Melbourne Spine
Comprehensive Pain Management Specialists

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Which doctor referred you to us?
Name: _____
Phone: (_____)_____-_____
Fax: (_____)_____-_____

Today's Date:

_____ / _____ / _____

CONTACT INFORMATION

Name: _____DOB: _____/_____/_____ Sex: _____

Social Security Number: _____

Address: _____

Home Phone: (_____)_____-_____ Cell: (_____)_____-_____

Work Phone: (_____)_____-_____ Email: _____

Emergency Contact Name: _____ Emergency Contact #: (_____)_____-_____

Primary Care Doctor (PCP): _____ PCP's Office #: (_____)_____-_____

How did you hear about our office? _____

INSURANCE INFORMATION

Primary Insurance
Primary Carrier: _____

Address: _____

Phone #: (_____)_____-_____Policy #: _____ Group #: _____

Secondary Insurance
Primary Carrier: _____

Address: _____

Phone #: (_____)_____-_____Policy #: _____ Group #: _____

PAIN LOCATION 1 (please circle your answers)

1a. Where is your MAIN pain located? (location)

- Head/Headaches
- Face
- Neck
- Upper/Mid Back
- Lower Back
- Shoulder Area
- Hip/Buttocks
- Tailbone
- Knee
- Elbow
- Other (describe):

4. When did it start? (onset)

Yesterday
_____ Hours ago
_____ Days ago
_____ Weeks ago
_____ Months ago
_____ Years ago

1b. What side is it? (location)

- Right Side
- Left Side
- Both Sides

2. Where does it shoot to? (radiate)

- Head
- Neck
- Arms | Fingers
- Legs | Toes
- Buttock
- Abdomen
- Face
- Other (describe):

3a. How often does the pain occur? (character)

- Happens all the time (constant)
- It comes and goes (intermittent)

3b. What is the intensity? (character)

- Mild
- Moderate
- Severe

3c. Describe it: (character)

- Sharp
- Dull
- Throbbing
- Aching
- Burning
- Stabbing
- Cramping
- Tearing
- Other (describe):

5. How did the pain start? (Precipitating events)

- Nothing
- Motor vehicle accident
- Fall
- Lifting
- Bending
- Lifting
- Twisting
- Throwing
- Pushing heavy object
- Pulling a load
- Job with lifting
- Other (describe):

6. Where did it start? (place of occurrence)

- Home
- Vacation
- Work
- Motor Vehicle Accident
- Other (describe):

7. Any of these associated with your pain? (associated)

- Fever
- Weight loss
- Back stiffness
- Muscle tenderness (Paravertebral mm)
- Radiating pain to arms (Radicular pain - arms)
- Radiating pain to legs (Radicular pain - legs)
- Numbness, where?
- Weakness, where?
- Changes in sex? (Sexual dysfunction)
- Wetting/Soiling your pants and not know it? (Incontinence - urinary, bowel)
- None
- Other (describe):

8. What makes the pain better? (better with…)	**9. What makes the pain worse?** (worse with…)
➢ Rest ➢ Bending Backwards (back extension) ➢ Bending Forwards (back flexion) ➢ Changes in body position -- sitting, walking, lying down? ➢ Bending at your hip (hip flexion) ➢ Straightening your hips/legs out (hip extension) ➢ Twisting your legs inwards? (internal hip rotation) ➢ Twisting your legs outwards? (external hip rotation) ➢ Massage ➢ Ice ➢ Heat ➢ Stretching ➢ Aspirin ➢ **NSAIDs** - motrin, ibuprofen, naproxen, advil, etc ➢ **Muscle relaxants** – flexeril (cyclobenzaprine), zanaflex (tizanadine), etc. ➢ **Nacrotics** - Percocet, Vicodin, oxycodone, hydrocodone, morphine, hydromorphone, etc ➢ Nothing ➢ Other (describe):	➢ Rest ➢ Bending Backwards (back extension) ➢ Bending Forwards (back flexion) ➢ Twisting movements ➢ Bending at your hip (hip flexion) ➢ Straightening your hips/legs out (hip extension) ➢ Twisting your legs inwards? (internal hip rotation) ➢ Twisting your legs outwards? (external hip rotation) ➢ Coughing / Straining / Laughing (Valsalva) ➢ Sitting ➢ Any Movement ➢ Nothing ➢ Other (describe): **10. How bad is the pain?** Using a scale of 0 to 10, with 0=no pain and 10 = worst pain: 0 1 2 3 4 5 6 7 8 9 10

PAIN LOCATION 2 (please circle your answers): Are there any other areas of your body that hurt?

