For office use only

Rm_____ Img_____

_____

NEW PATIENT EVALUATION FORM

Name: _____ **Date of Birth**: _____

How were you referred to Valley Health Interventional Spine?

☐Physician:_____ ☐Relative/Friend

☐Internet:_____ ☐Other:_____

What is your primary concern?

☐Lower Back Pain ☐ Hip/Leg Pain

☐ Neck Pain ☐ Shoulder/Arm Pain

☐ Mid Back pain ☐Other/ Please describe: _____

How long have you had this pain? _____ Days _____ Weeks ____ Months ____ _Years

Onset: ☐Gradual ☐ Quick/Acute (please select the box that best applies)

☐Spontaneous ☐ Accident/Trauma (please select the box that best applies)

History of Prior Symptoms: ☐Yes ☐ No

Please indicate the quality your pain/discomfort:

☐Electrical /Burning ☐ Sharp ☐Dull/Achy ☐Numbness/Tingling

Is your pain due to an Injury or Work Related Condition? ☐Yes ☐No

What activities increase and/or decrease your pain?

Activity	Increases Pain	Decreases Pain
Sitting		
Standing		
Walking		

<u>Please list current and prior medications you have taken for your Pain (or attach list):</u>

Name of Medication	Dose in mg/g	Daily Frequency

Please indicate any current or prior treatments for your pain:

TREATMENT	TYPE	DATE
Surgery		
Injections		
Physical Therapy		
Other		

Surgical History:

Please list any other surgeries and their approximate dates

Surgery	**Date**

Review of Systems:

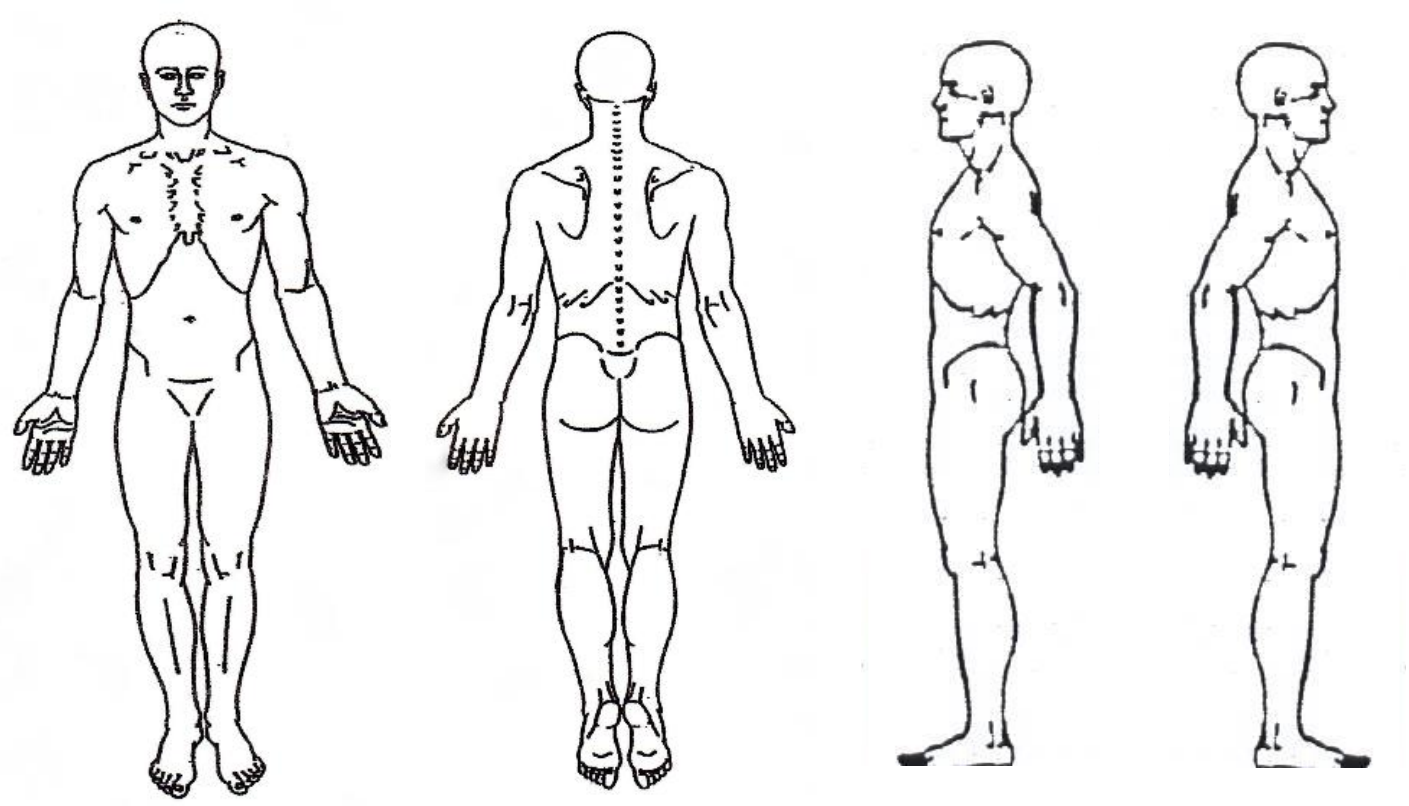
Please mark any of the following symptoms that you have experienced in the last six (6) months:

Constitutional: ☐ Weight Loss ☐ Weight Gain ☐ Fatigue ☐ Fever / Sweats ☐ Heat/Cold Intolerance ☐ Weakness	**Neurological:** ☐ Memory Loss ☐ Seizures ☐ Numbness/Tingling ☐ Speech Problems ☐ Weakness ☐ Headache ☐ Fainting ☐ Coordination Problems	**Musculoskeletal:** ☐ Joint Pain ☐ Joint Swelling ☐ Joint Redness ☐ Muscle Cramps ☐ Weakness	**HEENT:** ☐ Vision Changes ☐ Loss of Hearing ☐ Ringing in Ears ☐ Dizziness/ Vertigo ☐ Sinus Problems ☐ Sore Throat ☐ Masses/Nodes ☐ Nasal Discharge ☐ Ear Pain
Cardiovascular: ☐ Palpitations ☐ Chest Pain ☐ Shortness of Breath ☐ Circulation Problems	**Respiratory:** ☐ Shortness of Breath ☐ Cough ☐ Wheezing	**Gastrointestinal:** ☐ Diarrhea ☐ Constipation ☐ Stomach Pain ☐ Nausea/Vomiting ☐ Jaundice ☐ Heartburn ☐ Indigestion	**Genitourinary/ Urinary:** ☐ Painful Urination ☐ Blood in Urine ☐ Loss of Bladder Control ☐ Difficulty Urinating ☐ Frequent Urination
Skin: ☐ Rash ☐ Hives ☐ Pruritus/Itching ☐ Skin Changes	**Psychiatric:** ☐ Anxiety ☐ Depression ☐ Mood Changes ☐ Sleep Disturbance	**Male:** ☐ Penial Discharge ☐ Sore on Penis ☐ Lump on Testicle	**Female:** ☐ Vaginal Discharge ☐ Breast Pain ☐ Breast Lump /Sore ☐ Pelvic Pain

Pain Diagram

Draw the location of your pain on the figures below; please indicate the type of pain by using the key:

Aching	Burning	Stabbing	Pins & Needles	Numbness
X X X X	**^ ^ ^ ^**	**_ _ _ _**	**+ + + +**	**O O O O**



Draw a line to indicate your usual level of pain on the scale below:

No Pain Worse Pain Possible

Please complete ONLY if you have Back/Leg Pain

Oswestry Disability Questionnaire

The purpose of the following questionnaire is to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please mark only the box that indicates the statement which most clearly describes your problem.

Section 1- Pain Intensity
- □ I have no pain at the moment.
- □ The pain is very mild at the moment.
- □ The pain is moderate at the moment.
- □ The pain is fairly severe at the moment.
- □ The pain is very severe at the moment.
- □ The pain is the worst imaginable at the moment.

Section 2- Personal Care (e.g., Washing, Dressing)
- □ I can look after myself normally without causing extra pain.
- □ I can look after myself normally but it causes extra pain.
- □ It is painful to look after myself and I am slow and careful.
- □ I need some help but manage most of my personal care.
- □ I need help every day in most aspects of self-care.
- □ I do not get dressed, wash with difficulty, and stay in bed.

Section 3- Lifting
- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights, but it gives me extra pain.
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- □ I can lift only very light weights.
- □ I cannot lift or carry anything at all.

Section 4- Walking
- □ Pain does not prevent me walking any distance.
- □ Pain prevents me walking more than 1 mile.
- □ Pain prevents me walking more than a quarter of a mile.
- □ Pain prevents me walking more than 100 yards.
- □ I can only walk using a cane or crutches.
- □ I am in bed most of the time and have to crawl to the toilet.

Section 5- Sitting
- □ I can sit in any chair as long as I like.
- □ I can only sit in my favorite chair as long as I like.
- □ Pain prevents me sitting more than 1 hour.
- □ Pain prevents me sitting more than half an hour.
- □ Pain prevents me sitting more than 10 minutes.
- □ Pain prevents me from sitting at all.

Section 6-Standing
- □ I can stand as long as I like without extra pain.
- □ I can only stand as long as I like but it gives me extra pain.
- □ Pain prevents me standing more than 1 hour.
- □ Pain prevents me standing more than half an hour.
- □ Pain prevents me standing more than 10 minutes.
- □ Pain prevents me from standing at all.

Section 7- Sleeping
- □ My sleep is never disturbed by pain.
- □ My sleep is occasionally disturbed by pain.
- □ Because of pain I have less than 6 hours sleep.
- □ Because of pain I have less than 4 hours sleep.
- □ Because of pain I have less than 2 hours sleep.
- □ Pain prevents me from sleeping at all.

Section 8- Sex Life (if applicable)
- □ My sex life is normal and causes no extra pain.
- □ My sex life is normal but causes some extra pain.
- □ My sex life is nearly normal but is very painful.
- □ My sex life is severely restricted by pain.
- □ My sex life is nearly absent because of pain.
- □ Pain prevents me any sex life at all.

Section 9- Social Life
- □ My social life is normal and causes me no extra pain.
- □ My social life is normal but increased the degree of pain.
- □ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g sport, etc.
- □ Pain has restricted my social life and I do not go out as often.
- □ Pain has restricted my social life to my home.
- □ I have no social life because of pain.

Section 10- Traveling
- □ I can travel anywhere without pain.
- □ I can travel anywhere, but it gives me extra pain.
- □ Pain is bad, but I manage journeys over 2 hours.
- □ Pain restricts me to journeys of less than 1 hours.
- □ Pain restricts me to short necessary journeys under 30 minutes.
- □ Pain prevents me from traveling except to receive treatment.