# PATIENT INFORMATION

Date: Name: Dob: Age: Height: Weight: BMI:

Referring Provider: Primary Care Provider

# PAIN HISTORY

**Chief Complaint** (Reason for your visit today)  Pain  Weakness  Other

1. Where is the pain located -  Low Back  Mid Back  Buttock

Thigh  Leg  Generalized

Joints (Hip/ Knee/Ankle)  Other

1. Is the pain more in your back or in your leg?  Back  Legs: More in which Leg?  Right  Left
2. Does this pain radiate? If yes, where?  Buttock  Thigh  Leg

Other

Please indicate (circle) the severity of the pain as it is most of the time (0=no pain, 10=worst pain).

|  |  |
| --- | --- |
| Location | Pain usually/now |
| Back | 0 1 2 3 4 5 6 7 8 9 10 |
| Right Leg | 0 1 2 3 4 5 6 7 8 9 10 |
| Left Leg | 0 1 2 3 4 5 6 7 8 9 10 |
| Other: | 0 1 2 3 4 5 6 7 8 9 10 |
| Other: | 0 1 2 3 4 5 6 7 8 9 10 |

1. Use this diagram to indicate the area of your pain. Mark the location with given symbol in the table below.

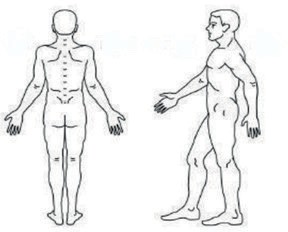
|  |  |
| --- | --- |
| **- - -** | Numbness |
|  | Pins and needles |
|  | Burning Pain |
| ∆∆∆ | Stabbing Pain |
| xxx | Aching Pain |



**Right**

**Left**

**Left Right**

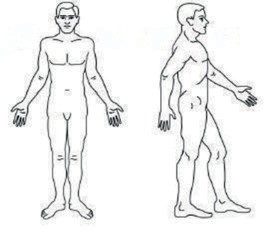


**Left**

**Right**

**Right**

**Left**



**Right**

**Left Right**

**Left**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| E) Approximately when did this pain begin? | Days | Weeks | Months | Years. |
| F) What caused your current pain episode? | Fall | Vehicular Accident | Lifting | Don’t Know |

Other

1. How did your current pain episode begin?  Gradually  Suddenly
2. How often does the pain occur?  Constantly unrelated to activities  Intermittent -unrelated to activities (Few times  Every day /  Every week /  every month).

Only with activities  Constantly present but aggravated by activities.

1. When is your pain at its worst?

Mornings  Daytime  Evenings

 Middle of the night  Always the same

1. Check all the following that describe your pain:  Dull/Aching  Hot/Burning  Shooting

Stabbing/Sharp  Cramping  Numbness

Spasming  Throbbing  Squeezing

 Tingling/Pins & Needles  Tightness.

1. What effect does each of the following have on your pain?

Better Worse Same Better Worse Same

Bending Backward    Bending Forward

Changes in Weather    Climbing Stairs

Coughing/Sneezing    Driving

Lifting Objects    Looking Upward

Looking downward    Rising from sitting

Sitting    Standing

Walking    Other

1. Since your pain began how it has changed?  Improved  Worsened  Stayed the same.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Associated Symptoms** |  | | | |
| 1. Numbness tingling: | Groin | Thigh | Knee | Leg |
|  | Ankle | Foot | Sole | Right |
|  | Left | Both |  |  |
| 2. Weakness in the leg: | Thigh | Knee | Leg | Ankle |
|  | Foot | Right | Left | Both |
| * Do you | Drag your feet | Buckle in your knees, |  | Get cramps in your legs, |

Increased numbness and weakness --- ***when you walk for some time.***

1. Joint Swelling/ Stiffness:  Hip  Knee  Ankle  Foot joints

 Hand joints  Right  Left  Both.

1. Morning Stiffness in back:  Yes  No.–if yes  Lasts more than 30 min
2. Fever Chills  Yes  No -- Explain
3. Loss of bladder control  Yes  No - Explain
4. Loss of bowel control  Yes  No - Explain
5. Balance related problems  Yes  No - Explain

# WORKMANS COMPENSATION

Is your pain the result of a  Fall  accident  Injury -- on the job?

