sex
☐ Self-Care	☐ Hobbies	☐ Job Performance
☐ Driving	☐ Social Life	☐ Exercise
☐ Lifting	☐ Traveling	☐ Shopping
☐ Household Chores		☐ Cooking
☐ Other _____		

6. When is the pain worst? (Circle one)

Morning Afternoon Evening Night

7. If pain limits activity, please full in all that apply:

I can't tolerate walking more than _____ blocks.

I can't tolerate sitting more than _____ minutes.

I can't tolerate standing more than _____ minutes.

I can't tolerate lying more than _____ minutes.

8. Do you experience weakness? Yes or No

If yes, please describe (include location)_____

Have you had any of the following imaging studies? If yes, please include the date.

IF SO, PLEASE FORWARD A COPY OF THE REPORT TO THE OFFICE PRIOR TO YOUR APPOINTMENT!

X-ray _____ Bone Scan_____ MRI_____

CT scan _____ EMG _____

Below, indicate past treatments for your neck/back condition and include the date of treatment:

Nerve Block_____ Steroid Injections_____

Physical Therapy_____ Psychotherapy_____

Acupuncture_____ Surgery_____

Chiropractic_____ Failed Medications_____

Other_____

If surgery is recommended, what would be your timeframe available for scheduling? _____

REVIEW OF SYSTEMS:

GENERAL
Fatigue □ NO □ YES
Weight loss □ NO □ YES
Weakness □ NO □ YES
Swollen Lymph nodes □ NO □ YES

HEAD
Visual problems □ NO □ YES
Ear pain, decreased hearing □ NO □ YES
Difficulty swallowing □ NO □ YES
Other_____

CHEST, HEART, AND LUNGS
Shortness of breath □ NO □ YES
Chest pain or pressure attacks □ NO □ YES
Frequent cough □ NO □ YES
Swollen ankles □ NO □ YES
Valve disorder □ NO □ YES
Sleep Apnea □ NO □ YES
DVT □ NO □ YES
Stents □ NO □ YES
Other_____

ENDROCRINE
Thyroid condition ☐ NO ☐ YES
Diabetes ☐ NO ☐ YES
Other_____

KIDNEY
Difficulty in passing urine □ NO □ YES
Getting up at night to urinate □ NO □ YES

GASTROINTESTINAL
Poor appetite ☐ NO ☐ YES
Indigestion or vomiting ☐ NO ☐ YES
Change in bowel habits ☐ NO ☐ YES
Pass blood from rectum ☐ NO ☐ YES

MUSCULOSKELETAL
Decreased Range of Motion □ NO □ YES
Joint Swelling □ NO □ YES
Joint Stiffness □ NO □ YES
Muscle Aches/Pains □ NO □ YES

NEUROLOGICAL
Dizziness/Vertigo □ NO □ YES
Headaches □ NO □ YES
Strokes □ NO □ YES
Seizures □ NO □ YES
Tremor □ NO □ YES
Numbness □ NO □ YES

PSYCHOLOGICAL
Anxiety □ NO □ YES
Depression □ NO □ YES
Other_____

History of Cancer? Yes No
If yes, type: _____
Chemo: Yes No
Radiation: Yes No

Please notify the MD/NP/PA/RN if you are pregnant: Yes No

Current Medication:	Dosage:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Any allergies to: Shellfish Iodine Latex Contrast/IV dye

Allergies	Reaction
1.	
2.	
3.	

Social History:

1. **Are you a:** Current Smoker / Never Smoker / Former Smoker **Quit Date:** _____
   Type: _____ **Packs/day**:_____ **Years:** _____
2. **Do you use chewing and/or smokeless tobacco?** Yes or No **Have you quit?** Yes or No
   When? _____
3. **Do you drink alcohol?** Yes or No **Type(s):** _____ **Amount**: _____ **How often**:_____
4. **Do you use illicit (street) drug**s? Yes or No **Type(s):** _____ **Last used**:_____
5. **Marital Status**: Single Married Cohabitating Separated Divorced Widowed
6. **Who do you live with**? Alone Spouse Children Parents Other:_____
7. **What is your occupation**? _____
8. **Are you disabled**? Yes or No **If yes, note disability**: _____

Medical/Personal History:

Are you right- or left-handed? Right Left Ambidextrous

Past Medical History:

_____

_____

Past Surgical History and Dates:

_____

_____

Family Medical History:

_____

Please share any other information you would like us to know:

_____

_____

Preferred Pharmacy:

Name:_____ Phone Number:_____

Address:_____

If this form was completed by someone other than the patient, please list the name, relation to the patient and the reason that the patient was unable to complete the form.

Form Completed by_____ Date_____