St Luke's
Spine Institute

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Initial Physiatry Questionnaire

Date: _____ Date of First Visit: _____

Please complete this form prior to your first visit to the Spine Institute.

Name: _____ Age: _____ Date of birth: _____

Referring Physician: _____ Primary Care Physician: _____

What is the main problem for which you are seeking treatment?

_____

How long have you had this current pain problem? _____Years_____ Months _____Weeks

Please check: Are you ❑ Right Handed ❑ Left Handed

How did your current pain start?

- ❑ Injury at work **Date of accident:**_____
- ❑ Injury – not at work
- ❑ Motor vehicle accident
- ❑ Illness, non-injury
- ❑ Treatment caused (e.g. radiation, surgery, etc.)
- ❑ Undetermined
- ❑ Other (please describe): _____

In general, over the past month, the intensity of pain has been:

- ❑ Mild
- ❑ Moderate
- ❑ Moderate – Severe
- ❑ Severe

- With 10 being the most severe, rate your pain from 0 – 10 _____
- With 10 meaning your pain greatly interferes with your activities of daily living and 0 meaning the pain does not interfere with activities of daily living, rate your pain from 0 – 10 _____

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)

In general, during the past month, when has your pain been the worst: (Please check one)

- ❑ Morning
- ❑ Afternoon
- ❑ Evening
- ❑ Night
- ❑ No typical pattern

Please describe your pain: (Check all that apply)

❑ Burning	❑ Sharp	❑ Pressure-like
❑ Cramping	❑ Dull/Aching	❑ Throbbing
❑ Shooting	❑ Cutting	❑ Other (describe):_____
❑ Numbness	❑ Pins and Needles	

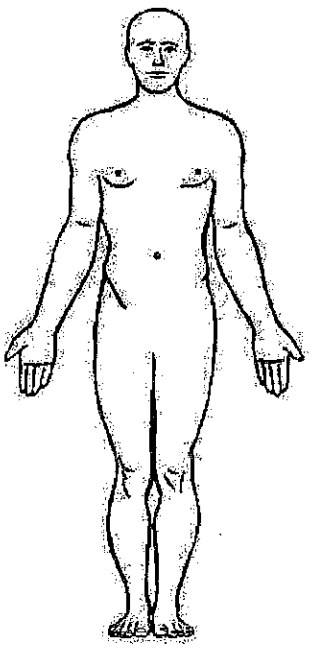
Have you had pain, numbness, tingling, weakness:

❑ Upper extremities ❑ Lower extremities

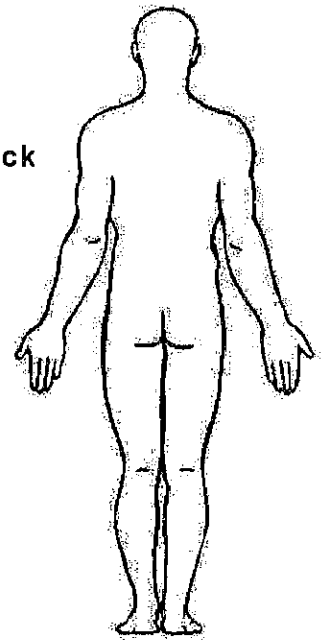
❑ Dropping objects ❑ Other (describe):_____

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



How do the following affect your pain? (Please check one for each item.)

	DECREASE	NO CHANGE	INCREASE
Prayer	❑	❑	❑
Lying down	❑	❑	❑
Standing	❑	❑	❑
Bending	❑	❑	❑
Sitting	❑	❑	❑
Walking	❑	❑	❑
Exercise	❑	❑	❑
Relaxation	❑	❑	❑
Coughing/Sneezing	❑	❑	❑
Bowel movements	❑	❑	❑
Menstruation	❑	❑	❑

Do you use a: ❑ Cane ❑ Walker ❑ Wheelchair ❑ No assistance device ❑ Brace

Please list the names of the physicians you have seen for this pain problem and the year:

_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

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

Study: _____ Facility where taken: _____ Year: _____

Study: _____ Facility where taken: _____ Year: _____

Study: _____ Facility where taken: _____ Year: _____

Study: _____ Facility where taken: _____ Year: _____

PAIN TREATMENTS: (Please check your response to all the treatments you have tried.)