1a. Where is your OTHER pain located? (location)	**1b. What side is it?** (location)	**3a. How often does the pain occur?** (character)
➢ Head/Headaches ➢ Face ➢ Neck ➢ Upper/Mid Back ➢ Lower Back ➢ Shoulder Area ➢ Hip/Buttocks ➢ Tailbone ➢ Knee ➢ Elbow ➢ Other (describe): **4. When did it start?** (onset) Yesterday _____ Hours ago _____ Days ago _____ Weeks ago _____ Months ago _____ Years ago	➢ Right Side ➢ Left Side ➢ Both Sides **2. Where does it shoot to?** (radiate) ➢ Head ➢ Neck ➢ Arms | Fingers ➢ Legs | Toes ➢ Buttock ➢ Abdomen ➢ Face ➢ Other (describe):	➢ Happens all the time (constant) ➢ It comes and goes (intermittent) **3b. What is the intensity?** (character) ➢ Mild ➢ Moderate ➢ Severe **3c. Describe it:** (character) ➢ Sharp ➢ Dull ➢ Throbbing ➢ Aching ➢ Burning ➢ Stabbing ➢ Cramping ➢ Tearing ➢ Other (describe):

5. How did the pain start? (Precipitating events)	**6. Where did it start?** (place of occurrence)	**7. Any of these associated with your pain?** (associated)
➢ Nothing ➢ Motor vehicle accident ➢ Fall ➢ Lifting ➢ Bending ➢ Lifting ➢ Twisting ➢ Throwing ➢ Pushing heavy object ➢ Pulling a load ➢ Job with lifting ➢ Other (describe):	➢ Home ➢ Vacation ➢ Work ➢ Motor Vehicle Accident ➢ Other (describe):	➢ Fever ➢ Weight loss ➢ Back stiffness ➢ Muscle tenderness (Paravertebral mm) ➢ Radiating pain to arms (Radicular pain - arms) ➢ Radiating pain to legs (Radicular pain - legs) ➢ Numbness, where? ➢ Weakness, where? ➢ Changes in sex? (Sexual dysfunction) ➢ Wetting/Soiling your pants and not know it? (Incontinence - urinary, bowel) ➢ None ➢ Other (describe):

8. What makes the pain better? (better with…)	**9. What makes the pain worse?** (worse with…)
➢ Rest ➢ Bending Backwards (back extension) ➢ Bending Forwards (back flexion) ➢ Changes in body position -- sitting, walking, lying down? ➢ Bending at your hip (hip flexion) ➢ Straightening your hips/legs out (hip extension) ➢ Twisting your legs inwards? (internal hip rotation) ➢ Twisting your legs outwards? (external hip rotation) ➢ Massage ➢ Ice ➢ Heat ➢ Stretching ➢ Aspirin ➢ **NSAIDs** - motrin, ibuprofen, naproxen, advil, etc ➢ **Muscle relaxants** – flexeril (cyclobenzaprine), zanaflex (tizanadine), etc. ➢ **Nacrotics** - Percocet, Vicodin, oxycodone, hydrocodone, morphine, hydromorphone, etc ➢ Nothing ➢ Other (describe):	➢ Rest ➢ Bending Backwards (back extension) ➢ Bending Forwards (back flexion) ➢ Twisting movements ➢ Bending at your hip (hip flexion) ➢ Straightening your hips/legs out (hip extension) ➢ Twisting your legs inwards? (internal hip rotation) ➢ Twisting your legs outwards? (external hip rotation) ➢ Coughing / Straining / Laughing (Valsalva) ➢ Sitting ➢ Any Movement ➢ Nothing ➢ Other (describe): **10. How bad is the pain?** Using a scale of 0 to 10, with 0=no pain and 10 = worst pain: 0 1 2 3 4 5 6 7 8 9 10

REVIEW OF SYSTEMS (please circle any of the below that you have experienced)

