Virginia Interventional Spine Associates
Initial Patient Questionnaire

Name: _____ Date: _____-_____-_____
Last First MI

D.O.B.: _____-_____-_____ Age: _____ ❍ Male ❍ Female

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

HISTORY OF PRESENT ILLNESS:

Chief Complaint: ❍ Left ❍ Right ❍ Head ❍ Neck ❍ Chest ❍ Abdomen
Pain Location ❍ Arm ❍ Back ❍ Foot ❍ Hand ❍ Shoulder ❍ Hip
❍ Leg ❍ Other _____

Radiation of Pain: ❍ No ❍ Yes Where _____

Date of Onset: _____-_____-_____ **When first seen by a doctor:** _____-_____-_____

Did you have an injury? ❍ No ❍ Yes _____

Quality: ❍ Sharp ❍ Dull ❍ Burning ❍ Aching ❍ Throbbing ❍ Shooting ❍ tingling
❍ Stabbing ❍ Other _____

Pain Level: Present Intensity: _____/10 Lowest Intensity: _____/10 Highest Intensity: _____/10
Is your pain <u>always</u> present? ❍ Yes ❍ No

Sleep: Do you have trouble… ❍ going to sleep? ❍ staying asleep?
If you have problems with sleep, is it… ❍ related to your pain? ❍ for some other reason?

Increases Pain: ❍ Sitting ❍ Standing ❍ Lying down ❍ Walking ❍ Physical Activity
❍ Morning ❍ Afternoon ❍ Evening ❍ Other _____

Decreases Pain: ❍ Sitting ❍ Standing ❍ Lying down ❍ Walking ❍ Medications ❍ Heat
❍ Physical Activity ❍ Relaxation Techniques ❍ Other _____

Neurologic Dysfunction: ❍ Numbness ❍ Weakness ❍ Coldness ❍ Skin Discoloration
❍ Bowel/Bladder Problems ❍ Other _____

Weight Change: ❍ Loss _____lbs ❍ Gain _____lbs

<u>PREVIOUS TREATMENT</u>:

Injections	❍ Yes	❍ No
TENS	❍ Yes	❍ No
Biofeedback	❍ Yes	❍ No
Chiropractor	❍ Yes	❍ No
Psychotherapy	❍ Yes	❍ No
Physical Therapy	❍ Yes	❍ No
Other	_____	

<u>DIAGNOSTIC STUDIES</u>:

X-rays	❍ Yes	❍ No
NCS/EMG	❍ Yes	❍ No
CAT Scan	❍ Yes	❍ No
MRI	❍ Yes	❍ No
Bone Scan	❍ Yes	❍ No

