St Luke's
Spine & Pain Associates

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East Stroudsburg, PA 18301

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Welcome to St. Luke's Spine & Pain Associates,

On behalf of our staff and providers, we would like to welcome you. We understand that pain is a daily part of life for many people, and is often undertreated or ignored. We want to assure you that we will take your pain and the impact that it has on your life seriously.

For your benefit, we would like to familiarize you to our service. For each patient, we evaluate the history and root cause of your pain, a diagnosis is made and we determine a clinical pathway. We believe in utilizing a multidisciplinary approach to pain with an emphasis on reactivation of the patient to the fullest extent possible.

In order to accomplish this, we utilize many diagnostic and treatment modalities, including, but not limited to; interventional therapeutic procedures, radio frequency ablations, dorsal column stimulation, electro diagnostics, augmented with appropriate medications. Surgery will be advised only when non-operative care cannot achieve necessary results. We do all of this with the hope of maximizing your pain relief, physical function and quality of life.

We also have office policies in place to protect you and your well-being. At St. Luke's Spine & Pain Associates, we feel that the patient-provider relationship needs to be built on a foundation of mutual trust in order to permit high quality, effective and safe care to our patients.

Here are some common policies that all patients need to be aware of, upon their initial consultation at St. Luke's Spine & Pain Associates.

1. The first visit is a consultation only; no procedures/injections are performed on the first visit, as this time is utilized to thoroughly evaluate your individual needs and identify a potential clinical pathway.
2. Medication prescriptions are not given on the first office visit, without exception. If you are currently taking prescription medication for pain or potentially need to, a toxicology screening will be conducted and a compliance contract shall be presented to you for signature.
3. If you are currently receiving medication from another practice, please ensure that you have enough supply to last during our evaluation process.
4. As a courtesy to all our patients, anyone that arrives more than 15 minutes late must be rescheduled.

Most importantly you can expect us to listen and validate your specific concerns. We will offer our expert advice and develop customized clinical pathways with a goal of reducing your pain and improving your quality of life. Everything we do is designed with your health and safety in mind. We strive to treat you with the respect, kindness and compassion that you deserve.

We look forward to your visit with us.

St. Luke's Spine & Pain Associates providers and staff

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INITIAL PAIN QUESTIONNAIRE

Patient Name: _____ Age: _____ Date of Birth: _____
Referring Physician: _____ Primary Care Physician: _____
Specific Complaint: _____
Length of current pain problem: _____ Years _____ Months Are you: ☐ Right Handed ☐ Left Handed
Occupation: _____

How did your current pain start?
☐ Injury at work: **Date of accident:** _____
☐ Injury – not at work: **Date of accident:** _____
☐ Motor vehicle accident: **Date of accident:** _____
☐ Illness, non-injury
☐ Treatment caused (e.g. radiation, surgery, etc.)
☐ Undetermined
☐ Other (please describe): _____

Over the past month, the intensity of pain has been:
☐ Mild
☐ Moderate
☐ Moderate – Severe
☐ Severe

Pain Scale: (Rate 0 – 10)
Current pain (10 most severe): _____
Interference with daily activities: _____

How often do you have pain? (Check one)
☐ Constantly (100% of the time)
☐ Nearly constantly (60 – 95% of the time)
☐ Intermittently (30 – 60% of the time)
☐ Occasionally (less than 30% of the time)

During the past month, when has your pain been the worst: (Check one)
☐ Morning
☐ Afternoon
☐ Evening
☐ Night
☐ No typical pattern

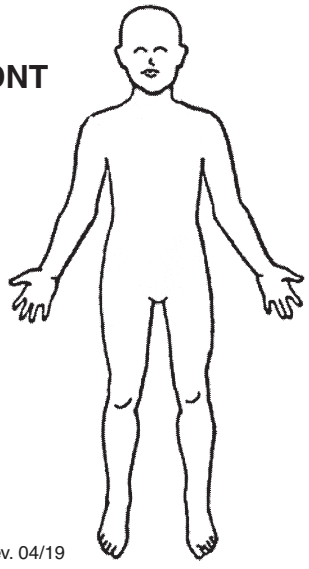
Please describe your pain: (Check all that apply)
☐ Burning ☐ Cutting
☐ Cramping ☐ Pins and Needles
☐ Shooting ☐ Pressure-like
☐ Numbness ☐ Throbbing
☐ Sharp ☐ Dull/Aching
☐ Other (describe): _____

