BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

IMPORTANT PLEASE
READ!

Patients without insurance are considered Self-Pay:

New Patient Consultation: $350
(There is no guarantee of treatment)

Follow up visits: $150 (Each visit)

We DO NOT accept checks

Payment is due at the time of service

We require all new patients to arrive 30 minutes prior to their scheduled appointment. If for any reason this packet is not completed upon arrival, the appointment will be rescheduled and a $50 rescheduling fee will be applied to your account.

BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

To Our New Patients,

We would like to welcome you to our practice. As a new patient, we realize how difficult it can be to become established with a new healthcare provider. Therefore, we will make every effort to make this transition as easy as possible—with some assistance from you.

To make your first visit simple, you will find all of the required forms for new patients enclosed in this packet. It is important that we receive as much medical information about you as possible to facilitate the best medical care.

For your first office visit, you must bring several items:

- Completed information packet
- Insurance card(s)
- Driver's license or state-issued photo identification
- All prescription medications you are currently taking in their original containers

(If you choose, you may complete the information packet online at www.blueridgepm.com. You will need to contact us for an invitation. You will need to start it several days before your appointment to ensure everything is received in time.)

Your referring provider will forward your medical records to us before your first visit. You may bring any diagnostic tests (MRI, X-ray, etc.) or personal information related to your condition as well.

Please note: **new patient appointments are for consultations only—there is no guarantee of treatment on this visit.**

We also require that new patients **arrive and check in thirty (30) minutes prior to their scheduled appointment time** with the information packet already completed. If you do not arrive thirty (30) minutes prior to your appointment with the completed packet, you will be rescheduled.

Insurance co-pays and/or payment are due at the time of service. For your convenience, we accept Visa, MasterCard, Discover, and American Express. While we do accept cash, we do not accept checks. If you are scheduled for a follow-up appointment after your initial visit you are required to arrive and check in fifteen (15) minutes early prior the your appointment time. If you are not at the appointment fifteen minutes early, you will be rescheduled.

Patient must have a driver for ALL procedures done in office.

By signing below, you are agreeing to these terms and certify you have read and understand the requirements:

Appointment Date: _____ Appointment Time: _____

Required Arrival Time: _____ Provider: _____

Location: _____ Date: _____

Patient Signature: _____

Please do not hesitate to call if you have questions: (540) 444-5670.

Sincerely,

Blue Ridge Pain Management Associates, PC

BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

To Salem Office:

100 Knotbreak Road

Salem, VA 24153

540-444-5670

From I-81

From I-81 take Exit 141 (If going North take a left onto Electric Road. If going South take a right onto Electric Road.) After passing Lakeside Kroger you will bear right onto Texas street then turn right onto Knotbreak Road. Our office is on the left.

To Christiansburg Office:

95 Ponderosa Drive

Christiansburg, VA 24073

From I-81:

Take Exit 118B-C-A for US 11/460
Take Exit 118B, merge onto 460W
Take Exit 4B toward VA-114 W/Radford
Merge onto Peppers Ferry Road
Turn Right onto Arbor Drive
Turn Right onto Ponderosa Drive
We are the last building on the Right. Behind Enterprise Rent-A-Car.

From I-77:
Take Exit 9 for US-460 toward Princeton/Pearisburg VA
Take a left onto US-460 E
Take Exit 4A-4B toward VA-114 W/Radford
Merge onto Peppers Ferry Road
Turn Right onto Arbor Drive
Turn Right onto Ponderosa Drive
We are the last building on the Right. Behind Enterprise Rent-A-Car

To Roanoke Office:

1101 1st Street, SW

Roanoke, VA 24016

From 220:

Take Exit 6 for Elm Ave

(If going North take a left onto Elm Ave: If going South take a right onto Elm Ave) Take a left onto

Jefferson Street; Take a right onto Albemarle Ave; Go 1 block;

Blue Ridge Pain Management is on your left.

BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

Cancellation and Missed Appointment Policy

At Blue Ridge Pain Management, it is our goal to provide quality medical care in a timely manner. "No Shows" and "Late Cancellations" inconvenience those individuals who need access to medical care in a timely manner. Please familiarize yourself with our policies.

