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THE FOLLOWING MULTI-PAGE QUESTIONNAIRE IS A VERY IMPORTANT TOOL THAT IS USED TO ASSESS YOUR PAIN CONDITION AS WELL AS THE APPROPRIATE TREATMENTS FOR YOUR PROBLEM.

PLEASE READ AND FILL OUT EVERY SINGLE ITEM IN THIS FORM, INCLUDING THE DEMOGRAPHIC AND FINANCIAL INFORMATION ON THE FIRST THREE PAGES. PLEASE ALSO INCLUDE YOUR SIGNATURE WHERE REQUESTED. FAILURE TO COMPLETE OR SIGN THIS FORM COULD RESULT IN A DELAY IN YOUR APPOINTMENT.

PLEASE BRING THE COMPLETED FORM ALONG WITH ANY PERTINENT FILMS, REPORTS, DOCTOR NOTES, ETC. FOR YOUR INITIAL CONSULTATION.

AN INFORMED PATIENT MAKES BETTER DECISIONS ABOUT TREATMENT OPTIONS OFFERED BY HIS OR HER PHYSICIAN. THEREFORE, IF YOU HAVE ACCESS TO THE INTERNET, PLEASE VISIT MY WEBSITE'S "TREATMENTS" SECTION AND TAKE A FEW MINUTES BEFORE YOUR APPOINTMENT TO REVIEW THE INFORMATION ON TREATMENTS AVAILABLE FOR YOUR AND OTHER CONDITIONS.

THANK YOU VERY MUCH IN ADVANCE FOR YOUR COOPERATION!! ☺

Name: _____ Date: _____ Height: _____

Weight: _____ Social Security Number: _____

Date of Birth: _____ Age: _____

Address: Street _____

City _____ State _____

Zip _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Driver's License #: _____

Driver's License State: _____

Employer's Name & Address: _____

Spouse's Name: _____

Spouse's Date of Birth: _____

Spouse's Employer & Work Number: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Person Not Living With you:

_____ Emergency Contact's

Relation to You: _____

Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Name:

Claims Address: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

ID #: _____

Group #: _____

Subscriber Relation to Patient: Self ____ Spouse ____ Child ____ Other ____

Secondary Insurance Name: _____

Claims Address: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

ID #: _____

Group #: _____

Subscriber Relation to Patient: Self ____ Spouse ____ Child ____ Other ____

In consideration of the medical services to be rendered to me today and in the future, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF **Interventional Spine & Pain, PA** . IN ACCORDANCE WITH THEIR REGULAR RATES AND TERMS. I also hereby authorize direct payment to Interventional Spine & Pain, PA of any insurance benefits otherwise payable to me for said services, and I further authorize this office to release any medical information necessary to process my claim(s). I understand that I am responsible for any charges not covered by this assignment. Should my account be referred to an attorney or licensed collection agency for collection, I shall be responsible for any attorney's fees and collection expenses. I understand that, as a courtesy, Interventional Spine & Pain, PA will file a claim with my insurance. If my insurance has not paid within sixty (60) days of the date of filing,

I understand that I may be made responsible for the total balance of the account. A photostatic copy of this agreement shall be considered effective and valid as the original.

Signature of Patient or Responsible Party

Date

MEDICAL RECORDS RELEASE

I understand that, as part of my plan of treatment, **Interventional Spine & Pain, PA** may refer me to other physicians or healthcare facilities for treatment and/or tests. I hereby authorize Dr. Zeballos and his office staff to release any medical and/or financial information necessary to facilitate such a referral. I further authorize other physicians and healthcare facilities to release my medical records to **Interventional Spine & Pain, PA**. Finally, I authorize **Interventional Spine & Pain, PA** to release my medical records to my referring physician, primary care physician, workers compensation case manager or adjuster, and my attorney.

A photostatic copy of this agreement shall be considered effective and valid as the original.

Signature of Patient or Responsible Party

Date

MEDICARE LIFETIME SIGNATURE ON FILE (FOR MEDICARE PATIENTS ONLY)

I request that payment of authorized Medicare benefits be made on my behalf to Interventional Spine & Pain, PA. for any services rendered to me by the physicians or medical staff or Interventional Spine & Pain, PA. I authorize any holder of medical information about me to release to the Healthcare Financing Administration (HCFA) and its agents any information necessary to determine these benefits or benefits payable for related services.

