Dr. Kristen E. Cardamone

11 Overlook Rd, MAC II, Suite 180, Summit, NJ 07901
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NEW PATIENT QUESTIONNAIRE

Name: _____ Date: _____ DOB: _____

Referred by:_____ Height: _____ Weight:_____

Primary Doctor and contact tel/fax:_____

Reason for visit:_____

History:

When did your pain first start? *(be specific as you can)*: _____
_____

What were circumstances surrounding how pain began? _____
_____

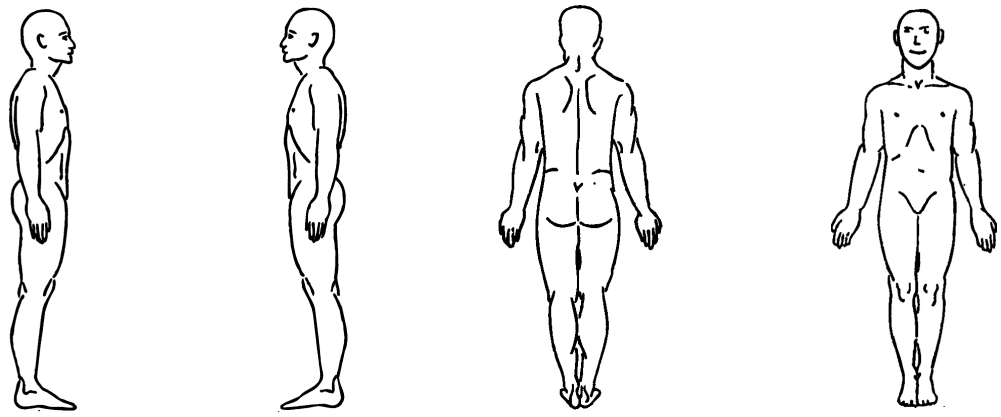
Was it the result of an accident or injury? Yes No Is there any litigation involved? Yes No

Does the pain radiate from this part of your body to another area(s)? If yes, where? _____
_____

Please circle the words that best describe your pain:

ACHING	HOT	SHOOTING	SHARP	COLD
BURNING	NUMB	SEVERE	STABBING	TINGLING

Please indicate where your pain is below:



On a scale of 1-10 with 1 being no pain and 10 being the worst possible pain, please circle your pain scale right now:

1 2 3 4 5 6 7 8 9 10

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On a scale of 1-10 with 1 being no pain and 10 being the worst possible pain, please circle the most pain you have been in over the past two weeks:

1 2 3 4 5 6 7 8 9 10

Please circle if your pain is:

Constant Intermittent Brought on by Aggravating Factors

Is there a time of day when your pain is usually: *Better?* AM or PM *Worse*? AM or PM

Are there activities that make your pain worse? (walking, sitting, climbing stairs, etc.)?_____

_____

What positions/treatments seem to offer some relief for your pain? _____

_____

Diagnostic Tests:

Please circle any diagnostic test you have had for this condition:

MRI CAT SCAN EMG XRAY OTHER_____

Please circle any treatment you have had for pain and duration of treatment:

Acupuncture Chiropractor Heat/Cold Massage Physical Therapy Other:_____

Pain Medications or Supplements Tried for this condition(indicate names): _____

_____

What Injections have you had for this condition and be specific on type and body region:_____

_____

Surgeries/Procedures for this condition (indicate type): _____

All Current Medications and Supplements:

Please list all medications currently being taken for pain and any other prescription medications or supplements you are taking for *any* condition. Or alternatively please attach a detailed list to this packet.

Medication/Supplement	Amount(Mg)	Frequency	What is it for?	Who prescribed?

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Medication/Supplement	Amount(Mg)	Frequency	What is it for?	Who prescribed?

Allergies:

Please list any known allergies (food/meds/environmental) you have and the reaction they cause.

☐ Check if you have no known drug allergies

Allergy (medication, food, etc.)	Reaction

Do you have any ongoing medical problems?_____

_____

Have you had any past surgeries? Please list with the years:

_____

_____

Do you have any relevant family medical history?

_____

_____

Social History:

Marital Status: Single Married Divorced Widowed Committed Relationship

Work Status: Working Not Working Retired Disabled

Do you smoke? Yes No If so how much?_____

Do you drink alcohol? Yes No If so how many drinks/week?_____

Circle the number to indicate the extent of problems you are having with each of the following:

	Low levels				Average					Severe
Anxiety	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10

Do you use an assistive device to get around? Cane Walker Wheelchair Scooter

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Have you ever or are you currently being exposed to water damage/flooding in home or work? (Describe): _____

_____

Have you had any regular home or occupational exposure to chemicals, pesticides, heavy metals? (Explain): _____

_____

Please list all travel locations prior to onset of your symptoms: _____

In the past three days:

What was a typical Breakfast:_____

What was a typical Lunch:_____

What was a typical Dinner: _____

Do you snack at all during day and if so what do you eat? _____

How many glasses of water do you drink a day? _____

How many days in a week do you exercise? 1 2 3 4 5 6 7

What type of exercise do you do? _____

What do you do for stress relief/relaxation and how often? _____

Review of Symptoms:

Do you CURRENTLY have problems with any of the following?

	Yes	No		Yes	No
Headaches (where?_____)	☐	☐	Constipation	☐	☐
Heart Palpitations	☐	☐	Swelling	☐	☐
Chronic cough	☐	☐	Difficulty Sleeping	☐	☐
Heartburn	☐	☐	Blurred Vision	☐	☐
Chest Pain	☐	☐	Hearing Changes	☐	☐
Wheezing	☐	☐	Mercury fillings	☐	☐
Diarrhea	☐	☐	Currently Pregnant	☐	☐
Bowel/Bladder Incontinence	☐	☐	Weakness	☐	☐
Shortness of Breath	☐	☐	Multiple joint pain	☐	☐
Rashes	☐	☐	Tingling/burning	☐	☐
Excessive Fatigue	☐	☐	Loss of Libido	☐	☐
Rapid mood swings	☐	☐	Hair loss/dry skin	☐	☐
Confusion/Brain fog	☐	☐	Unintended wt loss/gain	☐	☐

Please sign, date and return this questionnaire to our office by email: info.icwellness@gmail.com or fax: 908-522-2207 NO LATER than 24 hours prior to your appointment in order for the doctor to properly review all your detailed information in advance and offer you the most comprehensive visit that you deserve!

Patient Signature:_____ Date:_____

Reviewed by Dr. Cardamone:_____ Date:_____