Contact Blue Ridge Pain Management promptly if you are unable to show up for an appointment. If it is necessary to cancel or reschedule your appointment, we require you call 72 hours in advance as these appointments are in high demand. Please call 540.444.5670. If you are unable to reach the receptionist, please leave a detailed message with your name, phone number, and the best time to contact you.

Late Cancellation /Reschedule

Fee $50.00

No Show

Failure to be present at the time of a scheduled appointment will be recorded in your medical record as "no-show." After 3 No- Show appointments, you may be discharged from our practice.

Fee $50.00

Late Cancellation/ Reschedule/No Show for Discograms & Rhizotomy Procedures

Fee $75.00

Please note, you will be required to pay this fee before we can reschedule your appointment.

BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

Patient Registration Form

Patient Information

Last Name: _____ First: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Cell: _____ Work: _____

SSN: _____ Date of Birth: _____

Email: _____

Sex (circle one) Male Female Title (circle one) MR / MRS / MS

Marital Status (circle one) Married / Single / Divorced / Separated

Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Telephone: _____

Responsible Party

Guarantor's Name: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Guarantor's SSN: _____ Guarantor's Date of Birth: _____

Guarantor's Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Company

Insurance Company: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

Secondary Insurance Company

Insurance Company: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

In order for us to service your account or to collect any amounts you may owe us, you authorize our office or any agent or service provider of our office (including but not limited to collection agencies), to contact you at any telephone number associated with your account, including cellular wireless telephone numbers, which could result in charges to you. Methods of contact include but are not limited to the use of pre-recorded/artificial voice messages, automatic telephone dialing systems,predictive telephone dialing systems, automated SMS text message reminders, emails converted to text messages, and facsimile as applicable.

I hereby authorize Blue Ridge Pain Management, P.C. to release medical information to any physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Blue Ridge Pain Management Associates, P.C. of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photo-copy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient Signature: _____ Date: _____

BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

Prescription Monitoring Program Consent

The treating provider you will be seeing today will not prescribe any prescriptions until he/she has accessed the information contained in the Virginia Prescription Monitoring Program (PMP) files for prescriptions on Schedule II-V drugs that may have been previously dispensed to you as a patient.

Patient Name: _____

Date of Birth: _____

Street Address: _____

City: _____ State: _____

Zip Code: _____

This authorizes all providers of Blue Ridge Pain Management Associates, P.C. to request and receive from the Virginia Department of Health Professions any and all records held by the Department relating to Schedule II-V controlled substances dispensed to the patient named above.

I understand that this authorization permits the Department of Health Professions to disclose confidential health care records to the prescriber named above. A copy of this authorization shall be included in my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law.

I understand that, if not previously revoked, this consent will expire one year after the date of my signature unless otherwise specified.

Patient Signature: _____ **Date:** _____

Note: This authorization form is in addition to and separate from any other disclosure forms that you may have signed.

BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

Prescription Refill Policy

All prescription refill requests and medical questions will be processed after 3:00pm each business day. We are not available after 4:00pm Monday—Thursday or after 12:00pm on Fridays. We are also not available for these questions nights, weekends, or holidays. We require **72 hours notice** on all prescription refill requests. Allow 3 (three) business days for you refill request to be completed. We are not a walk-in clinic. Patients will only be seen at scheduled appointment times.

I have read and understand the above statement: _____ (initial here)

When calling for a prescription refill, please press the appropriate extension for the nurse line or tell the receptionist that you are calling for a prescription refill. Be prepared to leave a detailed voicemail, which must contain the following:

- Your full name & date of birth
- Telephone number AND the best time to reach you
- Pharmacy name and telephone number
- Prescription name and dosage (i.e., the milligrams and when you are prescribed to take it, such as three times a day)

When calling to leave a general message for the nursing staff or Physician, please press the appropriate extension or tell the receptionist that you are calling to leave a message for the clinical staff. Be prepared to leave a voicemail with the following information:

- Your full name & date of birth
- Telephone number & the best time to reach you
- A detailed but short message

If you are calling due to an emergency, please do not leave a message—call 911 or report to your nearest Emergency Room.

We appreciate your cooperation with this procedure.