Have you had weakness in your:
☐ Upper extremities ☐ Lower extremities
☐ Dropping objects
☐ Other (describe): _____

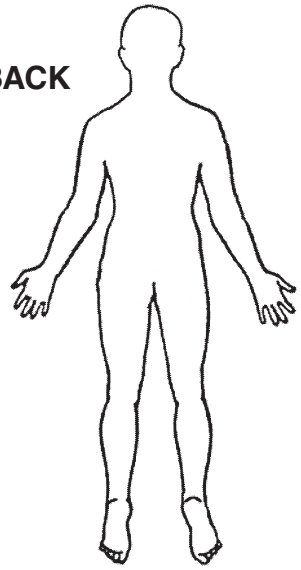
Do you use a:
☐ Cane ☐ Walker
☐ Wheelchair ☐ No assistance device

PAIN LOCATION: ***Please mark the location(s) of your pain on the diagrams with an "X". If entire areas are painful, please shade in these areas.***

FRONT



BACK



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How do the following affect your pain? (Check one for each item)

	DECREASE	NO CHANGE	INCREASE		DECREASE	NO CHANGE	INCREASE
Prayer	☐	☐	☐	Exercise	☐	☐	☐
Lying down	☐	☐	☐	Relaxation	☐	☐	☐
Standing	☐	☐	☐	Coughing	☐	☐	☐
Bending	☐	☐	☐	Sneezing	☐	☐	☐
Sitting	☐	☐	☐	Bowel Mvmt	☐	☐	☐
Walking	☐	☐	☐	Menstruation	☐	☐	☐

List other treating physicians for your pain problem and the year:

Physician	Year	Physician	Year

List all studies you have had for this problem: (X-rays, MRIs, CT Scans, Blood Tests, Myelograms)

Study	Facility	Year	Study	Facility	Year

List all current non-pain medications you are taking:

Name	Dose	Frequency	Name	Dose	Frequency

List all surgeries you have had in the past and the approximate date:

Date	Type of Surgery/Procedure

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INITIAL PAIN QUESTIONNAIRE

PAST MEDICAL HISTORY: (Check all that apply)

- ☐ Alcoholism
- ☐ Anxiety
- ☐ Asthma or Wheezing
- ☐ Bleeding Problem
- ☐ Chest Pain or Angina
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ GERD/Reflux
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Psychiatric Problems
- ☐ Seizure or Epilepsy
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Name of Psychiatrist/Therapist: _____
- ☐ Arthritis (specify location): _____
- ☐ Cancer (specify type): _____
- ☐ Other (specify): _____

PAIN TREATMENTS: (Check your response to all the treatments you have tried)

	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF		NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
Surgery	☐	☐	☐	Heat/Ice	☐	☐	☐
Traction	☐	☐	☐	Psychotherapy	☐	☐	☐
Nerve block	☐	☐	☐	Acupuncture	☐	☐	☐
Nerve Injection	☐	☐	☐	Hypnosis	☐	☐	☐
Physical Therapy	☐	☐	☐	Biofeedback	☐	☐	☐
Exercise	☐	☐	☐	TENS	☐	☐	☐
Osteopathic Manipulation	☐	☐	☐	Chiropractic Manipulation	☐	☐	☐

Answer the below yes and no questions:

	NO	YES	
Do you smoke **tobacco?**	☐	☐	If yes, packs per day _____, _____ years smoking
Do you smoke **marijuana?**	☐	☐	If yes, how frequently _____
Do you drink **alcohol?**	☐	☐	If yes, how frequently _____
Are you currently on **blood thinning medication?**	☐	☐	
Do you have an **allergy to latex?**	☐	☐	If yes, what is your reaction _____
Do you have an **allergy to contrast dye?**	☐	☐	If yes, what is your reaction _____

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PAIN MEDICATIONS: (Check all medication you have used for the treatment of pain and if they provided relief)

Opioids	CURRENT	PAST	PROVIDED RELIEF		CURRENT	PAST	PROVIDED RELIEF
Codeine	☐	☐	☐	Oxycodone (Percocet)	☐	☐	☐
Demerol	☐	☐	☐	Oxycontin	☐	☐	☐
Fentanyl (Duragesic)	☐	☐	☐	Oxymorphone (Opana)	☐	☐	☐
Hydrocodone (Vicodin)	☐	☐	☐	Propoxyphene (Darvocet)	☐	☐	☐
Hydromorphone (Dilaudid)	☐	☐	☐	Tapentadol (Nucynta)	☐	☐	☐
Methadone	☐	☐	☐	Tramadol (Ultram)	☐	☐	☐
Morphine (MSContin)	☐	☐	☐	_____	☐	☐	☐

