KOCHAN PAIN TREATMENT CENTER
Andrew Kochan, M.D. | Diplomate, Board of Physical Medicine

NEW PATIENT GOALS

Name _____ Date _____

What are your goals in seeking treatment with Dr. Kochan?

_____

_____

_____

What are your expectations?

_____

_____

_____

How many hours on an average do you sleep at night?_____ Do you wake up because of pain?_____

Do you need to take sleep medications because of pain? _____ If yes, which ones? _____

_____

Do you exercise? _____ If yes, how often? _____ What type?_____

_____

Do you drink alcohol? _____ If yes, how often? _____

Do you smoke cigarettes? ____ If yes, how many/day? _____ Did you ever? ____ When did you stop?_____

Were you or are you subject to second-hand smoke? _____ For how long? _____

Do you consider yourself normal weight? _____ Too thin? _____ Too heavy? _____ Way too heavy? _____

Are you on a diet? _____ If yes, what type? _____

Please list any bone fractures or severe trauma you have had and the year it occurred.

_____

_____

_____

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