A photostatic copy of this agreement shall be considered effective and valid as the original.

Signature of Patient or Responsible Party

Date

COMPREHENSIVE MEDICAL QUESTIONNAIRE

Referring Physician: _____

Primary Care Physician: _____ **Please list the names of any healthcare professionals who have been involved in the evaluation and / or treatment(s) of your pain condition (please print names):**

Orthopedic Surgeon: _____

Physiatrist / Rehabilitation Specialist: _____

Spine Surgeon: _____

Chiropractor: _____

Neurologist: _____

Acupuncturist: _____

Neurosurgeon: _____

Pain Medicine Specialist: _____

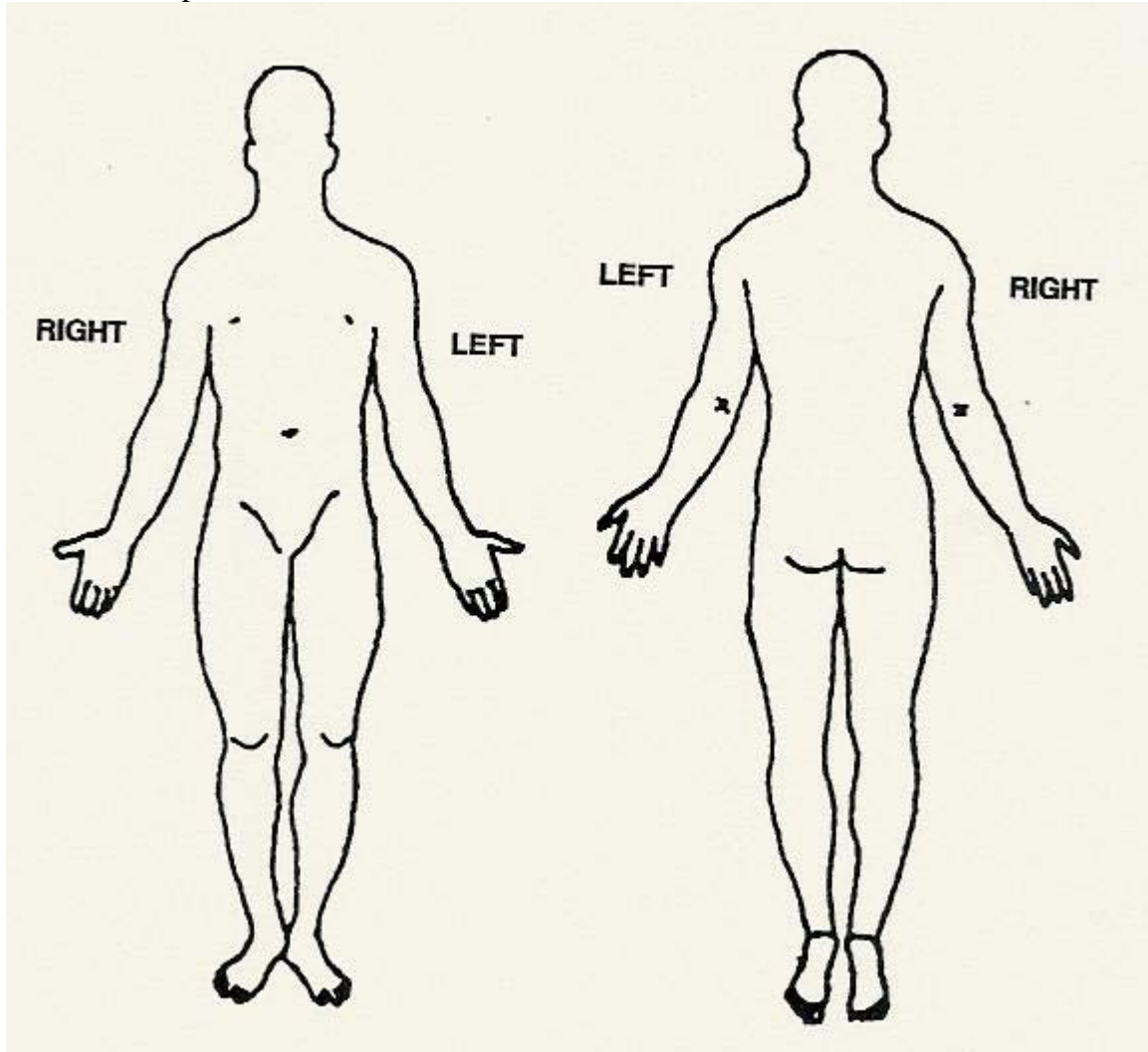
Rheumatologist: _____

Other: _____

PAIN HISTORY

**1. PLEASE DESCRIBE YOUR PAIN PROBLEM Where is your pain?
Where does the pain spread or radiate? (Example – “Low back pain that radiates down the back of my left leg to the heel”):**

Please use the diagram below to demonstrate where your pain is located by shading the areas that are painful.



2. **WHEN did your pain begin?** (Please be as specific as possible - for example: “4 months ago”)

3-4. **HOW did your pain begin?** (Please check one and describe below)

	<u>Date of Accident</u>
<input type="checkbox"/> Pain Just Started By Itself	_____
<input type="checkbox"/> Injury or Accident At Work	_____
<input type="checkbox"/> Injury or Accident At Home	_____
<input type="checkbox"/> Motor Vehicle Accident	_____
<input type="checkbox"/> Following Surgery	_____
<input type="checkbox"/> Following Illness	_____
<input type="checkbox"/> Other Reason (specify): _____	_____

5. **WHAT DOES YOUR PAIN FEEL LIKE?** Please circle any of the words below which describes the character of your pain:

1	2	3	4
Sharp	Dull	Annoying	Penetrating
Burning	Aching	Miserable	Piercing
Electricity	Sore	Intense	Tight
Shooting	Hurting	Unbearable	Numb
Stabbing	Heavy	Troublesome	Squeezing
Lancinating	Tender	None	Cool
Tingling	Tiring		Cold
Throbbing	Sickening		Nauseating
Pounding	Terrifying		Agonizing
