TDC
THE DOCTORS CLINIC

# «ProviderFirstLastName»
# Interventional Spine/Pain

2200 NW Myhre Road • Silverdale, WA 98383 **(360) 830-1301**

## Patient Information

**Today's date:**
**Your name:** **Date of Birth:** **Age:**

Referring Physician: _____ **Primary Care Physician:** _____

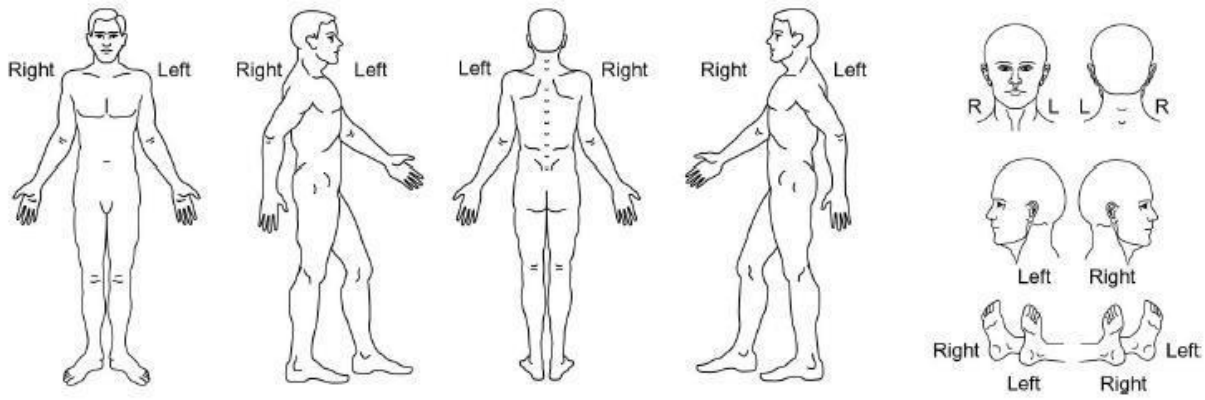
## Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"




## Onset of Symptoms

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

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**Patient Name _____**
**Pain Description**

**Check all of the following that describe your pain:**

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp
☐ Cramping ☐ Numbness ☐ Spasm ☐ Throbbing
☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness

**When is your pain at its worst?**

☐ Mornings ☐Daytime ☐ Evenings ☐ Middle of the night
☐ Always the same

**How often does the pain occur?**

☐ Constant ☐ Changes in severity but always present
☐ Intermittent (comes and goes) ☐ When did the pain start: Date _____

**If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?**
Right Now_____ The Best It Gets_____ The Worst It Gets_____

**Is your pain level affected by any of these daily living tasks:**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Bending Backward | | | Looking upward | | |
| Bending Forward | | | Looking downward | | |
| Changes in Weather | | | Rising from seated position | | |
| Climbing Stairs | | | Sitting | | |
| Coughing/Sneezing | | | Standing | | |
| Driving | | | Walking | | |
| Lifting Objects | | | Dressing | | |

Which of the above tasks are you **unable** to perform due to your pain?

_____
_____

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## Associated Symptoms

| | No | Yes | Comments |
|---|---|---|---|
| Numbness/Tingling | ☐ | ☐ | Where?_____ |
| Weakness in the arm/leg | ☐ | ☐ | _____ |
| Balance Problems | ☐ | ☐ | _____ |
| Bladder Incontinence | ☐ | ☐ | _____ |
| Bowel Incontinence | ☐ | ☐ | _____ |
| Joint Swelling/Stiffness | ☐ | ☐ | _____ |
| Fevers/chills | ☐ | ☐ | _____ |

**Please mark all of the following treatments you have used for pain relief: ☑**

| | No Change | Worsened Pain | Helped Pain |
|---|---|---|---|
| Spine Surgery | ☐ | ☐ | ☐ |
| Brace Support | ☐ | ☐ | ☐ |
| Hot Packs | ☐ | ☐ | ☐ |
| Cold Packs | ☐ | ☐ | ☐ |
| Massage Therapy | ☐ | ☐ | ☐ |
| TENS Unit | ☐ | ☐ | ☐ |
| Medications: _____ | ☐ | ☐ | ☐ |
| NSAIDS | ☐ | ☐ | ☐ |
| Tylenol | ☐ | ☐ | ☐ |

