Name____

Date of Birth ______________ **Today's Date**_____________

Welcome to Spine Care Specialists, LLC. Our goal is to reduce your pain and help improve your functioning level. Please complete this form **entirely** so we can better assist you in achieving your goals.

Chief Pain Complaint

What is the location(s) of the pain you have?

The location(s) of the worst pain/the pain you want treatment for?

When did the pain begin and how did the pain begin (car accident, fall, etc…)?

Does this problem cause you pain all of the time, almost all of the time, or just sometimes?

If the pain has increased over time, when did it get worse and what happened to make it worse?

On the scale below, what is your pain level? average (use ❍), worst (use □), and best (use **X**)

(**No pain**) 0___ 1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10___ (**Passed Out**)

On the scale below, what is your activity level? average (use ❍), least (use □), and greatest (use **X**)
(Include activities besides work such as daily routine, shopping, driving, reading, meeting people, etc.,)

0______ 1______ 2______ 3______ 4______ **5**______ 6______ 7______ 8_______ 9______ 10______

(**none, not even to bathroom**) — at 0; (**able to drive**) — at 5; (**working, fully active**) — at 10

Which activities did you stop or decrease to a large extent because of the pain?

If the pain is better controlled, what activities will you do that you are not able to do now?

What, if anything makes the pain feel WORSE: (Check all that apply)

- □Sitting
- □Standing
- □Lying Down
- □Bending
- □Walking
- □Cold
- □Heat
- □Exercise
- □Stretching
- □Physical Therapy
- □Massage
- □Increased Activity
- □Other: ___________________

____

____

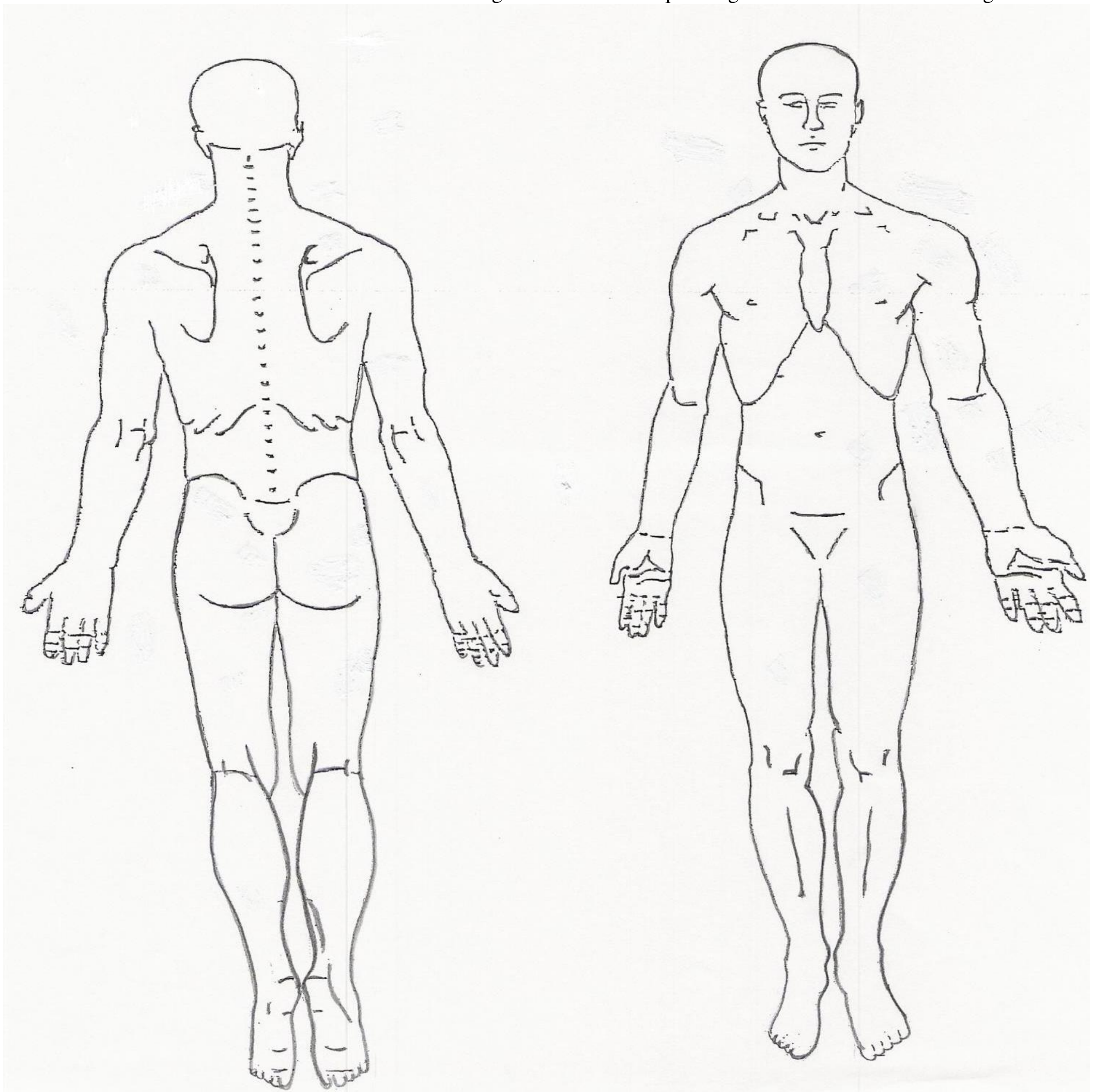
What makes the pain <u>BETTER</u>: (Check all that apply)