	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
Surgery	❑	❑	❑
Traction	❑	❑	❑
Nerve block/injection	❑	❑	❑
Physical Therapy	❑	❑	❑
Exercise	❑	❑	❑
TENS	❑	❑	❑
Heart/Ice Treatment	❑	❑	❑
Psychotherapy	❑	❑	❑
Acupuncture	❑	❑	❑
Hypnosis	❑	❑	❑
Biofeedback	❑	❑	❑
Chiropractic Manipulation	❑	❑	❑
Osteopathic Manipulation	❑	❑	❑

PAIN MEDICATIONS: (Please check all medications you have

Opioids	Current	Past	NSAIDs / Tylenol	Current	Past	Muscle Relaxants	Current	Past
Codeine	❑	❑	Acetaminophen (Tylenol®)	❑	❑	Alprazolam (Xanax®)	❑	❑
Demerol	❑	❑	Aspirin	❑	❑	Baclofen	❑	❑
Fentanyl (Duragesic®)	❑	❑	Celebrex	❑	❑	Carisoprodol (Soma®)	❑	❑
Hydrocodone (Vicodin®)	❑	❑	Ibuprofen (Advil/Motrin®)	❑	❑	Cyclobenzaprine (Flexeril®)	❑	❑
Hydromorphone (Dilaudid®)	❑	❑	Indocin	❑	❑	Diazepam (Valium®)	❑	❑
Methadone	❑	❑	Lodine	❑	❑	Lorazepam (Ativan®)	❑	❑
Morphine (MSContin®)	❑	❑	Meloxicam (Mobic®)	❑	❑	Metaxalone (Skelaxin®)	❑	❑
Oxycodone (Percocet®)	❑	❑	Nabumetone (Relafen®)	❑	❑	Parafon Forte	❑	❑
Oxycontin	❑	❑	Naproxen	❑	❑	Robaxin	❑	❑
Oxymorphone (Opana®)	❑	❑	Oxaprozin (Daypro®)	❑	❑	Tizanidine (Zanaflex®)	❑	❑
Tapentadol (Nucynta®)	❑	❑	Piroxicam (Feldene®)	❑	❑	_____	❑	❑
Tramadol (Ultram®)	❑	❑	Salsalate/Trilisate	❑	❑	_____	❑	❑
_____	❑	❑	Toradol	❑	❑	_____	❑	❑
_____	❑	❑	_____	❑	❑	_____	❑	❑
			_____	❑	❑	_____	❑	❑

Other	Current	Past	Other	Current	Past	Other	Current	Past
Amitryptilline (Elavil®)	❑	❑	Carbamazepine (Tegretol®)	❑	❑	Capsaicin	❑	❑
Duloxetine (Cymbalta®)	❑	❑	Depakote	❑	❑	Diclofenac (Flector®)	❑	❑
Nortriptyline (Pamelor®)	❑	❑	Dilantin	❑	❑	Lidocaine patch (Lidoderm®)	❑	❑
Oral Steroids (eg: Prednisone®)	❑	❑	Gabapenin (Neurontin®)	❑	❑	Pennsaid	❑	❑
Paroxetine (Paxil®)	❑	❑	Imitrex	❑	❑	Voltaren Gel	❑	❑
Sertraline (Zoloft®)	❑	❑	Klonopin	❑	❑	Qutenza	❑	❑
Suboxone (Buprenorphine®)	❑	❑	Lyrica (Pregablin®)	❑	❑	_____	❑	❑
Venlafaxine (Effexor®)	❑	❑	Savella	❑	❑	_____	❑	❑
_____	❑	❑	Topiramate (Topamax®)	❑	❑	_____	❑	❑
_____	❑	❑	_____	❑	❑	_____	❑	❑

PAST MEDICAL HISTORY: Have you had any of the following? (Please check all that apply)

