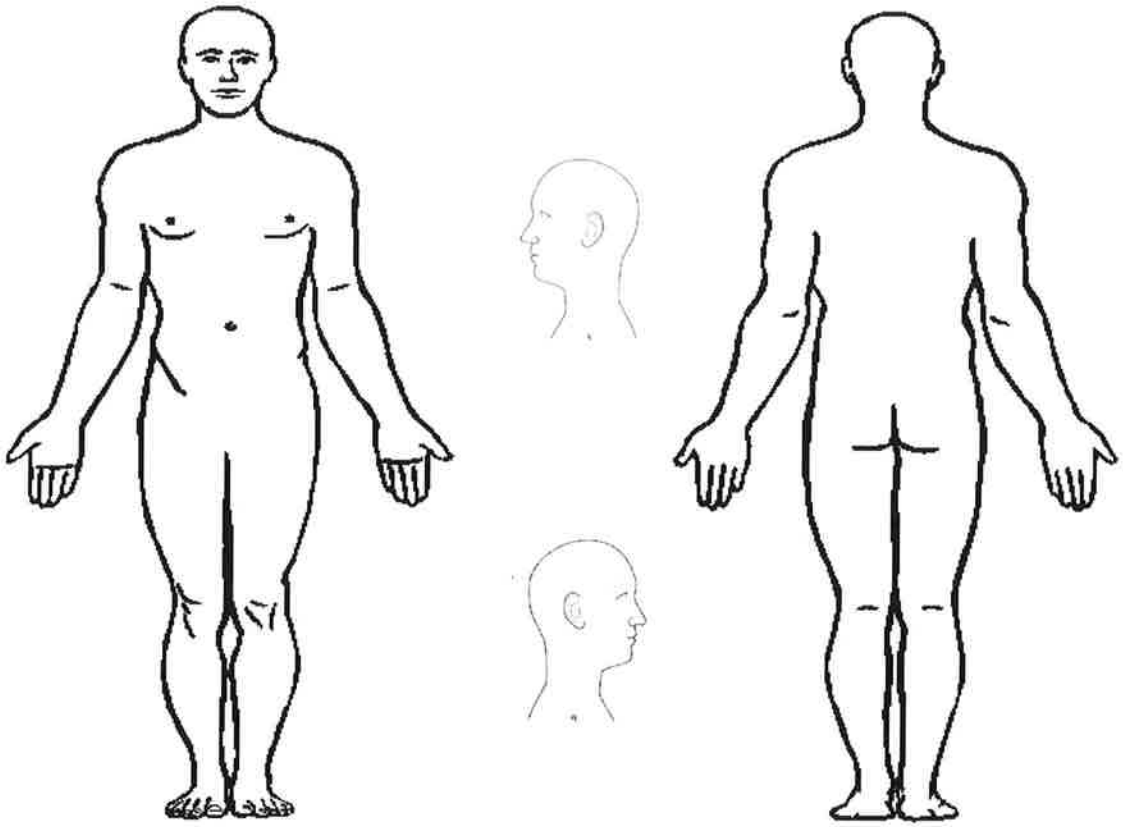
Virginia Interventional
Pain & Spine Center

Virginia Interventional Pain and Spine Center

*PLEASE BRING ALL COMPELTE PAGES TO YOUR APPOINTMENT-**DO NOT MAIL***

Patient First Name: _____ Middle initial: _____ Last Name: _____
Date of Birth: _____ Patient Age: _____ Height: _____ Weight: _____
Primary Care Provider: _____ Referring Provider: _____
Pharmacy: _____

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



Chief Complaint: _____
How long have you had the pain you currently feel? _____

What is the quality (description) of the pain?

☐ Aching	☐ Burning	☐ Boring/Drilling	☐ Throbbing	☐ Cold	☐ Crushing
☐ Gnawing	☐ Heaviness	☐ Hot	☐ Nagging	☐ Penetrating	☐ Pressure
☐ Raw	☐ Sharp	☐ Pins/Needles	☐ Shock-like	☐ Shooting	☐ Sore
☐ Stabbing	☐ Stinging	☐ Tightness	☐ Undetermined	☐ Cramping	☐ Other_____

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Associated Symptoms:

- ☐ Numbness/Tingling (Arm/Leg)
- ☐ Urinary Incontinence
- ☐ Swelling-Where_____
- ☐ Cool or Pale Skin
- ☐ Weakness (Arm/Leg)
- ☐ Loss of control of Bowel
- ☐ Redness-Where_____
- ☐ Other_____

Prior Diagnostic testing:

Test type	Date	Location
☐ MRI	_____	_____
☐ X-ray	_____	_____
☐ EMG	_____	_____
☐ CT Scan	_____	_____
☐ Myelogram	_____	_____

Prior Treatment or Procedures:

Have you tried	Date	Pain Relief?
☐ Physical therapy/TENS	_____	YES/NO
☐ Prior Pain Clinic	_____	YES/NO
☐ Chiropractic/ Acupuncture	_____	YES/NO
☐ Injections	_____	YES/NO
☐ Other: _____	_____	YES/NO

Past Medical History:

Cardiovascular
- ☐ Heart Attack
- ☐ Blocked Arteries
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Congestive Heart Failure

Respiratory
- ☐ Asthma
- ☐ TB
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ COPD
- ☐ Past/Current Smoker

Kidney/Liver
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Yellow Jaundice
- ☐ Cirrhosis
- ☐ Liver Failure
- ☐ Past/Current Alcohol User

Gastrointestinal
- ☐ Bleeding Ulcer
- ☐ Hiatal Hernia
- ☐ GERD/Acid Reflux
- ☐ Constipation
- ☐ IBS
- ☐ Trouble taking medication

Psychiatric/Nerves
- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks
- ☐ Bipolar
- ☐ Seizure
- ☐ Shingles

Endocrine/immune
- ☐ Thyroid problems
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ HIV or AIDS
- ☐ Cancer
- ☐ If so type_____

Musculoskeletal
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Blood disorder
- ☐ Anemia
- ☐ Frequent Infections

Past History
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional abuse
- ☐ Other:

_____

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Current Medications:

Please Include a list of all current medications, including but not limited to any narcotics, antidepressants, sleeping medications, muscle relaxants, tranquilizers and over the counter medications and anti-inflammatory medications.

Medication	Dose	How long have you been taking?	Does it Help?

Allergies:

Please list any known allergies.

_____

_____

_____

Past Surgeries:

Type of Surgery	Date	Any Complications?

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Review of Systems:

Please check all that apply.

General
- ☐ Weight Gain/Loss
- ☐ Fatigue
- ☐ Fever/Chills
- ☐ Weakness
- ☐ Trouble sleeping

Skin
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color Changes
- ☐ Hair and Nail Changes

Head
- ☐ Headache
- ☐ Head Injury
- ☐ Neck Pain

Ears
- ☐ Decreased Hearing
- ☐ Ringing in Ears
- ☐ Earache
- ☐ Drainage

Breasts
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-Exams
- ☐ Breast-Feeding

Vascular
- ☐ Calf pain with walking
- ☐ Leg Cramping

Hematologic
- ☐ Ease of bruising
- ☐ Ease of bleeding

Eyes
- ☐ Vision Loss/changes
- ☐ Glasses/Contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry/ double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts

Nose
- ☐ Sinus pain
- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay Fever
- ☐ Nosebleeds

Throat
- ☐ Non-healing sores
- ☐ Thrush
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness

Psychiatric
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of breath with activity
- ☐ Difficulty breathing laying down
- ☐ Swelling
- ☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

Urinary
- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Change in urinary strength

Musculoskeletal
- ☐ Muscle or Joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of Joints
- ☐ Swelling of Joints
- ☐ Trauma

Endocrine
- ☐ Heat or Cold intolerance
- ☐ Sweating
- ☐ Frequent Urination
- ☐ Thirst
- ☐ Change in appetite

Neck
- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Respiratory
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Painful Breathing

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Social History:

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Widowed

Children? ___YES/NO___ How Many? _____ Ages: _____

Education Level
☐ Less than 8th Grade ☐ Completed 8th Grade ☐ Some High School
☐ High School (GED) ☐ Some College ☐ College Graduate ☐ Advanced Degree

Substances

Caffeine Use:	☐ Yes ☐ No	Quit Using? _____(date)	Type: _____
Tobacco Use:	☐ Yes ☐ No	Quit Using? _____(date)	Type: _____
Alcohol Use:	☐ Yes ☐ No	Quit Using? _____(date)	Type: _____
Illicit Drug Use:	☐ Yes ☐ No	Quit Using? _____(date)	Type: _____

If you drink alcohol or use illicit drugs please answer the following.

Have you, a family member, or friend felt you should "cut down" on your drinking?	☐ Yes	☐ No
Has anyone every annoyed you by criticizing 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 symptoms (shaking/sweating) when you stopped drinking?	☐ Yes	☐ No
Have you ever abused prescription drugs?	☐ Yes	☐ No

If yes please explain. _____

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

If yes please explain. _____

Does the pain affect your mood?

Has pain affected your mood?	☐ Yes	☐ No

If yes please explain. _____
Please describe your current mood _____

Have you ever had any thoughts of wanting to die?	☐ Yes	☐ No
Do you (now or ever) have any panic attacks?	☐ Yes	☐ No
Do you ever feel irritable or angry due to your pain?	☐ Yes	☐ No
Do you every have thoughts of harming yourself or another person?	☐ Yes	☐ No

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 please explain. _____

Does the pain affect your sleep?

Does your pain awaken you from sleep during the night	☐ Yes	☐ No

How many hours do you sleep at night on average

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