☐Sitting
☐Standing
☐Lying Down
☐Changing Positions
☐Applying Heat
☐Applying Cold
☐Massage
☐Exercise
☐Stretching
☐Physical Therapy
☐Medications
☐Injections
☐Other: ___________________
____
____

Please mark the areas of pain on the picture below using the symbols listed to describe the type of pain you experience.

XXXXX: Aching ----------: Throbbing /////////////: Shooting □□□□□: Pins & Needles

^^^^^: Numbness VVVVV: Stabbing ◊◊◊◊◊◊: Squeezing ○○○○○: Burning



Name___________________________________ **Date** ________________________________

Past Treatments

Please circle the medications you have tried in the past to control pain:

NSAIDS/Anti-Inflammatory Meds	Celebrex, Vioxx, Bextra, Motrin/ Ibuprofen/ Aleve/ Naprosyn, Tylenol, Aspirin
Narcotic pain Medicines:	Morphine, Oxycotin, Methadone, Duragesic Patch, Vicodin, Lortab, Norco, Hydrocodone, Darvocet, Percocet, Oxycodone, Ultram
Anticonvulsants/ Nerve Pain Meds	Neurontin/Gabapentin, Lyrica/Pregabalin, Dilantin, Topamax, Keppra
Muscle Relaxants:	Flexeril/Cyclobenzaprine, Skelaxin/Metaxalone, Soma, Zanaflex/Tizanidine, Robaxin/Methocarbamol, Norflex/Orphenadrine, Baclofen
Antidepressants:	Paxil, Prozac, Celexa, Elavil/Amitriptyline, Zoloft, Lexapro, Effexor, Desyrel/ Trazadone, Pamelor/ Nortrptyline, Sinequan/ Tegretol, Cymbalta
Other Medicines:	Lidoderm Patch, Capsaicin, Catapress Patch, Flector Patch

Please list any other medications you have tried for pain relief in the past: (Attach a list if needed)

What treatments have you had in the past to control pain (Physical Therapy, Injections, Chiropractor, etc...)?

What has worked best?

Current Medications

Are you taking any **blood thinners** (coumadin/warfarin, plavix, aspirin, etc...)? If so, which one(s)?

Please list **ALL** of the medications from all sources **as you are actually taking them,** NOT as they were prescribed:

Medication Name	Strength	# Tablets At one Time	# Times Per day	Prescribing Doctor

Attach a separate list if additional space needed

Allergies

Please list medications, foods (and tape or Latex) to which you may be allergic or to which you had a reaction and the reaction/s you had for that particular medication or substance:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Have you ever had a reaction to intravenous **contrast (dye)** or **iodine**? If yes, what reaction did you have?

Medical History

Please check any medical conditions that you have (or have had).

Neuro: ☐Stroke, ☐Seizure, ☐Headaches, ☐Brain Aneurysm, ☐Neuropathy/Neuralgia

Cardiac: ☐High Blood Pressure, ☐ Irregular Heartbeat, ☐Congestive Heart Failure, ☐Heart Attack, ☐ Aortic Aneurysm

Pulmonary: ☐Asthma, ☐Bronchitis, ☐Pneumonia, ☐Emphysema, ☐COPD

GI: ☐Ulcers, ☐Reflux, ☐Hepatitis, ☐Pancreatitis, ☐Crohn's Disease, ☐Irritable Bowel Syndrome

Renal: ☐Kidney Disease, ☐Stones, ☐Kidney Failure

Blood:☐Blood Clots, ☐Anemia, ☐Sickle Cell Disease, ☐Other ______________________________

Endocrine: ☐Diabetes, ☐Hypothyroidism, ☐Other ____

Rheumatologic: ☐Osteoarthritis, ☐Rheumatoid Arthritis, ☐Lupus, ☐Osteoporosis

Psychiatric: ☐ Depression, ☐Anxiety, ☐Bipolar Disorder, ☐ Other __________________________

Please list any other medical conditions you have:

SURGICAL HISTORY : Please list all surgeries you have had:

Type of Surgery	Hospital Name	Surgery Date	Name of Surgeon

Attach a separate sheet if necessary

Have you been told you may need surgery for your current pain problem? If so, what type of surgery?

Name___________________________________ **Date** _________________________________

Have you had any problems or needed special precautions related to anesthesia? ☐ No ☐Yes, please explain:

Have any relatives or family members developed a high fever (malignant hypothermia) or died during anesthesia?
☐No ☐Yes. If Yes, which family members?

