



**22749 STATE ROAD 7 - ROUTE 441
SUITE E
BOCA RATON, FL 33428
Phone: 561-218-4951 - Fax: 561-218-4961
info@painbeegone.org**

Please print out and complete this new patient
questionnaire. Bring it when you visit our office.

Name _____ Social Security Number _____

Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number _____

Business Phone Number _____

Sex: Female ____ Male ____ Age ____ Date of Birth _____

Marital Status: Single Married Divorced Separated Widowed

Employer Name and Address: _____

Employer Phone Number: _____

Occupation: _____

Emergency Contacts:

1. Name _____ Relation _____

Phone Number _____

2. Name _____ Relation _____

Phone Number _____

Whom may we thank for referring you? _____

CHIEF COMPLAINTS:

Pain ____ Anxiety ____ Depression ____ Other _____

Duration ____ days /weeks/months/years

What do you think caused your pain? Check below, and indicate year if injury.

- heavy lifting strain: _____
- hit by car (walking, biking) _____
- car accident(s) _____
- motorcycle accident(s): _____
- fall from a height: _____
- fall on the ground: _____
- gunshot wound: _____
- physical assault: _____
- other cause(s) of injury which caused the pain: _____

What Kind of work did you do prior to your injury? _____

Number of Year(s) _____

| Present Medication/Treatment | Strength | Dosage | How long have you been taking this medication? |
|------------------------------|----------|--------|--|
| | | | |

Check other treatment being received:

Physical Therapy ____

Acupuncture ____

Behavioral Modification ____

Psychiatric Treatment ____

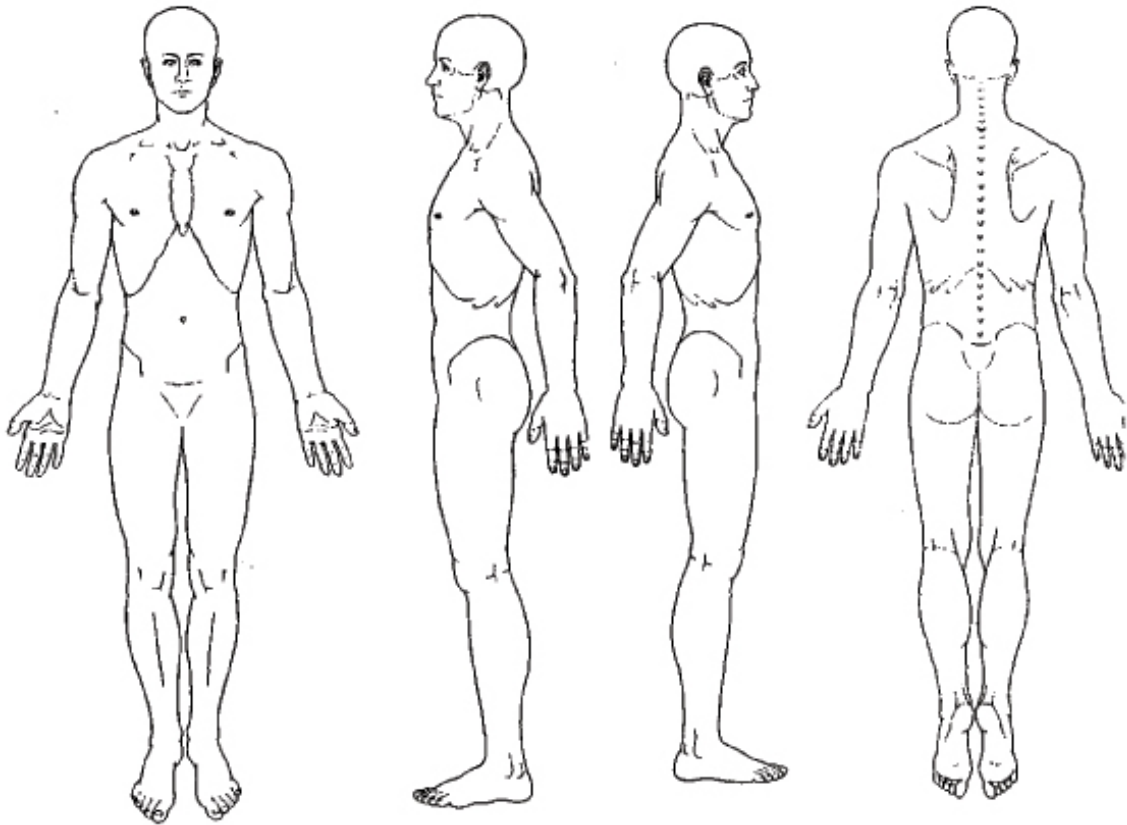
Narcotics ____

Duration of this treatment: ____ days ____ weeks ____ months ____ years

I. Please mark the location(s) of your pain. You may mark more than one location:

PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

- PPP Where you experience Pain
- NNN Where you experience Numbness
- TTT Where you experience Tingling
- BBB Where you experience Burning
- CCC Where you experience Cramping

PATIENT SIGNATURE _____ DATE _____