Patient Signature: _____ Date: _____

I acknowledge that I have read and understand the above prescription refill policy for Blue Ridge Pain Management Associates, P.C.

BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

Consent for the Use and Disclosure of Health Care Information

I, _____, understand that as part of my health care, Blue Ridge Pain Management Associates originates and maintains paper and/or electronic medical records describing my health history, symptoms, examination results, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health care professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Blue Ridge Pain Management Associates reserves the right to change their notice and practices prior to implementation in accordance with Section 164.520 of the Code of Federal Regulations. Should Blue Ridge Pain Management Associates change their notice, they will send a copy of any revised notice to the address that I have provided.

The following person(s) have the right to the use or disclosure of my health information:

Name: _____ Relationship: _____ Contact number: _____

Name: _____ Relationship: _____ Contact number: _____

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or electronically. **I fully understand and accept the terms of this consent.**

Name: _____ Date: _____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Blue Ridge Pain Management's Notice of Privacy Policies, detailing how my health information may be used and disclosed as permitted by federal and state law. **I understand the contents of this notice.**

However, **I request the following restrictions concerning the use of my personal medical information. If you do not have any restrictions, please write "none".**

_____

_____

_____

I permit Blue Ridge Pain Management Associates to leave telephone messages and/or contact me by mail at the telephone number and address that I have provided. I permit Blue Ridge Pain Management Associates to use my full legal name when checking in or out of the clinic. If I have any objections to the above, other arrangements may be made.

Name: _____ **Date:** _____

If not signed by the patient, please indicate relationship to patient:

Relationship: _____ Witness: _____

Office Use Only:

If patient or patient's representatives refuses to sign acknowledgement of receipt of notice, please document date and time notice was presented to the patient and sign below.

Presented (date and time): _____

BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:**

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (i.e. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Blue Ridge Pain Management Associates
100 Knotbreak Road
Salem, VA 24153

Date: _____

Patient Name: _____

OPIOID RISK TOOL

		Mark each box that applies	Office Use Only: Score If Female	Office Use Only: Score If Male
1. **Family History of Substance Abuse**	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. **Personal History of Substance Abuse**	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. **Age** (Mark box if 16 – 45)		[ ]	1	1
4. **History of Preadolescent Sexual Abuse**		[ ]	3	0
5. **Psychological Disease**	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	_____	_____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool.
Pain Medicine. 2005;6(6):432-442. Used with permission.

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BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

New Patient Information

Date of Initial Evaluation: _____

Name _____ Date of Birth _____ Age _____

Pharmacy Name and Telephone Number _____

Primary Care Physician Name and Telephone Number: _____

Referring Physician's Name and Telephone Number: _____

Chief Complaint: What is bothering you?

_____

_____

_____

How long have you had the pain you feel currently? _____

What caused your current pain to start? _____

_____

How often do you have this pain?

A. Constantly (80-100% of time)

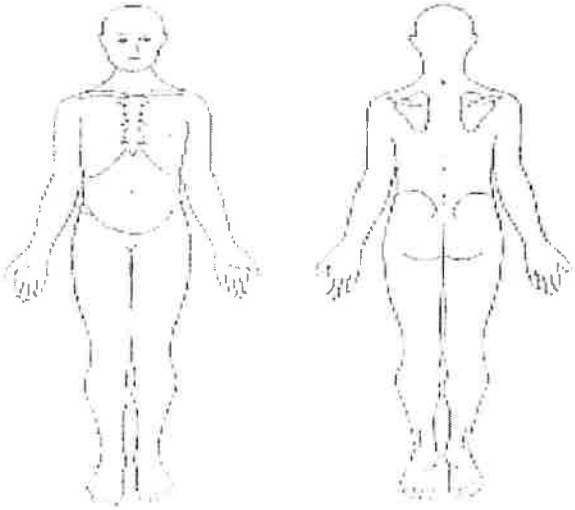
B. Nearly Constantly (50-80% of time)

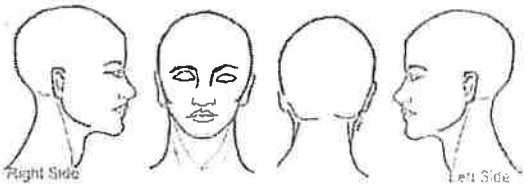
C. Intermittently (25-80% of time)

D. Occasionally (less than 25% of time)

History of Present Illness:

Please shade in the areas where you have pain on the diagrams below:





Sleep

Does pain usually awaken you from sleep during the night?

