Name: _____
D.O.B._____
Date:_____

INTERVENTIONAL SPINE SPECIALISTS

Initial Questionnaire

- **When did the pain first start? (Month and Year)**

- **How did the pain start? (Please circle all that apply)**

  Injury at work, Injury not at work, Accident, Surgery, Infection, No known cause, Other_____.

- **Did the pain start gradually or suddenly?**

- **Is the pain constant or comes and goes (intermittent)?**

- **How would you describe the pain? (Please circle all that apply)**
  Aching, Burning, Stabbing, Crampy, Sharp, Dull, Deep, Superficial, Knife-like, Throbbing, Shooting, Electric, Pins and needles, Other_____.

- **What makes the pain better? (Please circle all that apply)**
  Ice, Heat, Warm weather, Cold weather, Activity, Distraction, Pain medication, Standing, Sitting, Lying down, Walking, Bending forward, backward or sideward, Changing positions, Other_____.

- **What makes the pain worse? (Please circle all that apply)**
  Damp and Rainy weather, Activity and Stress, Ice, Heat, Warm weather, Cold weather, Activity, Distraction, Pain medication, Standing, Sitting, Lying down, Walking, Bending forward, backward or sideward, Changing positions, Other_____.

- **Does that pain wake you up at night?** Yes or No

- **Does the pain make you depressed?** Yes or No

- **Have you ever had suicidal thoughts or behaviors?** Yes or No

- **Please rate your pain level on a scale of 0 to 10. (0 is no pain and 10 is the worst pain you could ever imagine)**

0 1 2 3 4 5 6 7 8 9 10

(no pain) (extreme pain)

- **Are you able to function 100% (able to do all you wanted to do)?**
  Yes
  No

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- **Compared to when you were functioning at 100%, how would you rate your current functional level? (Please circle)**
  0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

- **Are you working?**
  Yes
  No

- **Are you receiving disability benefits for this pain problem or for any other medical problem?**
  Yes
  No
- **If yes, please specify:**
  Temporary, Permanent, Social Security, BWC, Other_____

- **If you are not currently receiving disability benefits, are you planning to apply for disability?**
  Yes
  No

- **Is litigation (law suit) regarding this pain problem:**
  Pending – Yes or No
  Possible in future – Yes or No
  Settled – Yes or No

- **Do you have a history of cancer?** Yes or No

- **Have you had any unexplained weight loss?** Yes or No

- **Do you have a current infection or immunosuppression (ex: recent Chemo-therapy, radiation therapy, HIV or AIDS)** Yes or No

- **Have you had a fever within the last week?** Yes or No

- **Have you recently had a work-related injury, major fall or motor vehicle accident with a suspected or actual fracture?** Yes or No

- **Have you had any accidents of the bladder?** Yes or No

- **Have you had any accidents of the bowels?** Yes or No

- **List all of your medical problems:**

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- **List all the surgeries you have had:**

- **List all your medications (with doses):**

- **List all of your drug allergies:**

- **Do you:**
  Smoke – Current everyday smoker Current some day smoker Former Smoker
  Never Smoked
  Consume Alcohol – Yes or No
  Abuse Drugs – Yes or No
  Smoke Marijuana (Pot) – Yes or No

- **Have you ever abused alcohol? Yes or No**

- **Have you ever abused street drugs (marijuana, cocaine, ecstasy, crack cocaine, heroin, etc.) or prescription drugs? Yes or No**

- **Does anyone in your family abuse drugs? Yes or No**

- **Have you tried any of these medications for pain control (please check yes or no):**

Medication	**YES**	**NO**
Baclofen		
Ultram / Tramadol		
Neurontin / Gabapentin		
Elavil / Amitriptyline		
Celebrex / Celecoxib		
Lyrica / Pregabalin		
Flexeril / Cyclobenzaprine		
Zanaflex / Tizanidine		
Robaxin / Methocarbamol		
Skelaxin / Metaxalone		

Name: _____
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- **What have you done for pain control until now since it started?**

  Physical Therapy YES or NO
  Epidural injections YES or NO
  Chiropractor YES or NO
  Advil/Ibuprofen or like medications YES or NO
  TENS Unit YES or NO

If yes for Physical Therapy, when and for how long?_____
Did it help? _____

- **Please list all other physicians who have treated you for pain in the last six months:**

I hereby verify that all of the above information is true to the best of my knowledge

Patient Signature _____

<u>For Physician Only</u>

<u>Patient Advised</u>