New Patient First Appointment Form

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Athena NP
1.0

Patient Name: ______________________ Appointment Date: ____________ Date of Birth: ____________

Please describe your <u>Main Problem</u> associated with this appointment

If you have pain, how long have you had this pain? ______________________

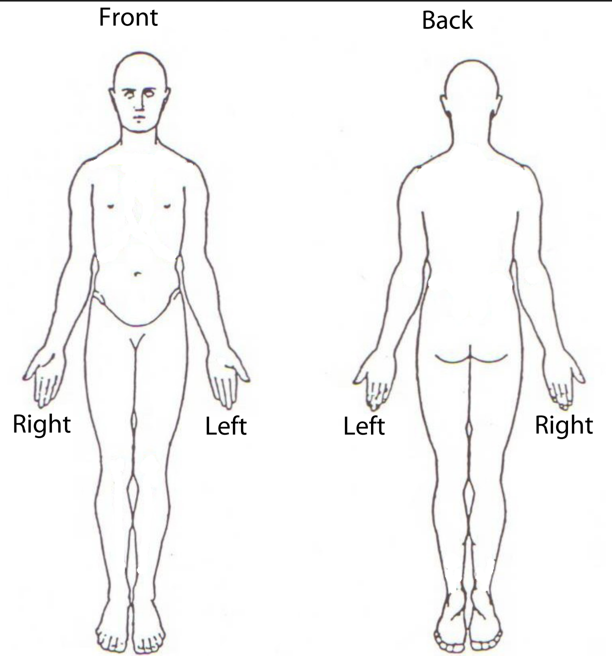
How bad is your pain now?

(Please check ONE box below)

- LEAST ☐ 0 No pain at all
- ☐ 1 Like an itch
- ☐ 2 Very minor (band aid)
- ☐ 3 Kind of annoying
- ☐ 4 Concerning but can still function
- ☐ 5 Like Tooth Ache or Bee sting
- ☐ 6 Serious - interferes with concentration
- ☐ 7 Distressing - can't live alone
- ☐ 8 Can't move as it hurts too bad
- ☐ 9 Like been mauled by a bear
- MOST ☐ 10 Unimaginable -passed out due to pain

Please mark the body diagram where you feel:

Ache
^^^^
^^^^
Burning
xxxx
xxxx
Numbness
0000
0000
Pins & Needles
////
////
Stabbing
====
====



Do you need work restrictions addressed for your employment or insurance forms? ☐ Yes ☐ No

(Females Only)
Are you or could you be pregnant?
☐ Yes ☐ No

______________________ Date ____________
Patient's Signature

***NOTE:** This form must be <u>completed</u> and <u>turned in</u> to our office at or before your scheduled **Arrival Time** or your appointment will be rescheduled.*

PROBLEM DETAILS:

How does the following affect your pain?

	INCREASES	DECREASES	NO EFFECT
Sitting	☐	☐	☐
Standing	☐	☐	☐
Lying down	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Walking	☐	☐	☐
Coughing/Sneezing	☐	☐	☐

What **treatments** have you had for your **Neck, Back** or **Nervous System** (i.e. Carpal Tunnel, Ulnar, etc) **problems**?

(For each row please select either **Yes** or **No**, Do not leave Blank)

	YES	NO	How long / Where?
Bed Rest	☐	☐	
Exercise	☐	☐	
Physical Therapy	☐	☐	
Chiropractic	☐	☐	
Injections	☐	☐	
Medications	☐	☐	
Type of Medications used to treat this problem:			
Other (specify)	☐	☐	

Do you have a Pulmonologist? If so please list their name:	Do you have a Cardiologist? If so please list their name:	Do you take a PRESCRIBED blood thinner? If yes who manages?:	Do you have a Family Doctor? If so please list their name:
______________	______________	______________	______________

REVIEW OF SYSTEMS: Have you recently experienced a problem with any of the following?

General / Constitutional

- [ ] None of the following
- [ ] Fever
- [ ] Weight gain
- [ ] Weight Loss

Musculoskeletal

- [ ] None of the following
- [ ] Joint swelling
- [ ] Joint pain
- [ ] Muscle spasm/cramps
- [ ] Muscle weakness

Neurologic

- [ ] None of the following
- [ ] Numbness
- [ ] Loss of coordination
- [ ] Head Aches
- [ ] Tremors
- [ ] Memory loss

Eyes

- [ ] None of the following
- [ ] Blindness
- [ ] Eye pain
- [ ] Blurry vision
- [ ] Sensitivity to light

Ear / Nose / Throat

- [ ] None of the following
- [ ] Hearing loss
- [ ] Ringing in ears
- [ ] Hoarseness
- [ ] Trouble swallowing

Cardiovascular

- [ ] None of the following
- [ ] Palpitations
- [ ] Fainting
- [ ] Ankle swelling
- [ ] Chest pain

Respiratory

- [ ] None of the following
- [ ] Wheezing
- [ ] Coughing up blood
- [ ] Shortness of breath
- [ ] Sleep apnea
- [ ] Cough

Gastrointestinal

- [ ] None of the following
- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Abdominal pain
- [ ] Loss of bowel control
- [ ] Indigestion

Genitourinary

- [ ] None of the following
- [ ] Loss of bladder control
- [ ] Painful urination
- [ ] Frequent urination

Skin

- [ ] None of the following
- [ ] Itching
- [ ] Rash

Hematologic/Lymphatic

- [ ] None of the following
- [ ] Abnormal bruising
- [ ] Bleeding

Allergic / Immunologic

- [ ] None of the following
- [ ] Rashes
- [ ] Hay fever
- [ ] Persistent infections
- [ ] HIV exposure

Patient Name: ______________________ Date of Birth: __________

Did a work injury or motor vehicle accident cause your pain or problem? ☐ Yes ☐ No *(if No please skip section below)*

IF YES - Please fill in the following <u>ONLY</u> if an Injury caused your pain or problem

What date did the injury occur? __________ Where did the injury occur? ______________________

Describe the injury

Are you currently working? ☐ Yes ☐ No If NOT working, last date worked? __________

HIPAA Contact(s)

Please list any person(s) that you give Regional Brain & Spine permission to discuss your medical care with.

Name:______________________ Phone Number:______________________

Name:______________________ Phone Number:______________________

Name:______________________ Phone Number:______________________