_____ Usually _____ Sometimes _____ Never

How many hours do you sleep each night? _____ Hours

Has your ability to sleep changed within the past two weeks? YES NO

How has it changed? _____

For what reason do you think it has changed? _____

Alleviating and Aggravating Factors

	Increases	Decreases	No change
Liquor			
Eating			
Heat			
Cold			
Weather Changes			
Massage			
Exercise			
Rest			
Lying Down			
Sitting			
Standing			
Walking			
Distraction (TV, etc.)			
Urination			
Bowel Movement			
Stress			
Fatigue			
Coughing			
Boredom			
Other _____			

Mood

Has pain affected your mood? _____ Describe your current mood: _____

Have you ever had any thoughts of wanting to die? YES NO

If yes, please describe: _____

Do you now or have you ever had panic attacks? YES NO

Do you feel tense or worry all the time? YES NO

Do you ever feel irritable or angry due to your pain? YES NO

Do you ever act in aggressive or angry ways due to pain? YES NO

Do you ever have thoughts of harming yourself or others? YES NO

If yes, please describe: _____

Do you have a history of mental health treatment (psychiatrist or psychologist)? YES NO

If yes, please describe: _____

Have you ever been hospitalized for psychiatric reasons?

If yes, when? _____ Please describe: _____

Prior Diagnostic Tests

	Date	Location	Attached Results? (if yes, check)
MRI			
X-Rays			
EMG			
CAT Scan			
Discogram			
Myelogram			

Other: _____

Prior Treatment or Procedures

	Have you tried?	Pain Relief ?(Yes/No)	Date Performed?
Epidural Steroid Injections			
Nerve Blocks			
Physical Therapy			
Chiropractor			
Acupuncture			
Pain Clinic			

**If yes, Physician's Name and Location _____

Traction			
TENS Unit			

Other _____

Past Surgical History

Type of Surgery	Date	Any Complications?

Past Medical History

Heart _____ Heart Attack _____ Blocked Arteries _____ High Blood Pressure _____ Heart Murmur _____ Stroke	Lungs _____ Asthma _____ TB _____ Emphysema _____ Sleep Apnea _____ COPD	Kidney/Liver _____ Kidney Failure _____ Kidney Stones _____ Yellow Jaundice _____ Cirrhosis _____ Liver Failure
Psychiatric/Nerves _____ Anxiety _____ Depression _____ Panic Attacks _____ Bipolar _____ Seizures _____ Shingles	Gastrointestinal _____ Bleeding Ulcers _____ Hiatal Ulcers _____ GERD/Reflux _____ Constipation _____ Nausea _____ Diarrhea	Endocrine/Immune _____ Thyroid Problems _____ Sugar Diabetes _____ Cancer If yes, type: _____ _____ HIV or AIDS
Musculoskeletal _____ Arthritis _____ Osteoporosis	Blood _____ Anemia _____ Frequent Infections	Past or Present _____ Physical Abuse _____ Sexual Abuse _____ Emotional Abuse

If other, please explain _____

Review of Systems

CV	Renal/Liver	HEM/OC
_____ Chest Pain	_____ Burning urination	_____ Easy Bleeding
_____ Palpations	_____ Blood in Urine	_____ Sores that don't heal
_____ Leg Swelling	_____ Yellow Jaundice	_____ New Lumps or Bumps
Respiratory	**Ortho/Rheumatology**	**Constitutional**
_____ Wheezing	_____ Joint Pain	_____ Fatigue
_____ Coughing	_____ Joint Swelling/ Redness	_____ Fever
_____ Sputum	_____ Cool Hands/Feet	_____ Rash
_____ Shortness of Breath	_____ "Popping/ Cracking" Joints	_____ Night Sweats
		_____ Weight Loss/Gain
Neuro	**GI**	**Endocrine**
_____ Numbness	_____ Abdominal Pain	_____ Cold/Heat Intolerance
_____ Weakness	_____ Constipation	_____ Excessive Thirst
_____ Dizziness	_____ Reflux/Burning	_____ Frequent Urination
_____ Headache	_____ Blood in Stool	_____ Hair/Skin Changes
_____ Confusion	_____ Grey or Black Stools	_____ Irregular Menstruation
_____ Tremor	_____ Nausea	_____ Decreased Sexual Desire
_____ Difficulty Speaking	_____ Vomiting	_____ Less Sexual
_____ Difficulty swallowing	_____ Diarrhea	_____ Currently in Menopause