CONSTITUTIONAL	EYES, EAR, NOSE, THROAT	RESPIRATORY
Weight gain – last 6 months	Recent changes in vision	Short of Breath
Weight loss – last 6 months	Recent changes in hearing	Cough
Night Sweats	Recent changes in smell	Sputum
Chills	Recent changes in taste	History of Tuberculosis
Fever	Dizziness	Wheezing
GASTROINTESTINAL	**GENITO-URINARY**	**CENTRAL NERVOUS SYSTEM**
Nausea	Blood in urine	Poor appetite
Vomiting	Urinary tract infections	Problem sleeping
Diarrhea	Unable to control bladder	Numbness/tingling feet
Indigestion	Unable to control bowel	Numbness/tingling hands
Abdominal pain	Rushing to go	Crying spells
Bloody or dark stools	Need to go frequently	Convulsions
CARDIOVASCULAR	**MUSCULOSKELETAL**	**SKIN**
Chest pain	Cramps	Easy bleeding
Palpitations	Attack of weakness	Any rashes
Shortness of breath with exercise	Joint pain/swelling	Easy bruising
Heart murmur	Morning stiffness	
Feet edema		

Behavioral Health: Are you experiencing any of the following?

❑Depression ❑Low Energy ❑Sleeping Problems ❑Anxiousness ❑Loss of Appetite ❑Panic Attacks
❑Sudden Weight Loss (if so, how much? And over what period of time?) _____

❑Other:_____

PAST MEDICAL HISTORY (please circle all that apply to your health)

Cardiac	Gastro-Intestinal	Immune/Endocrine	Respiratory
➢ Hypertension ➢ Heart attack ➢ Chest pain ➢ Heart failure ➢ Pacemaker ➢ Irregular rhythm ➢ Other:	➢ Hernia ➢ Ulcers ➢ Gastritis ➢ Pancreatitis ➢ GERD ➢ IBS ➢ Diverticulitis ➢ Other:	➢ Diabetes ➢ Tuberculosis ➢ Cancer ➢ Thyroid problems ➢ Arthritis ➢ Fibromyalgia ➢ Rheumatological ➢ Other:	➢ COPD ➢ Asthma ➢ Chronic cough or lung disease ➢ Emphysema ➢ Other:
Neurological	**Ear-Nose-Throat**	**Musculoskeletal**	**Hematological**
➢ Headaches ➢ Seizures ➢ Stroke/TIA ➢ Head Injury ➢ Epilepsy ➢ Sleeping Problems (such as sleep apnea) ➢ Other:	➢ Eye Disorders ➢ Ear Disorders ➢ Nasal Disorders ➢ Throat Disorders ➢ Other:	➢ Abnormal Muscle Function ➢ Loss of Joint Function ➢ Spine/Joint Pain ➢ Arthritis Pain ➢ Joint Replacement ➢ Generalized Aches/Pain ➢ Other:	➢ Bleeding disorder ➢ Inability to control bleeding from cuts ➢ Phlebitis/blood clots ➢ Transfusion ➢ Immune Problems ➢ HIV/AIDS ➢ Other:

SURGICAL & Pain Management HISTORY

What surgeries have you had (if any)?	Date:

Previous pain doctor's name (if any)? _____

Previous pain doctor's office#? (_____)_____-_____

Why are you changing pain doctors? _____

Have you had any procedures or injections before? If yes, please complete below:

Type of Procedure	How many?	Date of last procedure	Did it help?
Trigger Point Injections			
Radio Frequency Ablation (aka RFA or "burning the nerves") ❑Neck (cervical) ❑Upper back (thoracic) ❑Lower back (lumbar)			
Epidural Injection ❑Neck (cervical) ❑Upper back (thoracic) ❑Lower back (lumbar)			
Facet Joint/Nerve Injection ❑Neck (cervical) ❑Upper back (thoracic) ❑Lower back (lumbar)			
Sacroiliac joint injection (SI)			
Joint/Bursa Injections: ❑Shoulder ❑Elbow ❑Hip ❑Knee ❑Other:_____			
Botox for Migraines			
Pain Pump			
Spinal Cord Stimulator ❑Neck ❑Back			
Other (please describe): _____			

FAMILY HISTORY

	Age	Alive or Deceased?	If deceased, what is the reason?
Mother			
Father			

SOCIAL HISTORY

Occupation: _____Hobbies: _____

Marital Status: _____ # Children: _____ Do you receive disability compensation? **YES | NO**