Cramping	Punishing		Dreadful
Crushing	Blinding		Torturing
Pulling			

6. HOW DOES YOUR PAIN CHANGE WITH TIME? Please circle any of the words below that describe the pattern of you pain:

1	2	3
Continuous	Rhythmic	Brief
Steady	Periodic	Momentary
Constant	Intermittent	Transient

7. Which activities or body positions (e.g. walking, bending, etc.) bring on or WORSEN your pain?

Which activities or body positions (e.g. sitting, lying down, etc.) seem to IMPROVE your pain?

8. Which symptoms are associated with your pain (check all that apply):

- Weakness of arm(s) - Left / Right / Both
- Weakness of leg(s) - Left / Right / Both
- Numbness of arm(s)- Left / Right / Both
- Numbness of leg(s) - Left / Right / Both
- Loss of bladder or bowel control
- Tenderness of affected area
- Cool, pale skin
- Discolored or mottled skin
- Impotence
- Decreased sex drive
- Depression
- Other: _____
- Headaches
- Pain with only light touch
- Weight gain (How many lbs. past 6 mos? _____)
- Weight loss (How many lbs. past 6 mos? _____)
- Difficulty sleeping
- Pain awakens you at night
- Fever

9. Please help us to rate your pain on a numerical scale:

(0= No Pain At All 10= The Worst Pain Imaginable)

Today	0 1 2 3 4 5 6 7 8 9 10
On good days:	0 1 2 3 4 5 6 7 8 9 10
On bad days:	0 1 2 3 4 5 6 7 8 9 10
Average past week	0 1 2 3 4 5 6 7 8 9 10
Average past month	0 1 2 3 4 5 6 7 8 9 10

10. How does pain affect your lifestyle? (What can you no longer do because of your pain condition?)

11. Which TREATMENTS have been used for your pain? (Check all that apply)

	<u>Helpful?</u>	<u>WHEN did you receive this treatment?</u>
<input type="checkbox"/> Pain Killers	Yes__ No__	_____
<input type="checkbox"/> Anti-Inflammatory Meds	Yes__ No__	_____
<input type="checkbox"/> Muscle Relaxants	Yes__ No__	_____
<input type="checkbox"/> Bedrest	Yes__ No__	_____
<input type="checkbox"/> Physical Therapy	Yes__ No__	_____
<input type="checkbox"/> Exercise	Yes__ No__	_____
<input type="checkbox"/> TENS (electrical stim)	Yes__ No__	_____