**Interventional Pain Treatment History**

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
☐ Joint Injection – Joint(s) _____
☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
☐ MILD (Minimally Invasive Lumbar Decompression) - _____
☐ Nerve Blocks – Area/Nerve(s) -_____
☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar
☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____
☐ Trigger Point Injections – Where_____
☐ Vertebroplasty/Kyphoplasty – Level(s) _____
☐ Other_____

Which of these procedures listed above have helped with your pain?

_____

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## Diagnostic Tests and Imaging

**Mark all of the following tests that you have related to your current pain complaints:**

☐MRI of the: _____ Date: _____
☐X-Ray of the: _____ Date: _____
☐CT Scan of the: _____ Date: _____
☐EMG/NCV study of the: _____ Date: _____
☐Other Diagnostic Testing: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

**Mark the following physicians or specialists you have consulted for your current pain problem(s):**

| | | **Effective** | **Not effective** |
|---|---|---|---|
| ☐ | Acupuncturist _____ | ☐ | ☐ |
| ☐ | Internist _____ | ☐ | ☐ |
| ☐ | Neurosurgeon _____ | ☐ | ☐ |
| ☐ | Psychiatrist/Psychologist _____ | ☐ | ☐ |
| ☐ | Chiropractor _____ | ☐ | ☐ |
| ☐ | Orthopedic Surgeon _____ | ☐ | ☐ |
| ☐ | Rheumatologist _____ | ☐ | ☐ |
| ☐ | Physical Therapist _____<br>**How long were you treated _____** | ☐ | ☐ |
| ☐ | Neurologist_____ | ☐ | ☐ |
| ☐ | Other _____ | ☐ | |

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## Current Medications

**Are you currently taking any blood thinners or anti-coagulants**?
☐ YES ☐ No
**If YES**, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other _____

**Please list all medications you are currently taking including vitamins. Attach additional sheet if required:**

| **Medication Name** | **Dose** | **Frequency** |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |
| 4) | | |
| 5) | | |
| 6) | | |
| 7) | | |
| 8) | | |
| 9) | | |
| 10) | | |

**Please list all past pain medications that you have been on at any point for your current pain complaints?**

| **Medication Name** | **Dose** | **Frequency** |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |
| 4) | | |
| 5) | | |

## Allergies

**Do you have any drug/medication allergies**? ☐ Yes ☐ No
**If so, please list all medications you are allergic to:**

| Medication Name | Allergic Reaction |
|---|---|
| 1) | |
| 2) | |
| 3) | |
| 4) | |
| 5) | |

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

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**Patient Name:_____**

## Review of Systems

**Mark the following symptoms that you currently suffer from:**

**Constitutional:**
☐ Chills ☐Difficulty sleeping ☐ Easy bruising
☐ Night Sweats ☐Fatigue ☐ Fevers
☐ Insomnia ☐ Low sex drive ☐ Tremors
☐ Unexplained Weight Gain ☐ Weakness
☐ Unexplained Weight Loss

**Eyes:**
☐ Recent Visual changes

**Ears/Nose/Throat/Neck:**
☐ Dental Problems ☐ Earaches ☐ Hearing Problems
☐ Nosebleeds ☐ Sinus problems

**Cardiovascular:**
☐ Chest Pain ☐ Bleeding Disorder ☐ Blood Clots
☐ Fainting ☐ Palpitations ☐ Swelling in feet
☐ Shortness of breath during sleep

**Respiratory:**
☐ Cough ☐ Wheezing ☐ Shortness of breath

**Gastrointestinal:**
☐ Constipation ☐ Acid Reflux ☐ Abdominal Cramps
☐ Diarrhea ☐ Nausea/Vomiting ☐ Hernia

**Musculoskeletal:**
☐ Back Pain ☐ Joint Pains ☐ Joint Stiffness
☐ Joint Swelling ☐ muscle spasms ☐ Neck Pain

**Genitourinary/Nephrology:**
☐ Flank Pain ☐ Blood in Urine ☐ Painful Urination
☐ Decreased Urine Flow/Frequency/Volume

**Neurological:**
☐ Dizziness ☐ Headaches ☐ Tremors
☐ Numbness/Tingling ☐ Seizures

**Psychiatric:**
☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems
☐ Suicidal Thoughts ☐ Suicidal Planning
☐ Thoughts of Harming Others

