PLEASE ANSWER ALL QUESTIONS

PATIENT NAME:_____D.O.B_____TODAY'S DATE:_____

1. Today's visit should be billed to Private/Medicare____ Workers comp____ Auto Insurance___

2. Today's visit is for *(Please check one)*: Follow-up____ Imaging studies____ EMG studies____
Other:_____

3. Do you have *(Please check all that apply)* Neck pain____ Arm pain____ Lower back pain____ Leg Pain_____
Other(Please describe):_____

4. Is your pain Right-sided____ Left-sided____ Both sides____

5. Since your last visit, are you Better____ Worse____ Same____

6. By what percentage have you improved or worsened?

0%____10%____ 20%____ 30%____ 40%____ 50%____ 60%____ 70%____ 80%____ 90%____ 100%____

7. Describe your pain *(Please check all that apply)*

Aching____ Burning____ Cramping____ Dull____ Numbing____ Pinching____ Pressure-like____ Sharp____
Shock-like____ Shooting____ Spasms____ Stabbing____ Tingling____

8. Is the pain *(Please check one)*: Continuous____ or Intermittent____

9: Is the pain worse *(Please check one)* In the Morning____ At Night ____ No Difference____

10. Since the last time you were here, your pain level has been:

On average: (LEAST) 1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10____ (SEVERE)

At its worse: (LEAST) 1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10____ (SEVERE)

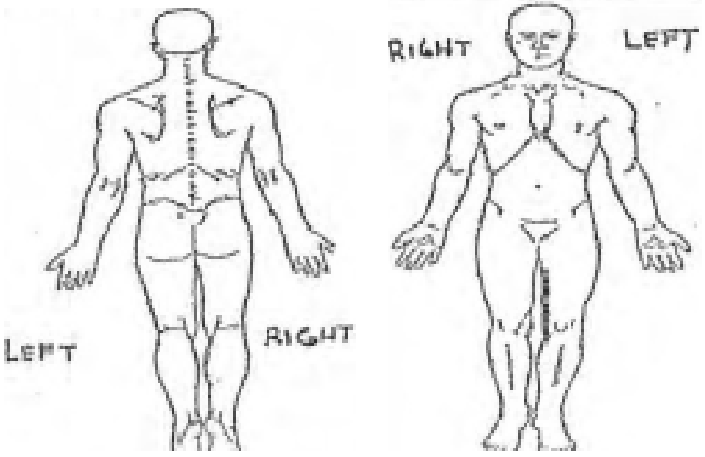
11. Does the pain interfere with your quality of life and activities of daily living? YES____ NO____

12. SINCE YOUR LAST VISIT please note any changes: Cardiac event:_____ Stroke event:_____

New on set of weakness_____ None:_____

Medication changes(please list): Discontinued:_____ New:_____

13. Use the diagram to indicate where your pain is:



14. IN THE LAST 3 TO 6 MONTHS HAVE YOU HAD ANY HOSPITALIZATIONS OR TREATMENT FOR CARDIAC PROBLEMS? YES____ NO____ *****IF YES, PLEASE DESCRIBE*:_____

15. How long can you do the following without pain (IN MINUTES): SIT_____ STAND_____ WALK_____

16. Have you had any falls? YES___ _ NO____ *****IF YES, when?*_____

17. Have you felt unsteady on your feet? YES____ NO____ Are you worried about failing? YES____ NO____

18. Do you use any devices? Cane___ Walker___ Wheel chair____ Other:_____

19. SINCE YOUR LAST VISIT HAVE YOU HAD ANY NEW IMAGING STUDIES NOT REVIEWED BY YOUR DOCTOR?

MRI____ X-RAY____ CT Scan____ Bone Scan____ Nerve conduction / Electrodiagnostic studies_____

20. What treatment have you received SINCE YOUR LAST VISIT *(Please check all that apply)*

No specific treatment____ Acupuncture____ Chiropractor____ Epidural injections____ EMG studies____ Facet injections____ Home exercises____ Knee injections____ Kyphoplasty____ Lumbar fusion device_____ Medications____ Massage therapy____ MILD_____ Myobloc / Botox____ Physical therapy____ PRP____ Radiofrequency ablation____ SI Joint injection____ SI Joint Fusion_____ Spinal cord stimulator____ Tenotomy Venous Ablation____

21. Are you currently working? Full-time____ Part-time____ Not working____ Retired____ Sedentary level____ Modified____ Occupation _____

22. Are you on disability? YES____ NO____ ******IF YES, DATE WHEN THE DISABILITY BEGAN*:_____

23. Do you smoke, vape or use any other form of tobacco? YES____ NO____ *IF YES, PLEASE CHECK ONE:*

Light smoker____ Medium smoker____ Heavy smoker____

Are you interested in *(Please check one)* Quitting____ Thinking about quitting____ Not ready to quit____

24. Do you consume alcohol? YES____ NO____ IF YES:

A. How often did you have a drink containing alcohol in the past year?_____
B. How many drinks do you have on a typical day when you were drinking in the past year?_____
C. How often did you have six or more drinks on one occasion in the past year?_____

25. Any **NEW** allergies to medications, seafood, shellfish or Xray/IV dye? YES____ NO____ *IF YES, PLEASE LIST REACTION*:_____

26. REVIEW OF SYMPTOMS: Do you have any of the following *(Please check all that apply)*

Painful joints____ Swollen joints____ Headaches____ Weight gain____ Weight loss____ Congestion____ Rash____ Blurred vision____ Dizziness____ Shortness of breath____ Chest pains____ Constipation____ Bowel incontinence____ Urinary incontinence____ Gait abnormality____ Seizures____ Anxiety____ Depression____

27. Height_____ Weight_____

28. For Medicare patients only: When did you last see your Primary Care Provider?
Date:_____