 Other

If yes, when was the date of injury:

BRIEFLY describe the mechanism of injury:

Are you currently under worker’s compensation?  No  Yes

* Have you ever had back/neck problems before this injury?  No  Yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| * When did the pain begun after the injury? | No | Yes, describe |
| * Is your current pain directly related to injury? | No | Yes, describe |

* Employer at the time of injury
* Does your job require any lifting, standing, or sitting?
* Do you think you can continue the current work with the pain?  No  Yes
* Is there an ongoing lawsuit related to your visit today?  No  Yes

PLEASE READ: This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer each section by checking the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CHECK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

|  |  |  |  |
| --- | --- | --- | --- |
| **SECTION 1 - Pain Intensity**  I can tolerate the pain I have without having to use pain medication.  The pain is bad, but I can manage without having to take pain medication.  Pain medication provides me with complete relief from pain. Pain medication provides me with moderate relief from pain. Pain medication provides me with little relief from pain.  Pain medication has no effect on my pain. | | | **SECTION 6 - Standing**  I can stand as long as I want without extra pain.  I can stand as long as I want, but it increase my pain. Pain prevents me from standing for more than I hour.  Pain prevents me from standing for more than 30 minutes. Pain prevents me from standing for more than 10 minutes. Pain prevents me from standing at all. |
| **SECTION 2 - Personal Care (Washing, Dressing, etc.)**  I can take care of myself normally without causing increased pain. I can take care of myself normally, but it increases my pain.  It is painful to take care of myself, and I am slow and careful.  I need help, but I am able to manage most of my personal care. I need help every day in most aspects of my care.  I do not get dressed, I was with difficulty, and I stay in bed. | | | **SECTION 7 - Sleeping**  Pain does not prevent me from sleeping well. I can sleep well only by using pain medication.  Even when I take medication, I sleep less than 6 hours. Even when I take medication, I sleep less than 4 hours. Even when I take medication, I sleep less than 2 hours.  Pain prevents me from sleeping at all. |
| **SECTION 3 - Lifting**  I can lift heavy weights without extra pain.  I can lift heavy weights, but it gives extra pain.  Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.  Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.  I can lift very light weights. | | | **SECTION 8 - Social Life**  My social life is normal and does not increase my pain. My social life is normal, but it increases my level of pain.  Pain prevents me from participating in more energetic activities (e.g., sports, dancing).  Pain prevents me from going out very often. Pain has restricted my social life to my home.  I have hardly any social life because of my pain. |
|  |  | I cannot lift or carry anything at all. |
| **SECTION 4 - Walking**  Pain does not prevent me walking any distance. Pain prevents me from walking more than 1 mile. Pain prevents me from walking more than ½ mile. Pain prevents me from walking more than 100 yards. I can only walk using a stick or crutches.  I am in bed most of the time and have to crawl to the toilet. | | | **SECTION 9 - Social Life**  I can travel anywhere without increased pain.  I can travel anywhere, but it increases my pain. My pain restricts my travel over 2 hours.  My pain restricts my travel over 1 hours.  My pain restricts my travel to short necessary journeys under  ½ hour.  My pain prevents all travel except for visits to the physician therapist or hospital. |
| **SECTION 5 - Sitting**  I can sit in any chair as long as I like.  I can only sit in my favorite chair as long as I like. Pain prevents me sitting more than one hour.  Pain prevents me sitting more than 30 minutes. Pain prevents me sitting more than 10 minutes. Pain prevents me sitting at all. | | | **SECTION 10 - Employment / Homemaking**  My Normal homemaking / job activities do not cause pain.  My Normal homemaking / job activities increase my pain, but I can still perform all that is required of me.  I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).  Pain prevents me from doing anything but light duties. Pain prevents me from doing even light duties.  Pain prevents me from performing any job or homemaking chores. |

