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:

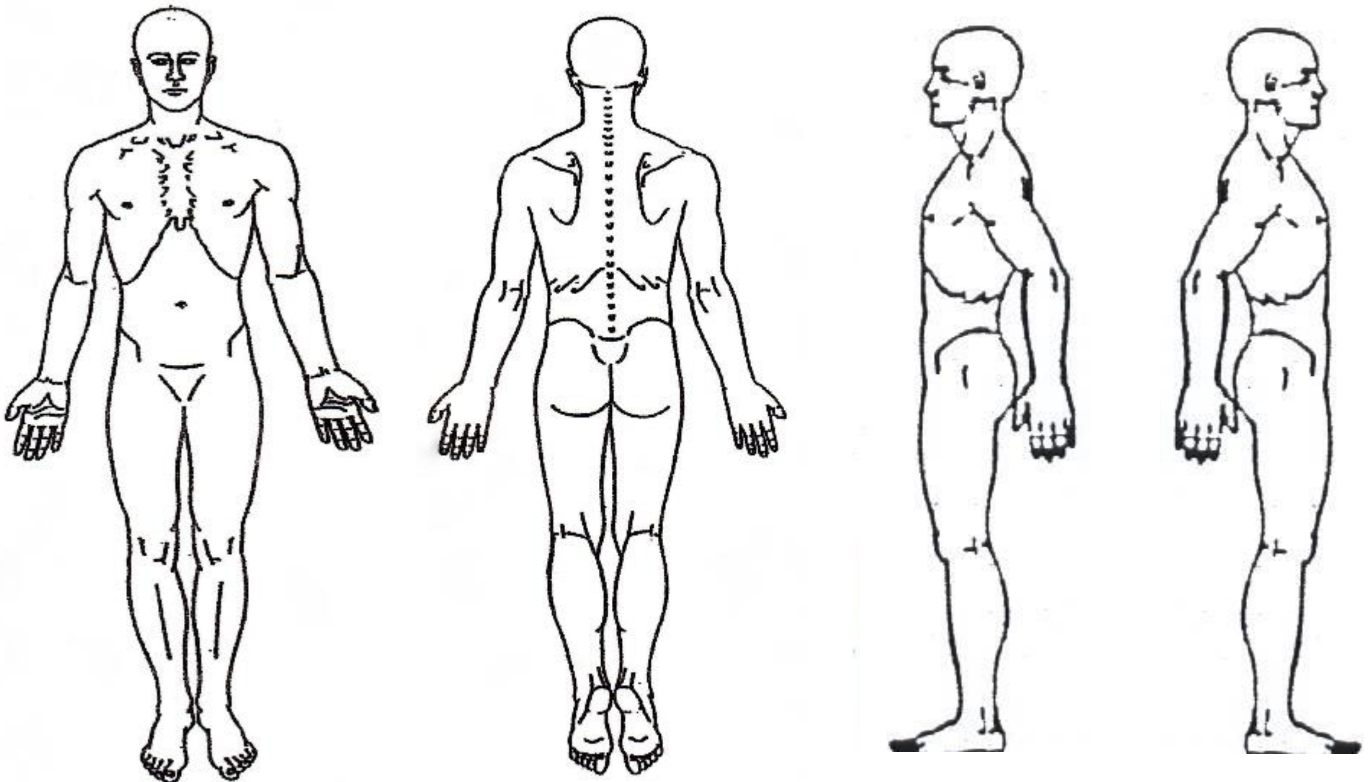
Please mark any of the following symptoms that you have experienced in the last six (6) months:

Constitutional:	**Neurological:**	**Musculoskeletal:**	**HEENT:**
☐ Weight Loss ☐ Weight Gain ☐ Fatigue ☐ Fever / Sweats ☐ Heat/Cold Intolerance ☐ Weakness	☐ Memory Loss ☐ Seizures ☐ Numbness/Tingling ☐ Speech Problems ☐ Weakness ☐ Headache ☐ Fainting ☐ Coordination Problems	☐ Joint Pain ☐ Joint Swelling ☐ Joint Redness ☐ Muscle Cramps ☐ Weakness	☐ 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 Neck/ Arm Pain

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

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

- ☐ 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. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without causing 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 items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – WORK

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 5 – HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 – SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ☐ I can drive my car without neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my care at all because of neck pain.

SECTION 9 – READING

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

SECTION 10 – RECREATION

- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have neck pain with most recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

PATIENT NAME ______________________________ DATE ______________

SCORE __________ [50] BENCHMARK -5 = __________

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