Name of Employer: _____

Tobacco Use

Status (please circle)	(please complete)
Current Smoker	If circled, how many cigarettes do you smoke per day? _____
Past Smoker	If circled, when did you quit? _____
Never Smoked	-

Alcohol Use

Please answer the following	*Please circle*	*Please answer the questions below if you circled "YES"*
Do you consume alcoholic beverages?	**YES | NO**	Please indicated the quantity of drinks you consume per day: Beer: _____ Wine: _____ Distilled Spirits/Hard Liquor _____ When was your last drink? _____ Have you ever been treated for drug or alcohol addiction, including being admitted to the hospital for alcohol or drug use? **YES | NO**

Please answer questions below	*Please circle*
Have you ever felt the need to cut down on your drinking?	**YES | NO**
Have people annoyed you by criticizing your drinking?	**YES | NO**
Have you ever felt guilty about drinking?	**YES | NO**
Have you ever felt you needed a drink first thing in the morning to steady your nerves or to get rid of a hangover?	**YES | NO**

Other Drug Use/Recreational Drug Use (for example: weed, cocaine, heroin, etc.)

Please Circle	*History*
Current User	Which substances, how much, and when was your most recent use? _____
Past User	Which substances, how much, and when was your most recent use? _____
Never	

Psychiatric History:

Do you have any psychiatric history, such as: anxiety, bipolar, depression, or any other disorder?	**YES | NO** *(If YES = Please complete this section below)*
What have you been diagnosed with in the past or currently?	1. _____ 3. _____ 2. _____ 4. _____
Is your treating physician a psychiatrist?	**YES | NO**
What is your treating physician's contact information so that we may coordinate your care?	Name: _____ Phone Number: (_____)_____-_____

MEDICATIONS

PLEASE LIST ALL YOUR MEDICATIONS:

****(if you brought a list of your medications, please give it to your front desk to copy)****

NAME	DOSE (in milligrams or grams)	How many times a day?	How long have you been taking it?

MEDICATION ALLERGIES

Drug	Reaction

PLEASE ANSWER THE FOLLOWING QUESTIONS RELATED TO YOUR PAIN MEDICATIONS:

To what extent are your pain medications improving your quality of life or ability to get through the day?

❑None ❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

Please answer below:

- ❑ My **pain medications** do not allow me to increase my function.
- ❑ I am stable on my current **pain medication** regimen.
- ❑ My **pain medications** help to improve my functioning and quality of life.

What activities do the pain medications allow you to do that you could not do without the medications?

Describe here:_____

Mark the following pain medication side-effects you are experiencing:

❑Confusion ❑Constipation ❑Dizziness ❑Drowsiness ❑Dry Mouth ❑Nausea ❑Vomiting ❑Weight Gain ❑Sexual (describe): _____ ❑NONE

Are you taking your pain medications exactly as prescribed?

❑YES ❑NO

Are you receiving any pain medications from any other doctor (including dentists, or ER physicians)?

❑YES ❑NO

If YES, please explain: _____

ARE YOU TAKING BLOOD THINNERS? (if yes, please complete below)

❑Coumadin (warfarin) ❑Lovenox (enoxaparin) ❑Aspirin (dose?_____) ❑Plavix (clopidogrel) ❑Ticlid (ticlopidine) ❑Heparin ❑Other _____

How long have you been taking these? _____

Which doctor is monitoring your blood thinners? _____

What is this doctor's phone number? (_____)_____-_____

ARE YOU CURRENTLY ON ANY ANTIBIOTICS? (if yes, please complete below)

DRUG NAME	WHAT CONDITION ARE YOU TREATING?

YOUR PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY PHONE: (_____)_____-_____

PHARMACY ADDRESS: _____

IMAGING

Have you had imaging (MRI, XRAY, CT) for your painful area within the last 6 months? YES | NO

If YES = Please give a copy of both the **CD and Radiology Report** to the front desk

If NO = We may order one for you during this visit

Signature **Date**

_____ _____ / _____ / _____

THANK YOU FOR TAKING THE TIME TO FILL OUT THE NEW PATIENT PACKET. THIS INFORMATION WILL HELP US IN OFFERING YOU A MORE COMPREHENSIVE EVALUATION AND TREATMENT PLAN. SEE YOU SHORTLY!

~ DR. ARORA ~