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## Past Medical History:

**Please list the names of other Pain Physicians** you have seen in the past:_____

**Mark the following conditions/diseases that you have been treated for in the past:**

- **General Medical**

☐ Cancer – Type _____
☐ Diabetes – Type_____

**Cardiovascular/Hematologic**
☐ Anemia
☐ Heart Attack
☐ Coronary Artery Disease
☐ High Blood Pressure
☐ Peripheral Vascular Disease
☐ Stoke/TIA
☐ Heart Valve

**Gastrointestinal**
☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ Constipation

**Urological**
☐ Chronic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinence
☐ Dialysis

**Neuropsychological**
☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizures ☐ Depression
☐ Anxiety ☐ Schizophrenia
☐ Bipolar Disorder

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**Head/Ears/Eyes/Nose/Throat**

☐ Headaches
☐ Migraines
☐ Head Injury
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Glaucoma

**Respiratory**

☐ Asthma
☐ Bronchitis/Pneumonia
☐ Emphysema/COPD

**Musculoskeletal/Rheumatologic**

☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Chronic Joint Pains

**Other Diagnosed Conditions**

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

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## Past Surgical History:

**Please list any surgical procedures you have had done in the past including date**:

1) _____ Date? _____
2) _____Date? _____
3) _____Date? _____
4) _____Date? _____
5) _____Date? _____

☐ I have **NEVER** had any surgical procedures performed.

## Family History

**Mark all appropriate diagnoses and your first degree relatives: Mother, Father, Brother, Sister**

☐Arthritis ***M, F, B, S*** ☐Cancer ***M, F, B, S*** ☐Diabetes ***M, F, B, S***
☐Headaches/Migraines ***M, F, B, S*** ☐High Blood Pressure ***M, F, B, S*** ☐Kidney Problems ***M, F, B, S***
☐Liver Problems ***M, F, B, S*** ☐Osteoporosis ***M, F, B, S*** ☐Rheumatoid arthritis ***M, F, B, S***
☐Seizures ***M, F, B, S*** ☐ Stroke ***M, F, B, S***

☐Other Medical Problems: _____
☐ I have no significant family medical history

## Social History

Occupation: _____ When was the last time you worked? _____
Who is in your current household? _____
Are there any stairs in your current home? _____ If so how many? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed
Are you currently under worker's compensation? ☐ No ☐ Yes
Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

**Alcohol Use:**
☐ Social Use ☐Never
☐ Daily use of alcohol

**Tobacco Use:**
☐ Current user ☐ Former user ☐ Never used
☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

**Illegal Drug Use:**
☐ Denies any illegal drug use ☐ Currently uses illegal drugs ☐ Formerly used illegal drugs (not currently using)

Have you received treatment at a methadone clinic or rehab facility? ☐ Yes ☐ No
(Ladies) Are you pregnant or contemplating pregnancy? ☐ Yes ☐ No

_____ _____

Provider's signature: Date

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**Patient Name:**_____ **DOB:**_____

**Today's Date:**_____

**Please complete the following form by checking the appropriate boxes.**

**THE OPIOID RISK TOOL (ORT)**

| Factor | | Score | |
|---|---|---|---|
| | | Female | 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] |
| | Illicit Drugs | ☐ [4] | ☐ [4] |
| | Prescription Drugs | ☐ [5] | ☐ [5] |
| 3. Age (If between 16 to 45) | | ☐ [1] | ☐ [1] |
| 4. History of Preadolescent Sexual Abuse | | ☐ [3] | ☐ [0] |
| 5. Psychological Disease | ADD, OCD, Bipolar, Schizophrenia | ☐ [2] | ☐ [2] |
| | Depression | ☐ [1] | ☐ [1] |
| | **TOTAL Score** | | |