Spine&Nerve DIAGNOSTIC CENTER

www.spinenerve.com

Name: _ _____ Date: _____

Medical Health Questionnaire---NEW PATIENT

Vitals (office use only): Height _____ Weight _____ BP _____ Pulse _____ Temp _____

I. **Current Information:**

a. What is the main problem that brought you to this visit (chief complaint)?

b. If you had an injury, how were you injured, and what was the date of your injury?

c. If you had an injury, have you ever had similar symptoms prior to the injury? If yes, were you ever treated by a medical provider for your symptoms?

d. What activities make your pain **worse** (please circle)?

Sitting Standing Walking Bending Lifting Laying down

e. What activities make your pain **better** (please circle)?

Sitting Standing Walking Bending Lifting Laying down

f. Please list all medications you are currently taking. Please list the drug, dosage, and how often you take it (ok to attach a list):

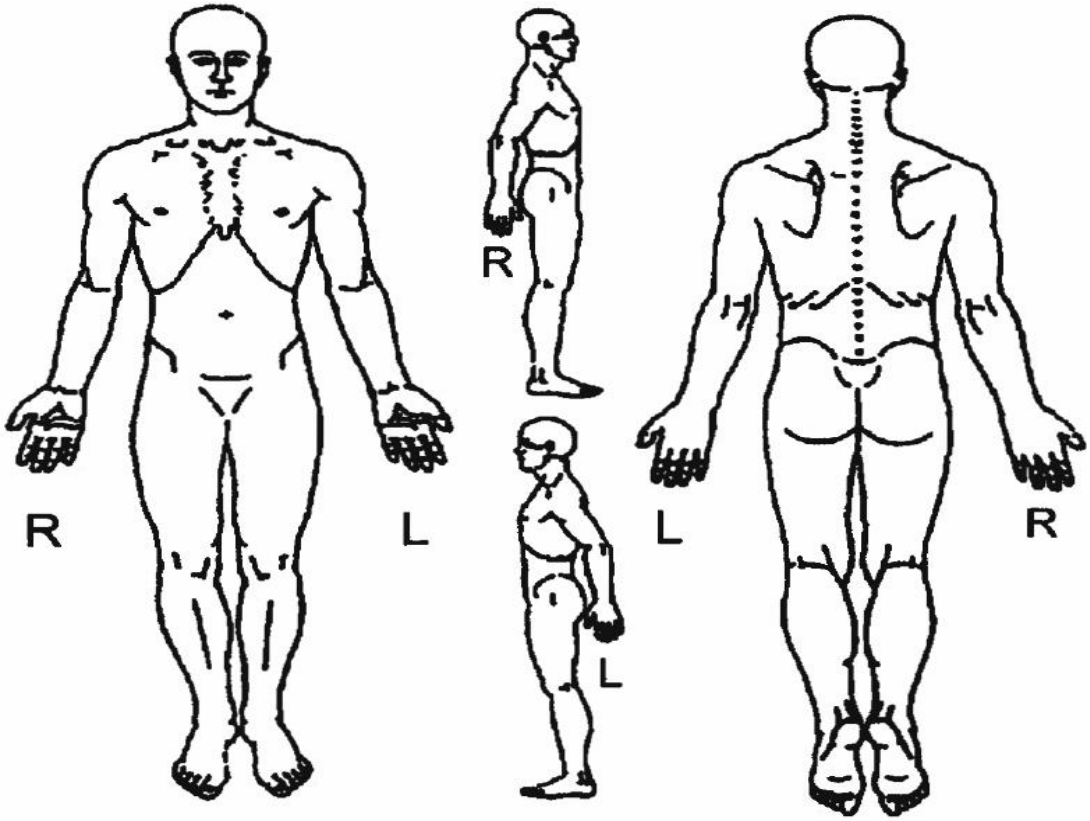
g. Please list any medications you are allergic to:
   i. Are you allergic to IODINE? Yes / No

h. Please circle any of the following imaging studies that have been done related to your problem:
   X-rays EMG/nerve study Bone Scan CT MRI

II. Pain Diagram:

a. Please mark your areas of pain by using the following descriptors to describe the quality of your pain:

Aching (AAAAA) Numbness (00000) Pins and Needles (…..) Burning (XXXXX) Stabbing (11111)



Please mark the number that represents the severity of your pain that you are currently experiencing **today** on a scale from 0 (no pain) to 10 (most severe pain).

PAIN LEVEL ***WITHOUT*** MEDICATIONS:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN SEVERE PAIN

PAIN LEVEL ***WITH*** MEDICATIONS:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN SEVERE PAIN

PAIN SCALE REFERENCE

0	**No Pain**
1	**Very Mild**
2	**Discomforting**
3	**Tolerable**
4	**Distressing**
5	**Very Distressing**
6	**Intense**
7	**Very Intense**
8	**Utterly Horrible**
9	**Excruciatingly Unbearable**
10	**Unimaginable Unspeakable**

What type of Treatment have you had *prior* to your visit with our office today?

