Virginia Interventional Pain & Spine Center

VIRGINIA INTERVENTIONAL PAIN & SPINE CENTER

PLEASE BRING TO YOUR APPOINTMENT - DO NOT MAIL

Date of Initial Pain Clinic Evalutaion: _____

Patient Last Name: _____ Patient First Name: _____ MI: _____

Date of birth: _____ Patient Age: _____ Ht: _____ Wt: _____

Primary Care Provider: _____

Referring Provider: _____

☐ No injury

☐ INJURY/ACCIDENT/ (Complete this section only if condition is a result of an accident or injury)

Auto Accident? ☐ Yes ☐ No Work-related injury? ☐ Yes ☐ No

Date of injury _____

Location of accident _____

How did accident occur? _____

If work-related injury, employer and phone: _____

History of Present Illness: Please shade in the areas where you have pain on the diagram below.

Pharmacy name and phone number: _____

Chief Complaint: _____

How long have you had the pain you feel currently? _____

What caused the pain to start? _____

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First and Last Name: _____ Date of Birth: _____

What Is The Quality (Description) Of The Pain?

- ☐ Aching
- ☐ Burning
- ☐ Boring or drillling
- ☐ Throbbing
- ☐ Cold
- ☐ Crushing
- ☐ Gnawing
- ☐ Heaviness
- ☐ Hot
- ☐ Nagging
- ☐ Penetrating
- ☐ Pressure
- ☐ Raw
- ☐ Sharp
- ☐ Pins & needles
- ☐ Shock-like
- ☐ Shooting
- ☐ Sore
- ☐ Stabbing
- ☐ Stinging
- ☐ Tightness
- ☐ Cramping
- ☐ Undetermined
- ☐ Quality not changed since onset
- ☐ Other _____

Associated Symptoms

A- Numbness/Tingling (Arms/legs) _____ B- Weakness - (Arms/Legs) _____

C- Urinary incontinence _____ D- Loss of control of bowels _____

E- Swelling - Where? _____ F- Redness _____

G- Cool or pale skin _____

Other: _____

Prior Diagnostic Testing

Test Type	Date	Location
MRI		
X-Rays		
EMG		
CT Scan		
Myelogram		
Other		

Prior Treatment Or Procedures

Treatment Type	Have you tried:	Pain Relief: Yes/No	Date Performed
Physical Theraphy/TENS			
Prior Pain Clinic			
Chiropractor/Acupuncture			
Injections			
Other			

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ALLERGIES

Past Medical History

Cardiovascular:	Respiratory	Kidney/liver	Gastrointestional:
Heart Attack ☐	Asthma ☐	Kidney Failure ☐	Bleeding Ulcers ☐
Blocked Arteries ☐	tb ☐	kidney Stones ☐	hiatal Hernia ☐
High Blood Pressure ☐	Empysema ☐	yellow Jaundice ☐	gerd/reflux ☐
Heart Murmur ☐	Sleep Apnea ☐	cirrhosis ☐	constipation ☐
Stroke ☐	Copd ☐	liver Failure ☐	irritable Bowel Syndrome ☐
Psychiatric/nerves:	**Endocrine/Immune:**	**musculoskeletal:**	Trouble Taking Meds ☐
Anxiety ☐	Thyroid Problems ☐	Arthritis ☐	**past Of Present:**
Depression ☐	diabetes ☐	osteoporosis ☐	Physical Abuse ☐
Panic Attacks ☐	cancer (Type) ☐	**blood:** ☐	Sexual Abuse ☐
Bipolar ☐	Hiv Or Aids ☐	Anemia ☐	Emotional Abuse ☐
Seizures ☐		frequent Infections ☐	
Shingles ☐			
Other ☐			

Past Relevant Surgical History:

Type of Surgery	Date	Any Complications

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Caffeine Use: Type (coffee, soda)?

Do you use tobacco? ☐ Yes ☐ No ☐ Quit/Year: Years of tobacco use: _____

Type of tobacco: _____ Qty: _____ Per ☐ Day ☐ Week ☐ Month

Do you drink alcohol? ☐ Yes ☐ No

Type of alcohol: _____ Qty: _____ Per ☐ Day ☐ Week ☐ Month

Have you, a family member, or friend ever felt you should "cut down" on your drinking? ☐ Yes ☐ No

Has anyone ever annoyed you by critizing your drinking? ☐ Yes ☐ No

Have you ever felt guilty about drinking? ☐ Yes ☐ No

Have you ever had a drink first thing in the morning? ☐ Yes ☐ No

Have you had withdrawal symptions (shaking/sweating) when you stopped drinking? ☐ Yes ☐ No

Have you ever abused prescription drugs? ☐ Yes ☐ No

(If yes, please explain: _____)

Illicit Drug Use: ☐ Yes ☐ No Type: _____

Was a doctor ever concerned (said) you were becoming addicted to prescription drugs? ☐ Yes ☐ No

(If yes, please explain: _____)

Mood:

Has pain affected your mood? _____ Describe your recent mood: _____

_____

_____

Have you ever had any thoughts of wanting to die?

Do you (now or ever) have any panic attacks?

Do you every feel irritable or angry due to your pain?

Do you have thoughts of harming yourself or another?

(If yes, please explain: _____)

Do you have a history of mental health treatment (psychiatrist or psychologist)? ☐ Yes ☐ No

(If yes, please explain: _____)

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

(If yes, when and please explain: _____)

Sleep

Does your pain awaken you from sleep during your night? ☐ Usually ☐ Sometimes ☐ Never

How many hours do you sleep each night? _____ Hours

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First and Last Name: _____ Date of Birth: _____

Employment History:

Current or Last Job: _____ Employer: _____

Present Employment Status (circle):

◯ Full Time ◯ Unemployed ◯ Homemaker

◯ Part Time ◯ Leave of absence ◯ Retired

What was your last day of work? _____ Still working? _____

Are you disabled? ☐ Yes ☐ No

Are you receiving disability payments? (For how long?) ☐ Yes ☐ No

Do you have a Work Comp or Social Security disability application pending? ☐ Yes ☐ No

Are you now, or do you anticipate a lawsuit because of your pain or injury? ☐ Yes ☐ No

Please be aware this Patient Medical History must be completed and signed prior to the patient's appointment date and time. If help is needed with this form, the patient or patient's representative must arrive at least 60 minutes prior to their appointment time so the we can assist, otherwise, the appointment will need to be re-scheduled for a later date.

_____ _____

Patient Signature Date

_____ _____

Reviwed by Date

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