## Please list all past pain medications that you have been on at any point for your current pain.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MEDICATION** | **DOSE** | **FREQUENCY** | **PERIOD APPROXIMATELY TAKEN** | **CURRENTLY TAKING** | **GOOD RELIEF** | **MODERATATE PAIN RELIEF** | **NO PAIN RELIEF** | **SIDE EFFECT EXPERIENCED** |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
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**Interventional pain treatment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **INTERVENTIONAL PAIN TREATMENT TYPE** | **REGION** | **NUMBER OF PROCDURES LAST YEAR** | **DATE OF THE LAST**  **PROCEDURES** | **AMOUNT OF PAIN**  **RELIEF MILD, MODERATE ,**  **EXCELLENT** | **SIDE EFFECT EXPERIENCED** |
| EPIDURAL STEORID INJ |  |  |  |  |  |
| FACET JOINT INJECTION |  |  |  |  |  |
| SACROILIAC JOINT INJECTION |  |  |  |  |  |
| MEDIAL BRANCH BLOCKS |  |  |  |  |  |
| RFA |  |  |  |  |  |
| SPINAL CORD STIMULATOR |  |  |  |  |  |
| TRIGGER POINTS |  |  |  |  |  |
| VERTEBROPLASTY/KYPHOPLASTY |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Physical therapy Details** |  | |
| * Have you had physical therapy for this problem? | Yes | No If Yes When/ Where |
| * Did this therapy help? | Yes | No explain |
| * Do you do any special exercises for your back or neck? | Yes | No explain |

Pain management DR - List the names of any previous pain management physicians you have seen in the past:

## PAST SURGICAL HISTORY Please list any surgical procedures you have had done in the past including date:

1. Date
2. Date
3. Date
4. Date
5. Date
6. Date

 I have NEVER had any surgical procedures performed.

## MEDICATIONS: Please list all medications you are currently taking including vitamins but excluding the pain medications.

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |

**INVESTIGATION HISTORY: Mark all the following tests that you have related to your current pain complaints in the last year.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Investigation** | **Region** | **Recent dates** | **Region** | **Recent Dates** |
| **MRI** |  |  |  |  |
| **CT scan** |  |  |  |  |
| **X-rays** |  |  |  |  |
| **EMG- NCV** |  |  |  |  |
| **Vascular studies** |  |  |  |  |
| **DEXA scan** |  |  |  |  |
| **Myelogram** |  |  |  |  |
| **Discogram** |  |  |  |  |
| **PET Scan** |  |  |  |  |

Other Diagnostic Testing: Date:

 I have not had ANY diagnostic tests for my current pain complaint.

## PREVIOUS CONSULTATIONS Mark the following physicians or specialists you have consulted for your current pain problem(s):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Specialty** | **Name** | **Treatments** | **Pain relief?** | **Last intervention**  **Dates** |
| **Acupuncturist** |  |  |  |  |
| **Neurosurgeon** |  |  |  |  |
| **Psychiatrist/Psychologist** |  |  |  |  |
| **Chiropractor** |  |  |  |  |
| **Orthopedic Surgeon** |  |  |  |  |
| **Rheumatologist** |  |  |  |  |
| **Internist** |  |  |  |  |
| **Physical Therapist** |  |  |  |  |
| **Neurologist** |  |  |  |  |

 Other:

List the names of any previous pain management physicians you have seen in the past:

# PAST MEDICAL HISTORY

Mark the following conditions/diseases that you have been treated for in the past:

## General Medical

 Cancer – Type

 Diabetes – Type I Type II Controlled?  Yes  No Blood Sugar Average weekly!

Last Hb A1c Any Diabetes related comorbidity

**Head/Ears/Eyes/Nose/Throat ** Headaches  Migraines  Head Injury

 Hyperthyroidism  Hypothyroidism  Glaucoma

**Hematologic-** Where you diagnosed or treated with conditions related to increased chances of

Blood clots,  Blockage of the blood vessels

Delayed healing of wounds,  Increased bleeding  Stoke/TIA

Peripheral Vascular Disease  Heart Valve Disorders

**ANTICOAGULANTS:** Are you currently taking any blood thinners or anti-coagulants?

Yes  No If Yes, which ones?  Aspirin

Plavix  Coumadin  Xarelto

Other

|  |  |  |  |
| --- | --- | --- | --- |
| **Musculoskeletal/Rheumatologic** | Bursitis | Carpal Tunnel Syndrome | Fibromyalgia |
|  | Osteoarthritis | Osteoporosis | Rheumatoid Arthritis |
|  | Chronic Joint Pains |  |  |

Have you been seeing any rheumatologist  if yes then what where you diagnosed with

What anti-arthritis medications you have been taking?