Family History

Do (or did) your parents have any medical illnesses?
(HEART, LUNG, ARTHRITIS, DIABETES, CANCER, NEUROLOGIC)

Has anyone in your family had the same problem as the one that is causing you pain?

Psychological Health History

Have you ever had a psychological evaluation, outpatient counseling, or inpatient treatment? If yes, please explain.

Social History

Please list all of the members of your household, their ages, and relationship to you.

1) ______________________________ ____ 2) ______________________________ ____
3) ______________________________ ____ 4) ______________________________ ____
5) ______________________________ ____ 6) ______________________________ ____
7) ______________________________ ____ 8) ______________________________ ____

Are you employed?

FULL-TIME ______ PART-TIME______ LOOKING-FOR-WORK______ RETIRED______ UNEMPLOYED______

Do you receive (or are you applying for) disability income?

PARTIAL______ TOTAL______ TEMPORARY______ PERMANENT______

Are you involved in (or considering) any legal proceedings related to your pain problem?

DISABILITY______ WORKERS COMPENSATION______ PERSONAL INJURY______ OTHER______

If yes, please explain:

Do you now, or have you ever used: (If never used, choose N/A)

1) Tobacco: ____Now ____ packs per day x ___ years; ____in the past & quit ___ years ago; N/A_____
2) Alcohol: ____Now ____ drinks per week x ___years; ____in the past & quit ___years ago; N/A_____
3) Street drugs: ____Now; which one(s)? ____; N/A_____
   ____In the past; which one(s)?_______________________________________

Have you ever had (or has any doctor, family member, or co-worker ever wanted you to have) an evaluation or treatment for use of alcohol, prescription drugs, or non-prescription drugs? If yes, please explain: __________
____

Diagnostic Studies

What tests have you had in the past for the present pain condition?

Test	What Body Part(s)	Where Performed	Approx Date(s) Performed
MRI			
CT Scan			
X-Ray			
EMG			
Bone Scan			
Other--			

Please list the name(s) and dates seen of any **other pain management physician** within the last 5 years

Name of Physician and Location	Dates Seen

Review Of Systems

Please circle if you are experiencing any of the following at the present time.

Constitutional: Fever, weight gain, weight loss, appetite change, night sweats, fatigue, chills

Eyes/Vision: Blurry/double vision, vision loss, tearing, redness, pain/sensitivity to light

Ear/Nose/Throat: Hearing loss, ringing in the ears, ear pain, nasal congestion, nasal drainage, nosebleeds, mouth/throat irritation, tooth problems

Heart/Cardiovascular: Chest pain/pressure, heart racing, palpitations, leg swelling, high blood pressure, low blood pressure

Respiratory: Cough, yellow/green sputum, blood in sputum, shortness of breath, wheezing

Gastrointestinal: Nausea, vomiting, diarrhea, constipation, blood in the stool, heartburn, difficulty swallowing

Genitourinary: Incontinence, abnormal bleeding, abnormal discharge, urinary frequency, urinary hesitancy, painful urination, impotence, sexual problem, infection, urinary retention.

Musculoskeletal: Neck pain, joint stiffness, joint redness.warmth, back pain, limb pain, muscle wasting, sprain/fracture

Neurologic: Headache, weakness, dizziness, change in voice, change in taste, loss/change in sensation, balance problems, coordination problems, speech problems, memory loss

Endocrine: Cold/heat intolerance, blood sugar problem, weight gain/loss, missed periods, hot flashes/sweats, change in body hair, change in libido, increased thirst, increased urination

Heme/Lymph: Swelling, bleeding problem, anemia, bruising, enlarged lymph node(s)

Allergy/Immunoligic: Itchiness, post-nasal drip, watery/itchy eyes, nasal drainage, immunosuppressed

Name____________________________________ **Date**________________________

Release of Medical Information to Family Members

During the course of your treatment, it may become necessary to discuss your condition with a family member or a friend. Below, please indicate with whom, if anyone, we may discuss your condition and/or treatment with:

Spouse/Significant Other Name:____

Family Member Name(s):____

Friend(s) Name(s):____

Restrictions

Please do not discuss my treatment with:____

I, ____________________________________, attest that the information provided on this form is true and accurate to the best of my knowledge.
(Patient printed name)

____ ____________________
Patient Signature Date

For Office Use Only

I reviewed the above information and discussed it with ____

Physician / PA Signature(s) _______________________________________ Date ___________________

Additional Notes on History or Physical Exam/Continuation of Plan of Care:

MY MEDICATION LIST

Physician:

Name:

DOB:

Please include all medications including over the counter and supplements.

MEDICATION	DOSAGE	TIMES/DAY	DATE/TIME LAST TAKEN	REFILL NEEDED	PHYSICIAN
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	

Signature:______________________________ **Date:**_______________

MA Initials: _______________