Other Symptoms

_____

_____

_____

Is there anything else you would like to tell me about your pain?

_____

_____

_____

Family History

What health problems or diseases do/did your parents and/or other family members have?

_____

_____

_____

_____

List any family members with a history of drug or alcohol abuse

_____

_____

Allergies

***If you do not have any allergies, write "none"

Current Medications

Even though you must bring your medication to the appointment you must still list them below.
********************If you do not list your medications you will not be seen.************************

Medication	Dosage (i.e. milligrams)	How often you take this medication	Prescriber

***If you need more space, please use the blank back page of this packet.

Prior Medications used to treat this pain or taken to treat the effects of this pain (includes narcotics, antidepressants, sleep medications, muscle tranquilizers, over the counter medications and anti-inflammatory medications)

Medication	Dosage (i.e. milligrams)	Did it help?	Why did you stop taking it?

Habits

Caffeine (coffee, tea, cola, energy drinks, etc.) _____ If yes, how many a day? _____

Nicotine (cigarettes, pipe, cigar, chew, etc.) _____ If yes, how many a day? _____

Alcohol _____ None

_____ Rarely (less than one drink per month)

_____ Occasionally (less than one drink per week)

_____ Regularly (drink 2-3 times per week)

_____ Almost Daily

Have you, a family member or friend ever felt you should "cut down" on your drinking? YES NO

Has anyone ever annoyed you by criticizing your drinking? YES NO

Have you ever felt guilty about your drinking? YES NO

Have you ever had a drink first thing in the morning as an "eye opener"? YES NO

Have you ever had withdrawal symptoms (shaking/sweating) when you stopped drinking? YES NO

Have you ever abused prescription medications? YES NO

If yes, please explain: _____

Have you ever used marijuana, other street drugs or "shot up"? YES NO

Has a Physician ever told you he/she was concerned that you were becoming addicted to a prescription medication? YES NO

If yes, please explain: _____

Have you ever committed a crime or served time in jail? YES NO

If yes, please explain: _____

Social History

Marital Status (circle one): Single Married Separated Divorced Widowed Remarried

Number of Children and ages: _____

Present Living Situation (check all that apply):

____ Alone ____With Spouse ___With Children ___With Parents ___ With Friend _____Other

Education (Check the Highest Grade/Degree Completed)

___ Less than 8th grade _____ Completed 8th grade _____ Some High School

____ High School/GED _____ Some College _____ College Graduate

____ Advanced Degree

Employment History

Current or Last Job _____ Employer _____

Present Employment Status

____ Full Time _____ Part Time _____ Unemployed

___ Leave of Absence ____ Retired _____ Student ___ Homemaker

When was your last day of work? _____

Are you still working? YES NO

Are you disabled? YES NO

Are you receiving disability payments? YES NO

For how long? _____

Do you have a Worker's Compensation or Social Security Disability Application Pending? YES NO

Are you now, or do you anticipate, a lawsuit because of your pain or injury? YES NO

Verbal Pain Scale

Rate the intensity of your pain overall by checking the level of your pain overall

_____ No Pain

_____ Mild Pain

_____ Very Uncomfortable

_____ Distressing

_____ Horrible

_____ Excruciating

Wisconsin Pain Disability Index

We would like to know how much of your pain is preventing you from doing what you normally do, or from doing it as you normally would. Please indicate the overall impact of pain in your life, **not** just when the is at its worst.

For each category, please CIRCLE the number that describes the level of disability you typically experience.

A score of "0" means NO disability at all.

A score of "10" means the activity is totally disrupted or prevented by pain.