Topicals	CURRENT	PAST	PROVIDED RELIEF		CURRENT	PAST	PROVIDED RELIEF
Capsaicin	☐	☐	☐	Voltaren Gel	☐	☐	☐
Diclofenac (Flector)	☐	☐	☐	Qutenza	☐	☐	☐
Lidocaine patch (Lidoderm)	☐	☐	☐	_____	☐	☐	☐
Pennsaid	☐	☐	☐	_____	☐	☐	☐

NSAIDS/Tylenol	CURRENT	PAST	PROVIDED RELIEF		CURRENT	PAST	PROVIDED RELIEF
Acetaminophen (Tylenol)	☐	☐	☐	Nabumetone (Relafen)	☐	☐	☐
Aspirin	☐	☐	☐	Naproxen	☐	☐	☐
Celebrex	☐	☐	☐	Oxaprozin (Daypro)	☐	☐	☐
Ibuprofen (Advil/Motrin)	☐	☐	☐	Piroxicam (Feldene)	☐	☐	☐
Indocin	☐	☐	☐	Salsalate/Trilisate	☐	☐	☐
Lodine	☐	☐	☐	Toradol	☐	☐	☐
Meloxicam (Mobic)	☐	☐	☐	_____	☐	☐	☐

Muscle Relaxants	CURRENT	PAST	PROVIDED RELIEF		CURRENT	PAST	PROVIDED RELIEF
Alprazolam (Xanax)	☐	☐	☐	Metaxalone (Skelaxin)	☐	☐	☐
Baclofen	☐	☐	☐	Parafon Forte	☐	☐	☐
Carisoprodol (Soma)	☐	☐	☐	Robaxin	☐	☐	☐
Cyclobenzaprine (Fexeril)	☐	☐	☐	Tizanidine (Zanaflex)	☐	☐	☐
Diazepam (Valium)	☐	☐	☐	_____	☐	☐	☐
Lorazepam (Ativan)	☐	☐	☐	_____	☐	☐	☐

Other	CURRENT	PAST	PROVIDED RELIEF		CURRENT	PAST	PROVIDED RELIEF
Amitryptilline (Elavil)	☐	☐	☐	Depakote	☐	☐	☐
Duloxetine (Cymbalta)	☐	☐	☐	Dilantin	☐	☐	☐
Nortriptyline (Pamelor)	☐	☐	☐	Gabapentin (Neurontin)	☐	☐	☐
Oral Steroids (eg Prednisone)	☐	☐	☐	Imitrex	☐	☐	☐
Paroxetine (Paxil)	☐	☐	☐	Klonopin	☐	☐	☐
Sertraline (Zoloft)	☐	☐	☐	Lyrica (Pregablin)	☐	☐	☐
Suboxone (Buprenorphine)	☐	☐	☐	Savella	☐	☐	☐
Venlafaxine (Effexor)	☐	☐	☐	Topiramate (Topamax)	☐	☐	☐
Carbamazepine (Tegretol)	☐	☐	☐	_____	☐	☐	☐

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REVIEW OF SYSTEMS: (Check all symptoms that you are currently experiencing)

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain

HENT
- ☐ Loss of Hearing
- ☐ Nose Bleeds
- ☐ Sore Throat

EYES
- ☐ Eye Pain
- ☐ Red Eyes
- ☐ Visual Disturbances

RESPIRATORY
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting

ENDOCRINE
- ☐ Frequent Urination
- ☐ Thirsty

URINARY
- ☐ Pain with Urination
- ☐ Blood in Urine

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain

SKIN
- ☐ Rashes
- ☐ Skin Wounds

NEUROLOGICAL
- ☐ Dizziness
- ☐ Headache
- ☐ Numbness

PSYCHIATRIC
- ☐ Difficulty Concentrating
- ☐ Anxiety
- ☐ Suicidal
- ☐ Depression

_____	_____	_____	_____
PATIENT SIGNATURE	**PRINTED NAME**	**DATE**	**TIME**

Please note that we do not determine disability.

Reviewed by: _____