* Have you been diagnosed with Osteoporosis and are under treatment for osteoporosis with one of the following medications?

**Cardiovascular/ ** Anemia  Heart Attack  Coronary Artery Disease  High Blood Pressure **Respiratory ** Asthma  Bronchitis/Pneumonia  Emphysema/COPD **Gastrointestinal ** GERD (Acid Reflux)  Gastrointestinal Bleeding  Stomach Ulcers  Constipation **Neuropsychological ** Multiple Sclerosis  Peripheral Neuropathy  Seizures  Depression

 Anxiety  Schizophrenia  Bipolar Disorder

**Urological ** Chronic kidney Disease  Kidney Stones  Urinary Incontinence  Dialysis

Other:

Have you ever been diagnosed with Dementia or Alzheimer’s disease?  Yes  No

Is there a chance that you are pregnant?  Yes  No

# ALLERGIES

Do you have any drug/medication allergies?  Yes  No If yes, please list all medications you are allergic to:

|  |  |  |  |
| --- | --- | --- | --- |
| **No.** | **Medication** | **Reaction** | **Alternatives if known** |
| **1** |  |  |  |
| **2** |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |
| **5** |  |  |  |

Topical Allergies:  Latex  Iodine  Tape  IV Contrast

Any other allergies:

## REVIEW OF SYSTEMS for Today

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Constitutional:** | Chills | Difficulty Sleeping | Easy Bruising | Night Sweats |
|  | Fatigue | Fevers | Insomnia | Low sex Drive |
|  | Tremors | Unexplained Weight Gain | Weakness | Unexplained Weight Loss |
| **Eyes:** | Recent Visual changes |  |  |  |
| **Ears/Nose/Throat/Neck:** | Dental Problems | Earaches | Hearing Problems | Nosebleeds |
|  | Sinus problems |  |  |  |
| **Cardiovascular:** | Chest Pain | Bleeding Disorder | Blood Clots | Fainting |
| Palpitations Swelling in feet Shortness of breath during sleep | | | | |
| **Respiratory:** | Cough | Wheezing | Shortness of breath |  |
| **Gastrointestinal:** | Constipation | Acid Reflux | Abdominal Cramps | Diarrhea |
|  | Nausea/Vomiting | Hernia |  |  |
| **Musculoskeletal:** | Back Pain | Joint Pains | Joint Stiffness | Joint Swelling |
|  | Muscle Spasms | Neck Pain |  |  |
| **Genitourinary/Nephrology:** |  | Flank Pain | Blood in Urine | Painful Urination |
| Decreased Urine Flow/Frequency/Volume | | | | |
| **Neurological:** | Dizziness | Headaches | Tremors | Numbness/Tingling |
|  | Seizures |  |  |  |
| **Psychiatric:** | Depressed Mood | Feeling Anxious | Stress Problems | Suicidal Thoughts |
|  | Suicidal Planning | Thoughts of Harming Others |  |  |

All other review of systems negative

# SOCIAL HISTORY

Are you: Married/Partnered/ Single/ Divorced/Separated /Widowed /Number of Children, if any:

Occupation: When was the last time you worked?

Who is in your current household?

Are there any stairs in your current home?  Yes  No If yes, how many?

 Temporary Disability  Permanent Disability  Retired  Unemployed Date started:

**Alcohol Use: ** Social Use  History of Alcoholism  Current Alcoholism  Never

Daily use of alcohol

**Tobacco Use: ** Current User  Former User  Never used  Packs per day?

How many years?  Quit Date:

**Illegal Drug Use: ** Denies any illegal drug use  Currently uses illegal drugs

 Formerly used illegal drugs

Have you ever abused narcotic or prescription medications?  Yes  No

* Do you have problems with  Blood transfusion  Use of bone grafts?

Use of donated organ tissue?

# FAMILY HISTORY

Mark all appropriate diagnoses as they pertain to your first-degree relatives:

|  |  |  |  |
| --- | --- | --- | --- |
| Arthritis | Cancer | Diabetes | Headaches/Migraines |
| High Blood Pressure | Kidney Problems | Liver Problems | Osteoporosis |
| Rheumatoid Arthritis | Seizures | Stroke | Other Medical Problems: |

 I have no significant family medical history.

Patient Signature Date

Reviewed by Date

MD Signature Date