❑ Alcoholism	❑ Depression	❑ High Cholesterol	❑ Stomach Ulcers
❑ Anxiety	❑ Diabetes	❑ Hypertension	❑ Stroke
❑ Asthma or Wheezing	❑ Emphysema	❑ Kidney Disease	❑ Thyroid Disease
❑ Bleeding Problem	❑ Fibromyalgia	❑ Liver Disease	❑ Addiction to Drugs
❑ Chest Pain or Angina	❑ GERD/Reflux	❑ Psychiatric Problems	
❑ Coronary Artery Disease	❑ Heart Attack	❑ Seizure or Epilepsy	

Name of Psychiatrist/Therapist: _____

Arthritis (specify location): _____

Cancer (specify type): _____

Other (specify): _____

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

Date	Type of Surgery/Procedure

ALLERGIES TO MEDICATIONS: List the names of all medications to which you are allergic. Medication

Medication	Type of Reaction

❑ **NO known drug allergies.**

Are you allergic to contrast dye used for x-rays? ❑ YES ❑ NO

Are you allergic to latex? ❑ YES ❑ NO

CURRENT MEDICATIONS YOU TAKE FOR PAIN:

Name	Dose	Frequency

Are these pain medications providing relief?

❑ None of the time

❑ Some of the time

❑ Most of the time

❑ All of the time

ALL OTHER CURRENT MEDICATIONS (OTHER THAN PAIN MEDICATION):

Name	Dose	Frequency

SOCIAL HISTORY:

- ❑ Employed full time Employers Name:_____ Phone:_____
- ❑ Employed part time Current occupation:_____
- ❑ Unemployed
- ❑ Retired
- ❑ Student
- ❑ Homemaker

Are you unemployed or employed part time due to your present pain condition? ❑ YES ❑ NO

PLEASE COMPLETE ALL QUESTIONS

Do you smoke? ❑YES ❑ NO Do you drink alcohol? ❑YES ❑ NO ❑ Beer ❑ Wine ❑ Liquor

How much nicotine per day?_____ How many glasses per week? _____

Do you use recreational drugs?_____

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Do you live alone? ❑ YES ❑ NO Who do you live with?_____

Are you pregnant? ❑ NO DYES ❑ N/A

LEGAL ISSUES: Please indicate any of the following claims you have filed related to your pain problem.

❑ Workers Compensation ❑ Social Security Disability Insurance

❑ Personal Injury/Liability ❑ Other Insurance

FAMILY HISTORY: Do you have a family history of the following?

Back Disorder	❑YES	❑NO	Heart disease	❑YES	❑NO
High Blood Pressure	❑YES	❑NO	Diabetes	❑YES	❑NO
Stroke	❑YES	❑NO	Thyroid Disease	❑YES	❑NO
Neuropathy	❑YES	❑NO	Cancer	❑YES	❑NO

Other:_____ If Yes, type of cancer _____

	Living (age)	Deceased (age)	Cause of death
Father			
Mother			
Brothers			
Sisters			

REVIEW OF SYSTEMS: Please check all symptoms that you have now or have recently had.

❑	Recent weight loss	❑	Wheezing
❑	Recent weight gain	❑	memory loss
❑	Fever	❑	Loss of consciousness
❑	Dizziness	❑	Seizures
❑	Difficulty swallowing	❑	Easy bruising
❑	Difficulty walking	❑	Easy bleeding
❑	Double or blurry vision	❑	Rash
❑	Muscle weakness	❑	Frequent urination
❑	Nausea	❑	Excessive thirst
❑	Vomiting	❑	Adrenal disease
❑	Constipation	❑	Hypothyroidism
❑	Diarrhea	❑	Hyperthyroidism
❑	Difficulty initiating urine stream	❑	Joint Stiffness
❑	Genital pain	❑	Decreased range of motion
❑	Chest pain	❑	Depression
❑	Heart palpitations	❑	Swelling (specify)_____
❑	Shortness of breath	❑	Pain in extremity (specify)_____

It is your responsibility to notify our office 48-hours prior to medication refill.
Please allow one week for completion of any forms.

Patient Signature: _____ **Date:** _____ **Time:** _____

❑ All other review of systems negative

ROS and PFSH reviewed by: _____ Date: _____ Time: _____
SIGNATURE OF PHYSICIAN

Updated: _____ Date: _____ Time: _____
SIGNATURE OF PHYSICIAN