PRIOR TREATMENTS (continued):

	<u>Helpful?</u>	<u>WHEN did you receive this treatment?</u>
<input type="checkbox"/> Chiropractic Therapy	Yes__ No__	_____
<input type="checkbox"/> Traction	Yes__ No__	_____
<input type="checkbox"/> Cortisone Injections	Yes__ No__	_____
<input type="checkbox"/> Epidural Injections	Yes__ No__	_____
<input type="checkbox"/> Other Nerve Blocks	Yes__ No__	_____
<input type="checkbox"/> Surgery	Yes__ No__	_____
<input type="checkbox"/> Psychotherapy	Yes__ No__	_____
<input type="checkbox"/> Biofeedback	Yes__ No__	_____
<input type="checkbox"/> Other _____		_____

Please list any medication(s) that you have taken *in the past* for your condition which has/have **NOT** helped to reduce or relieve your pain: _____

PAST MEDICAL & SURGICAL HISTORY:

12. Have you ever been diagnosed with or treated for any of the following health problems?
(Please check and circle all items that apply)

- | | |
|-------------------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Angina / Chest Pain | <input type="checkbox"/> Hepatitis (Circle Type: A / B / C) |
| <input type="checkbox"/> Angioplasty or Stent for blocked artery | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anxiety, Depression, or Panic Disorder | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Arrhythmia/Atrial Fibrillation /Cardiac Arrest | <input type="checkbox"/> Implantable Defibrillator |
| <input type="checkbox"/> Arthritis (Type?: Osteo / Rheumatoid) | <input type="checkbox"/> Kidney Failure / Dialysis |
| <input type="checkbox"/> Asthma / Wheezing | <input type="checkbox"/> Liver Disease / Cirrhosis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Neuropathy (Type? _____) |
| <input type="checkbox"/> Bleeding Disorder (Hemophilia, ITP, etc.) | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Paralysis (Describe _____) |
| <input type="checkbox"/> Congestive Heart Failure (year? _____) | <input type="checkbox"/> Previous Suicide Attempt |
| <input type="checkbox"/> Deep Venous Thrombosis (Blood Clot Leg) | <input type="checkbox"/> Pulmonary Embolism (blood clot to the lung) |
| <input type="checkbox"/> Diabetes (__ Type I __ Type II) | <input type="checkbox"/> Seizure or Epilepsy |
| <input type="checkbox"/> Drug or Alcohol Abuse / Addiction | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Emphysema, Chronic Bronchitis, or COPD | <input type="checkbox"/> Stomach or Duodenal Ulcer (Year _____) |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Headache (Migraine, Cluster, or Tension ?) | <input type="checkbox"/> Thyroid Disease (Under or Overactive?) |
| <input type="checkbox"/> Heart Attack (year? _____) | |

13. Please list any operation(s) you have had in the past:

- Year _____ Type of Operation _____
Year _____ Type of Operation _____
Year _____ Type of Operation _____
Year _____ Type of Operation _____
Year _____ Type of Operation _____

ALLERGIES:

14. Please list your ALLERGIES TO MEDICATIONS or OTHER DRUGS:

Name of Medication	Type or Reaction Experienced
_____	_____
_____	_____

15. Are you allergic to Iodine Contrast Dye (e.g. IVP Dye)? __Yes __No

If you answered yes, what type of reaction did you have?

16. Are you allergic to Aspirin or Anti-Inflammatory Medications (e.g. Ibuprofen)?

__Yes __No

If you answered yes, what type of reaction did you have?

