Montana Spine and Pain Center

Saint Patrick Hospital and Health Sciences Center
500 West Broadway, Missoula, Montana 59802
TEL: 406-327-1670 FAX: 406-329-5697

Patient: **Date:**

Referring Provider:

We would like to gather some information that will help with your evaluation. Please complete the following questionnaire as best you can. If there are questions you do not understand, you will be able to discuss this with your healthcare provider during the visit.

What condition do you need evaluated in the Montana Spine and Pain Center?

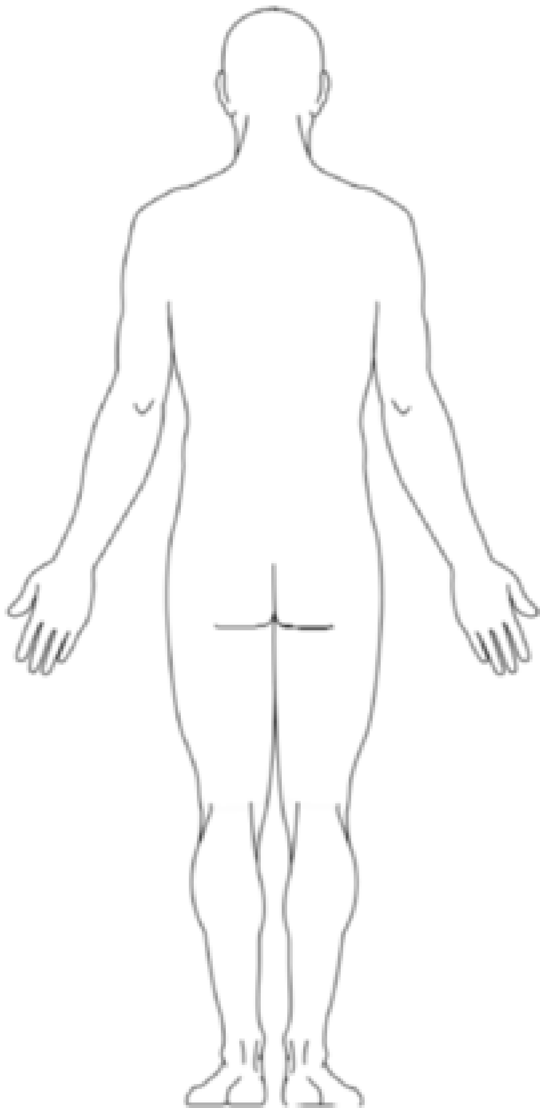
How long have you had the condition?

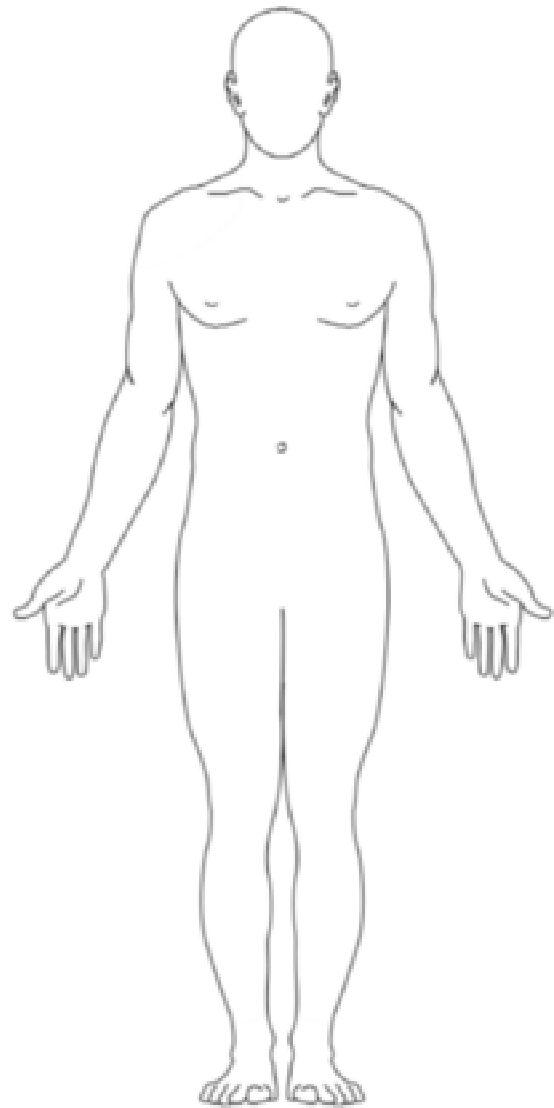
What caused the condition?