<u>VITAL SIGNS:</u> _____
Initials

BP: _____
HR: _____
Temp: _____
Resp: _____
Ht: _____ft _____in
Wt: _____lbs

_____ _____-_____-_____
Patient Signature Date

Name: _____ Date: _____-_____-_____
Last First MI

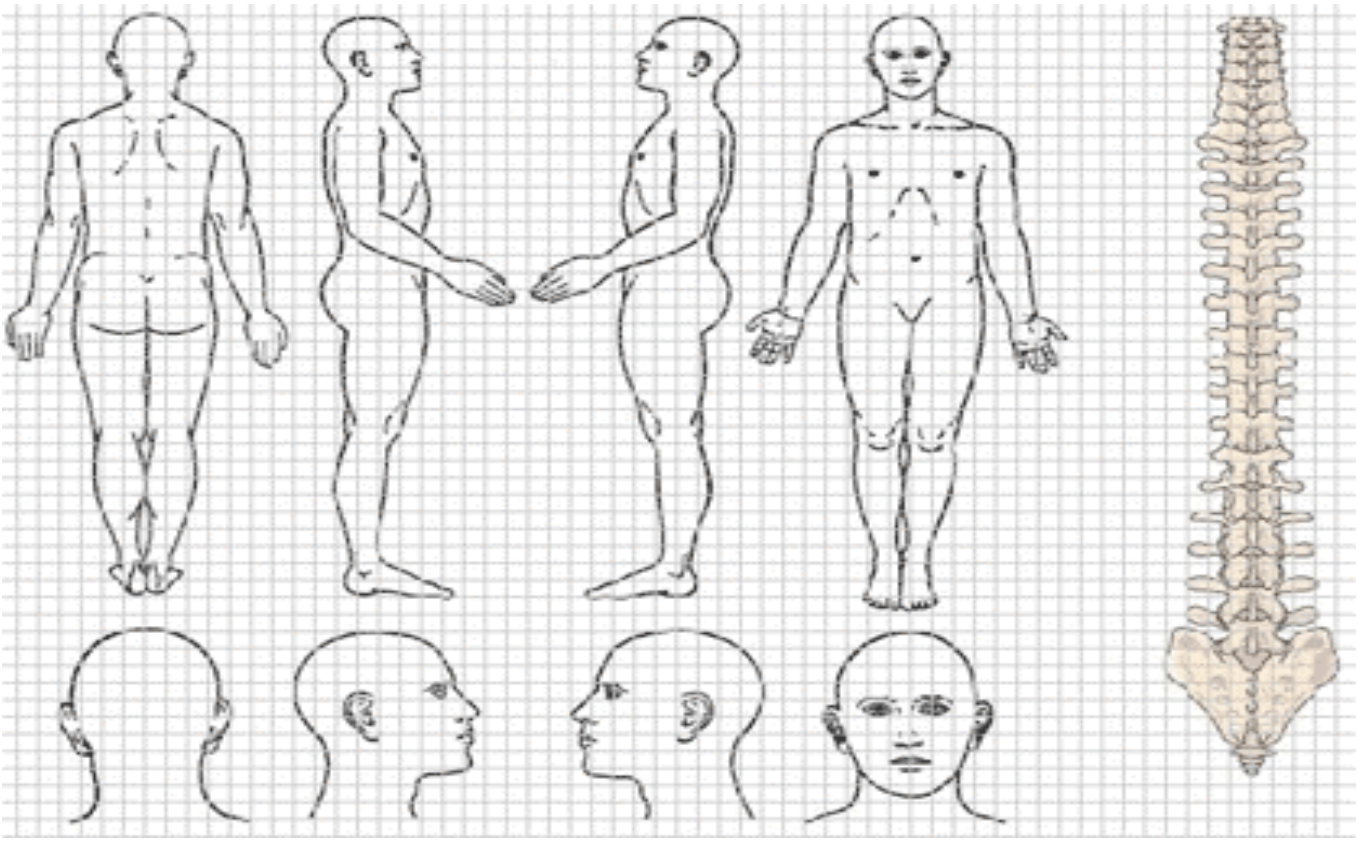
Approximately how many physician visits have you had for your pain in the last year? _____

How many visits to the emergency room have you had in the last year for pain? _____

Are you working now? ❍ Yes …… Does your job involve: ❍ heavy lifting ❍ standing ❍ sitting ❍ pushing/pulling
❍ No …… Do you plan to return to work? ❍ Yes ❍ No

Highest level of education completed: ❍ No school ❍ Elementary school ❍ High school/GED ❍ Some college ❍ College Grad ❍ Post-grad degree

SHADE AREAS WHERE YOUR PAIN OCCURS:



PHYSICAL EXAM:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

_____ _____-_____-_____
Patient Signature Date

Name: _____ Date: _____-_____-_____
Last First MI

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: (Please check all that apply to you)

❍ GI Ulcers
❍ Kidney Disease
❍ Bleeding disorders
❍ Diabetes
❍ Cancer
❍ Hearing loss/hearing aid
❍ Psychiatric Disorder
❍ Liver Disease
❍ Acid Reflux
❍ Epilepsy/Seizures
❍ Asthma/Bronchitis
❍ Tuberculosis
❍ Hypertension
❍ Bladder Disorder
❍ Heart Disease
❍ Depression
❍ Thyroid Disease
❍ Suicidal thoughts/Suicide attempt
❍ Joint disease/arthritis
❍ Urethral Discharge
❍ Skin rash
❍ Visual Problems
❍ Bowel Disorder
❍ Stroke
❍ Fever/chills/sweats
❍ Pacemaker
❍ Other _____

SURGERY	DATE	SURGERY	DATE

PLEASE LIST ALL ALLERGIES:	

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS: **(Bring all of your meds in their original containers to your appointment)**		

Family History:

Cancer ❍ No ❍ Yes _____
Diabetes ❍ No ❍ Yes _____
Heart Disease ❍ No ❍ Yes _____

Vaccination History:

Flu Shot ❍ No ❍ Yes (Date Received _____)
Pneumococcal ❍ No ❍ Yes (Date Received _____)

Social History:

Smoke: ❍ No ❍ Yes-Packs/year _____
Former Smoker: ❍ No ❍ Yes-Date quit _____-_____-_____
Alcohol Use: ❍ No ❍ Yes-How Much _____
Drink to relieve pain? ❍ No ❍ Yes
History of alcohol abuse? ❍ No ❍ Yes
History of drug (including marijuana) use or abuse? ❍ No ❍ Yes

_____ _____-_____-_____
Patient Signature Date

_____ _____-_____-_____
Nurse/MA Signature Date