Dr. Hu New Patient Packet

Patient name: _____ **Date**: _____

Who referred you, or how did you hear about Dr. Hu? _____

To ensure a quicker process, please read the questions thoroughly and give your best answer(s) possible.

1. What is the SINGLE WORST area of pain? (*DO NOT circle more than one area)

Neck	Shoulder	Arm	Hand/Wrist	Low back	Buttock	Leg	Foot/Ankle	Hip/Groin	Knee	Face/Head	Other:

Side:

LEFT	RIGHT	or	BOTH

2. When did the pain FIRST begin (an estimate is fine)? (month/year) _____/_____

3. Have you had any IMAGING of the painful area in the last 3 years? (MRI/XRAY/CT): YES or NO

   If Yes, and if you remember, where did you have the imaging done? _____

4. Does the pain RADIATE to other areas? YES or NO

   If you answered YES to the question above, what area does the pain RADIATE to? (Circle one)

Neck	Shoulder	Arm	Hand/Wrist	Low back	Buttock	Leg	Foot/Ankle	Hip/Groin	Knee	Face/Head	Other:

Side:

LEFT	RIGHT	or	BOTH

5. Is the pain (Circle one): CONSTANT or COMES and GOES

6. How would you describe the pain or discomfort? (Circle all that apply)

Aching	Throbbing	Sharp/Stabbing	Burning	Shooting	Numb/Tingling
Pressure	Sore	Squeezing/Gripping	Cramping	"Electric shocks"	Dull

7. The pain is **WORSENED** with? (Circle all that apply)

Standing	Lying flat on back	Walking	Bending Over	Sitting	Twisting	Inactivity/Resting	Laying on left side	Lying on right side
Weather Changes	Overhead arm movements	Driving	Looking up/down	Looking left/right	Sit-to-stand motion	Nothing makes it worse	Other (explain in the box to the right):	

8. The pain is **IMPROVED** with? (Circle all that apply)

Standing	Laying Flat	Walking	Bending Over	Sitting	Twisting Weather	Inactivity/Resting	Laying on left side	Laying on right side
Heat/Ice packs	Cold weather	Hot weather	Medications (OTC and prescription)	Massage	Yoga/Tai Chi	Acupuncture	Injections	Nothing Helps

9. Have you EVER had neck Surgery? YES or NO

   If you answered yes:

   What type of neck surgery? _____

   When did you have the surgery (month/year)? _____

10. Have you EVER had back surgery? YES or NO

    If you answered yes:

    What type of back surgery? _____

    When did you have the surgery? _____

11. What was the date of the last time you participated in physical therapy or chiropractic treatments (month/year)?

    _____

    How many sessions of therapy did you complete, or how many weeks of therapy?

    _____

    How did physical therapy and/or chiropractic treatments help? (Circle below)

Improved my pain	Improved my mobility	Improved my flexibility	No noticeable changes	Increased pain/made pain worse	Cost prohibitive

12. Do you CURRENTLY have, or have you EVER HAD any of the following devices? (Circle below)

Spinal Cord Stimulator	Intrathecal Pain Pump	Pacemaker or Defibrillator	Other implantable device (explain):

13. Do you have ACTIVE cancer? YES or NO
    If yes, what type? _____

14. Place an "X" in the box for **ONLY** the medications that you are currently on or have taken in the past. If this has helped or did not help. Leave blank if you have never taken the medication. If you mark TAKING, you should still mark if it is helping or not.

Help	No Help	Medication	Taking
		Aspirin	
		Motrin/Advil/Ibuprofen	
		Aleve/Naprosyn/Naproxen	
		Celebrex/Celecoxib	
		Diclofenac	
		Lidocaine Cream/Patches	
		Capsaicin Cream	
		Menthol Cream/Biofreeze	
		Voltaren/Diclofenac Gel	
		Flexeril/Cyclobenzaprine	
		Robaxin/Methocarbomol	
		Baclofen	
		Zanaflex/Tizanidine	
		Carisoprodol/Soma	
		Amitriptyline/Elavil	
		Nortriptyline/Pamelor	
		Wellbutrin/Bupropion	
		Venlafaxine/Effexor	
		Duloxetine/Cymbalta	
		Gabapentin/Neurontin	
		Pregabalin/Lyrica	

Help	No Help	Medication	Taking
		Topiramate/Topamax	
		Meloxicam/Mobic	
		Nucynta	
		Tramadol/Ultram	
		Codeine/Tylenol #3/#4	
		Hydrocodone/Norco	
		Morphine	
		Morphine ER	
		Oxycodone/Percocet	
		Oxycontin/Oxycodone ER	
		Methadone	
		Hydromorphone/Dilaudid	
		Fentanyl Patch	
		Clonazepam/Klonopin	
		Alprazolam/Xanax	
		Lorazepam/Ativan	
		Diazepam/Valium	
		TENS Unit	
		Epidural Injections	
		Trigger Point Injections	
		Facet Injections	

15. What is your PAIN Score on a scale of 1-10? (10 being the worst pain ever)

Now

1	2	3	4	5	6	7	8	9	10

Best

1	2	3	4	5	6	7	8	9	10

Worst

1	2	3	4	5	6	7	8	9	10

16. Do you **CURRENTLY** have any of the following symptoms? (Circle or describe any below)

Cardiovascular	**Respiratory**	**Neurological**	**Muscle/Joint disease**
Palpitations	Shortness of breath	Seizures	Swelling in joints
Leg Swelling	Chronic cough	Weakness	Arthritis/Joint
Chest pain/Angina	Wheezing	Loss of sensation in the rectal area, or the inner upper thigh	Frequent muscle spasm
Other:	Sputum production	Other:	Back or neck problems
Gastrointestinal	**Endocrine**	**Psych**	**Hematology**
Nausea	Excessive thirst	Depression/Anxiety	Bleed easy/bruising
Diarrhea	Change in or Loss of appetite	Other:	Taking antibiotics
Constipation	Heat/Cold intolerance	**General**	**Genitourinary**
Heartburn	Significant, night drenching sweats	Fever/Chills	New or sudden change in bladder incontinence
New or sudden change in bowel incontinence	Other:	Involuntary weight loss	Any other concerns not specified in this chart (explain):

17. Are you currently taking, or have you recently taken, blood thinning medications or supplements (including Aspirin)? Circle “Yes” or ”No” below.

YES or NO

If YES, which one(s)? _____

18. Have you recently taken/received steroids by mouth or otherwise (incl. steroid injections)? YES or NO

    If yes, which one(s)? _____

    When was the last time? (month/year) _____/_____

19. Do you use, or have you EVER used, the following?

    Alcohol: YES NO If yes, how much and how often? _____

    Street Drugs: YES NO If yes, which one(s), and when was the last use? _____

    Tobacco: YES NO If yes, how many cigarettes per day? _____