CURRENT MEDICATIONS:

Bring all current medications including prescription bottles to office visit

17. Please list the medications which you currently take strictly FOR PAIN:

Name of Pain Medication	Dosage and Number of pills per day
_____	_____
_____	_____
_____	_____

18. Please list the medications which you currently take FOR OTHER MEDICAL CONDITIONS:

Name of Medication	Name of Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

19. Do you take Aspirin? Yes No

If you answered yes, when was your last dose? _____

20. Do you take Coumadin, Plavix, Pletal, Aggrenox, or Ticlid? Yes No

If you answered yes, when was your last dose? _____

If you answered yes, will the prescribing physician allow you to discontinue this blood thinner medication for any length of time? Yes** No

** Please note that you MUST have permission from the physician who prescribes or manages the blood thinner in order to stop this medication.

22. Do you take any herbal medications? Yes No

If yes, list: _____

Do you take Vitamin E? Yes No

SOCIAL HISTORY

23. What is your current marital status? (Please check one)

- | | How Long? |
|------------------------------------------------|------------------|
| <input type="checkbox"/> Single- Never Married | |
| <input type="checkbox"/> Married | _____ years |
| <input type="checkbox"/> Divorced | _____ years |
| <input type="checkbox"/> Widowed | _____ years |
| <input type="checkbox"/> Separated | _____ years |

24. With whom do you live? (Check all that apply)

- I Live Alone
- With My Parents
- With Spouse
- With In-Laws
- With Children (ages? _____)
- With Other Relatives
- With Brothers or Sisters
- With Others (Significant Other, Roommate, etc.)

25. How far did you get in school? (Please check one)

- Less than 8th grade
- Completed College
- Completed 8th grade
- Technical or Business School
- Completed High School
- Advanced Degree (Type _____)
- Some College (___ years)

26. Do you currently smoke cigarettes? __ Yes __ No

If yes, how many packs do you smoke during an average day? _____ packs /day

If yes, for how many years have you smoked? _____ years

If no and you are a former smoker, when did you quit for good? _____

27. Do you drink alcoholic beverages? __ Yes __ No

If yes, how often? What is your drink of choice (i.e. beer, wine, gin, vodka, etc.)

- Never
- Daily or More Often
- Less Than Once A Week
- Several Times A Week
- About Once A Week
- I am a heavy drinker

How many drinks do you have each time you consume alcohol? _____

28. **Have you ever been diagnosed with or treated for drug or alcohol abuse?**

Yes No

If yes, when? _____

Please describe _____

Are you currently or have you ever used illicit drugs. Yes, No.

If yes, what drug and when was the last time used? _____

WORK HISTORY

29. **What is your employment status? (please check one)**

- Retired
- Able to work but currently unemployed
- Homemaker
- Not working, on Workers' Comp. leave from my job since _____
- Student
- Not working, on Disability since (date) _____
- Working Part Time
- Working Full Time (Light Duty)

30. **What is (was) your occupation or job title? (please describe)**

31. **Which of the following are regular requirements of your job? (Check all that apply to you)**

- Heavy Lifting (over 30 pounds)
- Light Lifting (15 - 30 pounds)
- Frequent Stooping, Bending, Twisting
- Standing For Long Periods of Time (over one hour at a time)
- Sitting For Long Periods of Time (over one hour at a time)
- Computer Work
- Other Physical Requirements (describe):

32. **How much work have you missed as a result of your pain problem? (check one)**

- None
- I have missed _____ days of work due to my pain problem
- I have missed _____ weeks of work due to my pain problem

I have missed _____ months of work due to my pain problem

Not applicable to my situation Other: _____

33. Please use the following space to address any other issues related to your pain condition not already covered in this questionnaire. Your comments and concerns are welcome:

WHICH DIAGNOSTIC STUDIES HAVE BEEN DONE TO EVALUATE YOUR PAIN PROBLEM:

If you have had any of the imaging done please bring copies of the reports or films including EMG/NCS, MRI, CT-scan, or X-rays to office visit

(Please check all that apply)

	<u>Ordered by Whom?</u>
<input type="checkbox"/> Blood Tests	_____
<input type="checkbox"/> X-Rays	_____
<input type="checkbox"/> MRI Scan	_____
<input type="checkbox"/> CT scan	_____
<input type="checkbox"/> EMG / Nerve Conduction Studies	_____
<input type="checkbox"/> Bone Scan	_____
<input type="checkbox"/> other? _____	_____

I certify that I have answered all of the above questions truthfully and to the best of my ability. _____

Patient Signature

Date