What symptoms are you experiencing?

On the picture below, mark the areas of your body where you feel:

Pain +++++ Numbness ===== Weakness xxxxx





Pain Questions

Does the pain keep you awake at night?	**Yes**	**No**
Do you have pain when you cough or sneeze?	**Yes**	**No**
Do you stumble when you walk?	**Yes**	**No**
Have you noticed your hands are clumsy?	**Yes**	**No**
Do you have trouble controlling your bladder?	**Yes**	**No**
Do you have trouble controlling bowel movements?	**Yes**	**No**
Do you have weakness anywhere?	**Yes**	**No**
Do you have numbness anywhere?	**Yes**	**No**
Do you have numbness in your crotch area?	**Yes**	**No**

Have you had any of the following?

Serious injuries	Cancer
Fever, chills or weight loss	Recent infection
IV drug abuse	Organ transplant

Have you missed work due to this episode of pain? **Yes** **No**

How much? ___________

When did you last work? ___________

Are currently off work due to this episode of pain? **Yes** **No**

Are you currently involved in any lawsuits due to this episode of pain? **Yes** **No**

If so, who is your attorney and where is the office located?

What are your major concerns about your health?

What goals do you hope to accomplish at the Montana Spine and Pain Center?

Pain Questions

How would you rate your pain TODAY? (Circle ONE answer)

None 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

What is the WORST the pain has been in the last week? (Circle ONE answer)

None 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

What is the BEST the pain has been in the last week? (Circle ONE answer)

None 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

What is the AVERAGE the pain has been in the last week? (Circle ONE answer)

None 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

During the last 24 HOURS, how much relief have you gotten from the pain treatments you are currently receiving? Please select the ONE ANSWER that comes closest to how much relief you have experienced.

None 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

CIRCLE the ONE number that best describes how your pain interferes with each activity. (0 = No Interfere 10 = Complete Interfere.)

General Activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Normal Work	0	1	2	3	4	5	6	7	8	9	10
Relationships	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

In each row below, circle the star that best describes your usual pain.

Description	None	Mild	Moderate	Severe
Throbbing	*	*	*	*
Stabbing	*	*	*	*
Sharp	*	*	*	*
Cramping	*	*	*	*
Gnawing	*	*	*	*
Hot-burning	*	*	*	*
Aching	*	*	*	*
Heavy	*	*	*	*
Tender	*	*	*	*
Splitting	*	*	*	*
Tiring-exhausting	*	*	*	*
Sickening	*	*	*	*
Fearful	*	*	*	*
Punishing-cruel	*	*	*	*

What is the level of intensity of your pain today? (Circle only one)

Mild Uncomfortable Distressing Horrible Excruciating

What surgical procedures have you had in the past? (Please list ALL surgical procedures and the year the procedure was performed.)

What test(s) have you had for your current problem?

X-rays	CAT Scan	MRI Scan
Bone Scan	Electrical Tests	Injections
Blood Tests	Discogram	Others:

Which of the following treatments have you tried in the past for this condition? (circle all that apply)

Anti-inflammatory Medications	Chiropractic
Non-narcotic Pain Medications	Massage
Narcotic Pain Medications	Yoga
Muscle relaxants	Meditation
Antidepressants	Acupuncture
Trigger Point Injections	TENS Unit
Spinal Injections	Pain pump
Surgery	Spinal Stimulator
Physical Therapy	Pain Program
Other:	

Past Medical Care

What other medical conditions do you currently have?

