Spine LLC: Patient Questionnaire

You can print it, email fax, mail or bring with you when you come to the office

Date:_____

Name: _____Date of Birth _____ Phone Number _____

Emergency Contact Name_____ Phone Number _____

Referring Physician: _____ Phone _____

Primary Care / Family Physician: _____ Phone _____

HISTORY OF PAIN:

1. What is the main complaint for which you are seeking treatment at the Pain Management Center?

_____

_____

2. How long have you had the pain problem you are currently experiencing?

_____

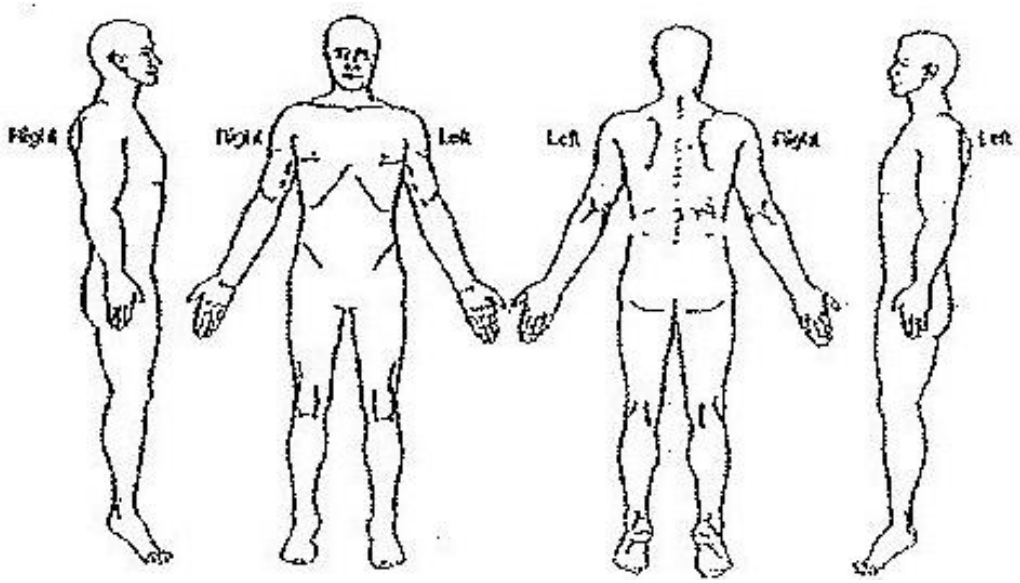
_____

3. What caused your pain to start?

_____

_____

4. On the diagram below, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.



5. Please circle the level of your pain on a scale of 0 to 10. (0= no pain; 10= worst imaginable pain)
   Worst Pain: 0 1 2 3 4 5 6 7 8 9 10
   Least Pain: 0 1 2 3 4 5 6 7 8 9 10

6. What type of pain do you have? (Check the box that best describes your pain.)
   ☐Aching ☐ Cramping ☐ Shooting ☐ Throbbing
   ☐Burning ☐ Piercing ☐ Stabbing ☐ Other

7. How often do you have pain?
   _____ Constantly _____ Intermittently

8. What makes your pain feel better? _____

   _____

9. What makes your pain feel worse? _____

   _____

10. Are there any other symptoms associated with your pain?
    ☐ Numbness ☐ Bowel Incontinence ☐ Tenderness of affected area
    ☐ Weakness ☐ Urinary Incontinence ☐ Pain with light touch

11. Are you depressed because of your pain? ___ Yes ___ No

12. Have you ever considered suicide to end your pain? ___ Yes ___ No

13. Has your pain affected any of the following? (Check all that apply.)
    ☐ Sleep ☐ Routine Activities ☐ Work

14. What other treatments have you had in the past to treat your pain?

Date	Type of Treatment	Pain Relief (%)

PAST MEDICAL HISTORY:

Please check any of the following conditions you have had or presently have:

☐ Diabetes	☐ Kidney disease	
☐ Cancer	☐ Thyroid disease	☐ HIV/AIDS
☐ Heart Problems	☐ Ulcer	☐ Hepatitis
☐ High blood pressure	☐ Bleeding problems	☐ Stroke
☐ Asthma, Emphysema	☐ Seizures	☐ Other

PAST SURGICAL HISTORY:

Date	Procedure

PERSONAL AND SOCIAL HISTORY:

1. What is your current martial status?
   ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/widower
2. Do you smoke? ___ Yes ___ No
3. Do you drink alcoholic beverages? ___ Yes ___ No
4. Do you use recreational drugs? ___ Yes ___ No
5. Present employment status:
   ☐ Full Time ☐ Unemployed ☐ Leave of absence ☐ Student
   ☐ Part Time ☐ Retired ☐ Homemaker

FAMILY HISTORY: (Check all that apply)

☐High blood pressure	☐ Heart Attack	☐Heart Disease
☐Hepatitis	☐ Asthma	☐Lupus
☐Diabetes	☐Seizures	☐Multiple Sclerosis
☐Depression	☐ Schizophrenia	☐ Alcoholism
☐Cancer	☐Thyroid disease	☐ Bleeding disorder
☐Other		

ALLERGIES: ☐ Yes ☐ No

If yes, please list: _____

MEDICATIONS:

Medications	Medications	Medications

DIAGNOSTIC STUDIES:

Test	Date	Facility Where Test Was Done
X-rays		
CT Scan		
MRI		
EMG/NCV		