Please circle any medications that you have tried in the past:

NSAIDS	MUSCLE RELAXERS	SLEEP AIDS	NERVE PAIN/MOOD STABILIZERS	OPIOIDS
Aspirin	Cyclobenzaprine (Flexeril)	Trazodone	Lidocaine patch	Hydrocodone/acetaminophen (Norco)
Ibuprofen (Advil/Motrin)	Methocarbamol (Robaxin)	Temazepam (Restoril)	Gabapentin	Oxycodone/acetaminophen (Percocet)
Acetaminophen (Tylenol)	Carisoprodol (Soma)	Eszopiclone (Lunesta)	Pregabalin (Lyrica)	Fentanyl patch (Duragesic)
Naproxen	Metaxalone (Skelaxin)	Zolpidem (Ambien)	Topiramate (Topamax)	Morphine
Celebrex	Baclofen		Amitriptyline	Oxycontin
Diclofenac	Tizanidine (Zanaflex)		Nortriptyline	Methadone
Nabumetone (Relafen)			Venlafaxine (Effexor)	Buprenorphine sublingual/patch
			Duloxetine (Cymbalta)	Nucynta
			Milnacipran (Savella)	Acetaminophen with Codeine (Tylenol #3)
			Quetiapine (Seroquel)	Tramadol
				Suboxone
				Other opioids:

Please indicate what type of therapy you have had in the past:

THERAPY	DATE / YEAR	NUMBER OF VISITS	HELPFUL: Y or N
Physical Therapy			
Chiropractic Therapy			
Acupuncture			
Massage Therapy			
Aquatic/Pool Therapy			
Yoga/Stretching/Tai Chi			
Meditation			
Functional Restoration Program			
Pain psychologist – Cognitive Behavioral Therapy			
Ice Pack			
HeatTENS unit H-wave			
Back brace			
SI (sacroiliac) joint belt			
Wrist brace			

Any other treatments (Bowen therapy, traction, prolotherapy, stem cell injections, etc.):

Please indicate what type of procedures you have had in the past:

CIRCLE IF APPLICABLE:		DATE/YEAR	NUMBER OF VISITS	HELFUL: Y or N
Epidural steroid injections	(neck) (mid back) (low back)			
Facet joint injections	(neck) (mid back) (low back)			
Radiofrequency ablation	(neck) (mid back) (low back)			
Injections of the:	(knee) (shoulder) (ankle)			
SI (sacroiliac) joint injections				
Trigger point injections	(neck) (mid back) (low back)			
Previous surgery – (neck or back)	(neck) (mid back) (low back)			
Spinal Cord Stimulator	(neck) (mid back) (low back)			

Have you seen a surgeon in the past for your symptoms? Yes or No

III. Past History:

a. Please list all past surgeries and all past hospitalizations. Please include the year for each:

b. Please circle any of the following that you have currently or in the past:

Meningitis, Encephalitis, Fainting, Epilepsy/Seizure disorder, Head injury, Unconsciousness, Diabetes, Lung disease, High blood pressure, Heart Disease/Heart Attack, History of Stomach Ulcers, Liver disease, Kidney Disease, Stroke, Cancer, Hepatitis, HIV/AIDS. Other:

IV. Social History:

a. Please circle all that apply to you:

Married Divorced Single Widow

Employed Unemployed Retired Disabled

b. Do you drink alcoholic beverages (wine, beer, cocktails)? _____

If so, how often, how much, and for how long? _____

c. Do you currently use tobacco? Yes or No---If yes, smoke/ chew /or vape?

d. Do you have any history of drug use or drug abuse? Please explain.

e. Have you ever been discharged from another medical practice because of medication noncompliance or urine toxicology result? If yes, please explain:

f. Are you currently employed?

g. What is your job title?

V. Family History:

a. Are there any diseases that run in your family? If yes, please list:

VI. Review of Systems (Please circle appropriate answer):

a. Do you have problems with:

Weight loss/gain	Fever	Chills	Shortness of Breath	Rash
Blurry Vision	Headaches	Nausea/Vomiting	Heartburn	
Constipation	Blood in stool	Easily bruises		
Joint Pain	Muscle Pain	Joint Swelling	Muscle Weakness	Stiffness
Muscle Spasm	Numbness	Dizziness	Leg/Ankle Swelling	Loss of Balance
Depression	Anxiety	Insomnia	Excessive Sleepiness	
Any loss of control of urine or stool?	Y or N	If yes, what are your symptoms?		

Spine&Nerve
DIAGNOSTIC CENTER

Name: _____
Date: _____ **DOB:** _____

PATIENT HEALTH QUESTIONNAIRE – 9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? ***Use "✓" to indicate your answer***	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thought that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __ __0___ + _____ + _____ + _____

= Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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INITIAL OPIOID QUESTIONNAIRE

Name: _____ **Today's Date: _____**

DOB: _____

1. Are you on opioid (narcotic) pain medications?

   YES NO

2. If you answered YES to question 1, what medications and what doses and frequency are you currently on? If answered NO, skip to question 5.

   YES NO

3. Who currently prescribes your opiate medications? Are they going to continue prescribing?

4. What other pain medications have you tried?

5. Do you believe that you may be requiring some opioid (narcotic) pain medication on this visit?

   YES NO

OPIOID RISK TOOL

Patient Name: _____ Date: _____

Please Circle One: Female Male

		Please Mark all that Apply YES	Please Mark all that Apply NO
1. Family history of substance abuse	• Alcohol • Illegal drugs • Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
2. Personal history of substance abuse	• Alcohol • Illegal drugs • Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
3. Age (mark if 16-45 years)		[ ]	[ ]
4. History of preadolescent Sexual abuse		[ ]	[ ]
5. Psychological disease	• Attention-deficit/hyperactivity disorder, obsessive compulsive disorder, bipolar disorder, schizophrenia • Depression	[ ] [ ]	[ ] [ ]

Name: _____ **Date:** _____

DOB: _____ **Provider:** _____

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems? *Use "✓" to indicate your answer*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(FOR OFFICE CODING: Total Score _____ = _____ + _____ + _____)

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