Heart Disease	Seizures
Diabetes	Asthma
High Blood Pressure	Stomach Ulcers
Gout	Thyroid Problems
Rheumatoid Arthritis	Cancer
Osteoarthritis	Liver Disease
Anemia	Hepatitis
Lung Disease	Depression
Kidney Disease	Head Injury
Sleep apnea	Other:

List ALL medications you are currently taking. (List the medication, dose and how often you take it.)

What pain medications have you tried in the past that have not worked? (List the medication and why it did not work.)

Do you have any allergies to medications? (List medication and type of reaction.)

Personal Habits

Do you use tobacco products? **Yes No**

Smoke? Yes No

Chew? Yes No

Do you drink alcohol? **Yes No**

How much each week? ________________________________

Do you currently use recreational drugs? **Yes No**

What substance? When?

______________________ ______________________

______________________ ______________________

______________________ ______________________

Do any members of your family have a history of alcohol abuse? **Yes No**

Do any members of your family have a history of using illegal drugs? **Yes No**

Do you have a history of alcohol abuse? **Yes No**

Have you ever used illegal drugs? **Yes No**

Have you ever abused prescription drugs? **Yes No**

Have you ever been in drug or alcohol treatment? **Yes No**

When? ______________________

Review of Systems

A review of systems allows us to be more thorough in our evaluation and help prevent missing any information that may affect your pain. If you are experiencing any symptoms from the following list, circle all that apply.

General Well Being

Weight Loss	Night Sweats	Fevers
Weight Gain	Fatigue	Chills
Snoring	Difficulty sleeping	Daytime drowsiness

Head, Ears, Eyes, Nose and Throat

Blurred vision	Double vision	Sensation of room spinning
Hearing problems	Ringing in the ears	Earaches
Nasal congestion	Nasal discharge	Nosebleeds
Sinus drainage	Hoarse voice	Problems swallowing
Sore mouth or throat	Bleeding gums	

Hormonal System

Increased sweating	Excessive thirst	Thinning hair
Hot flashes		

Lungs

Cough	Wheezing	Shortness of breath
Sputum	Coughing up blood	Stop breathing during sleep

Heart

Chest pain	Irregular heartbeat	Difficulty breathing when flat
Swelling in legs	Heart palpitations	

Intestines

Constipation	Gastric reflux	Nausea
Heartburn	Vomiting	Abdominal pain

Kidneys and Bladder

Frequency	Burning with urination	Difficulty controlling urine
Blood in urine		

Bones and Joints

Joint aches	Muscle weakness	Muscle cramps
Leg weakness		

Nervous System

Headache	Migraine	Fainting
Seizure	Crying spells	Depression
Numbness	Excessive sleeping	Anxiety
Tremors	Sleep disturbance	Panic Attacks

Blood System

Excessive bleeding	Blood clots	Easy bruising
Swollen glands		

Immune System

Allergies	Rash	Hives
Infections		

Emotional Health

Do you have a history of:

Depression	Yes	No
Bipolar disorder	Yes	No
Attention Deficit Disorder (ADD)	Yes	No
Obsessive Compulsive Disorder (OCD)	Yes	No
Schizophrenia	Yes	No
Panic/anxiety attacks	Yes	No

Did you have any of these problems before the onset of your pain problem? **Yes** **No**

Are you a victim of child abuse? **Yes** **No**

What kind? Physical Emotional Sexual

Are you currently in treatment with any of the following:

______ Psychiatrist

______ Clinical Psychologist

______ Clinical Social Worker

______ Counselor

______ Other Mental Health Professional

Thank you for providing us with this information. It is very useful in allowing us to make a thorough evaluation of your pain problem. Please return this form to the Administrative Assistant who checked you in this morning and we will move on to the next part of your evaluation.

Please remember to ask us if you have any questions about any aspect of your visit today.