1. Family/Home Responsibilities (include chores, duties in the house, errands or favors for family members, etc.)

   0 1 2 3 4 5 6 7 8 9 10

2. Recreation (includes hobbies, sports and similar leisure activities)

   0 1 2 3 4 5 6 7 8 9 10

3. Social Activity (includes participation with friends and other non-family members, including dining out and other social functions).

   0 1 2 3 4 5 6 7 8 9 10

4. Occupation (includes activities that are related to one's job, including non-paying jobs like volunteering).

   0 1 2 3 4 5 6 7 8 9 10

5. Sexual Activity (includes the frequency and quality of one's sex life).

   0 1 2 3 4 5 6 7 8 9 10

6. Self Care (includes activities of personal maintenance, like showering, driving, dressing, etc.).

   0 1 2 3 4 5 6 7 8 9 10

7. Life Support Activities (includes eating, sleeping, and breathing).

   0 1 2 3 4 5 6 7 8 9 10

Verbal Intensity Pain Rating (VIPR)

Describe the characteristics of your pain. Circle the letter in EACH column that best describes your average pain in the last month.

Intensity	Reactions	Sensations	
A. excruciating	A. agony	A. piercing	J. electric
B. very intense	B. intolerable	B. sharp	K. needles
C. severe	C. horrific	C. shooting	L. stinging
D. very strong	D. miserable	D. grinding	M. burning
E. intense	E. awful	E. aching	N. tingling
F. strong	F. distressing	F. throbbing	
G. uncomfortable	G. unpleasant	G. cramping	
H. moderate	H. uncomfortable	H. pressure	
I. mild	I. tolerable	I. numb	

Associated Symptoms

Are there any symptoms associated with your pain?

A. Numbness—where? _____
B. Weakness—where? _____
C. Urinary Incontinence? _____
D. Lose control of bowel movements? _____
E. Swelling—where? _____
F. Tenderness to touch? _____
G. Cool or pale skin? _____
H. Redness? _____
I. Other? _____

Visual Analog Pain Scale (VAPS)

Rate your pain by placing an "X" on the line to describe your WORST pain in the past month.

No Pain _____ Worst Pain Possible

Rate your pain by placing an "X" on the line to describe your LEAST pain in the past month.

No Pain _____ Worst Pain Possible

Rate your pain by placing an "X" on the line to describe your AVERAGE pain in the past month.

No Pain _____ Worst Pain Possible

Rate your pain by placing an "X" on the line to describe your pain RIGHT NOW.

No Pain _____ Worst Pain Possible

Short Form McGill Pain Questionnaire

Check the column to indicate the level of your pain for each word:

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot/Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring/Exhausting				
Sickening				
Fearful				
Cruel/Punishing				

Interference Scale

Check the one that best applies to the patient.

100% _____ The patient is totally bedridden and needs an ambulance for transportation.

99% _____ The patient is bedridden; however, is able to use the bathroom or bedside commode.

80% _____ The patient is not bedridden; however, is confined to a wheelchair.

70% _____ The patient is up in the house; however, is confined to a wheelchair.

60% _____ The patient is able to perform limited household chores and is able to perform self-care activities. This is the first stage of normalcy.

50% _____ The patient is able to make short trips (less than 30 minutes) and is ambulatory in the yard.

40% _____ The patient is able to take longer trips (less than 2 hours). This may include grocery shopping, mall shopping; however, the patient does require rest breaks.

30% _____ The patient is able to participate in Physical Therapy even on a limited basis and is capable of performing minimal activities of daily living (i.e., bathing, dressing, etc.).

20% _____ The patient can participate in normal activities for short periods of time with frequent rest breaks.

10% _____ The patient can participate in normal activities for longer periods of time with rest breaks.

0% _____ The patient is participating in normal activities.

Oswestry Disability Questionnaire

Patient, Please check only 1 per section.****

Section 1 — Pain Intensity	Office Use Only
____ I have no pain at this moment.	(0 points)
____ The pain is very mild at the moment.	(1 point)
____ The pain is moderate at the moment.	(2 points)
____ The pain is fairly severe at the moment.	(3 points)
____ The pain is very severe at the moment.	(4 points)
____ The pain is worst imaginable at the moment.	(5 points)

Section 2 — Personal Care	Office Use Only
____ I can look after myself normally.	(0 points)
____ I can look after myself normally but it causes pain.	(1 point)
____ It is painful to look after myself and I am slow.	(2 points)
____ I need some help but can manage most of my personal care.	(3 points)
____ I need help every day in most aspects of my care.	(4 points)
____ I do not get dressed without help, wash myself with difficulty and stay in bed.	(5 points)

Section 3 — Lifting	Office Use Only
____ I can lift heavy weights without extra pain.	(0 points)
____ I can lift heavy weights but it gives me extra pain.	(1 point)
____ Pain prevents me from lifting heavy weights off the floor but I can manage if they are placed on a table.	(2 points)
____ Pain prevents me from lifting heavy weight but I can manage light to medium weights if conveniently placed.	(3 points)
____ I can lift only very light weights.	(4 points)
____ I cannot lift or carry anything at all.	(5 points)

Section 4 — Walking	Office Use Only
____ Pain does not prevent me walking any distance.	(0 points)
____ Pain prevents me from walking more than 1/2 a mile.	(1 point)
____ Pain prevents me from walking more than 1/4 a mile.	(2 points)
____ Pain prevents me from walking more than 500 yards.	(3 points)
____ I can only walk using a stick, cane or crutches.	(4 points)
____ I am in bed most of the time.	(5 points)

Section 5 — Sitting	Office Use Only
____ I can sit in any chair as long as I like.	(0 points)
____ I can only sit in my favorite chair as long as I like.	(1 point)
____ Pain prevents me sitting for more than 1 hour..	(2 points)
____ Pain prevents me from sitting for more than 30 minutes.	(3 points)
____ Pain prevents me from sitting for more than 10 minutes	(4 points)
____ Pain prevents me from sitting at all.	(5 points)

Section 6 — Standing **Office Use Only**

___ I can stand as long as I like. (0 points)

___ I can stand as long as I want but it gives me extra pain.. (1 point)

___ Pain prevents me from standing for more than 1 hour. (2 points)

___ Pain prevents me from standing for more than 30 minutes.. (3 points)

___ Pain prevents me from standing for more than 10 minutes. (4 points)

___ Pain prevents me from standing at all. (5 points)

Section 7 — Sleeping **Office Use Only**

___ My sleep is never disturbed by pain. (0 points)

___ My sleep is occasionally disturbed by pain. (1 point)

___ Because of pain I have less than 6 hours of sleep. (2 points)

___ Because of pain I have less than 4 hours of sleep. (3 points)

___ Because of pain I have less than 2 hours of sleep. (4 points)

___ My pain keeps me from sleeping at all. (5 points)

Section 8 — Sex Life (if applicable) **Office Use Only**

___ My sex life is normal and causes no extra pain. (0 points)

___ My sex life is normal but causes some extra pain. (1 point)

___ My sex life is nearly normal but is very painful. (2 points)

___ My sex life is severely restricted by pain. (3 points)

___ My sex life is nearly absent because of the pain. (4 points)

___ Pain prevents any sex life at all. (5 points)

Section 9 — Social Life **Office Use Only**

___ My social life is normal and gives me no extra pain. (0 points)

___ My social life is normal but increases the degree of pain. (1 point)

___ Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. sports). (2 points)

___ Pain has restricted my social life and I do not go out as often. (3 points)

___ Pain has restricted my social life to my home. (4 points)

___ I have no social life because of pain. (5 points)

Section 10 — Traveling **Office Use Only**

___ I can travel anywhere without pain. (0 points)

___ I can travel anywhere but it gives me extra pain. (1 point)

___ Pain is bad but I manage journeys over 2 hours. (2 points)

___ Pain restricts me to journeys of less than 1 hour. (3 points)

___ Pain restricts me to short necessary journeys of less than 30 minutes (4 points)

___ Pain prevents me from traveling except to receive treatments. (5 points)

******Office Use Only******

Total score = SUM (points for all 10 sections)

Disability in percent = (total score) / 50 * 100

If not all questions are answered then

Disability in percent = (total score) / (5 * [number of questions answered]) * 100