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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 THEAPPROPRIATE 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: _____

Email Address:_____

Address: Street _____

City _____ State _____

Zip _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Driver's License #/State: _____

Spouse Name & Contact # _____

Designated Pharmacy:

_____

## EMERGENCY CONTACT INFORMATION

**Emergency Contact Person NOT Living With You:**

Name: _____

Relation to You: _____ Phone # _____

# COMPREHENSIVE MEDICAL QUESTIONNAIRE

Referring Physician: _____

**P**rimary **C**are **P**hysician: _____**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):**

Neurosurgeon/Ortho Spine: _____

Physiatrist / Rehabilitation Specialist: _____

Orthopaedic Surgeon: _____

Neurologist: _____

Pain Medicine Specialist: _____

Rheumatologist: _____

Chiropractor: _____

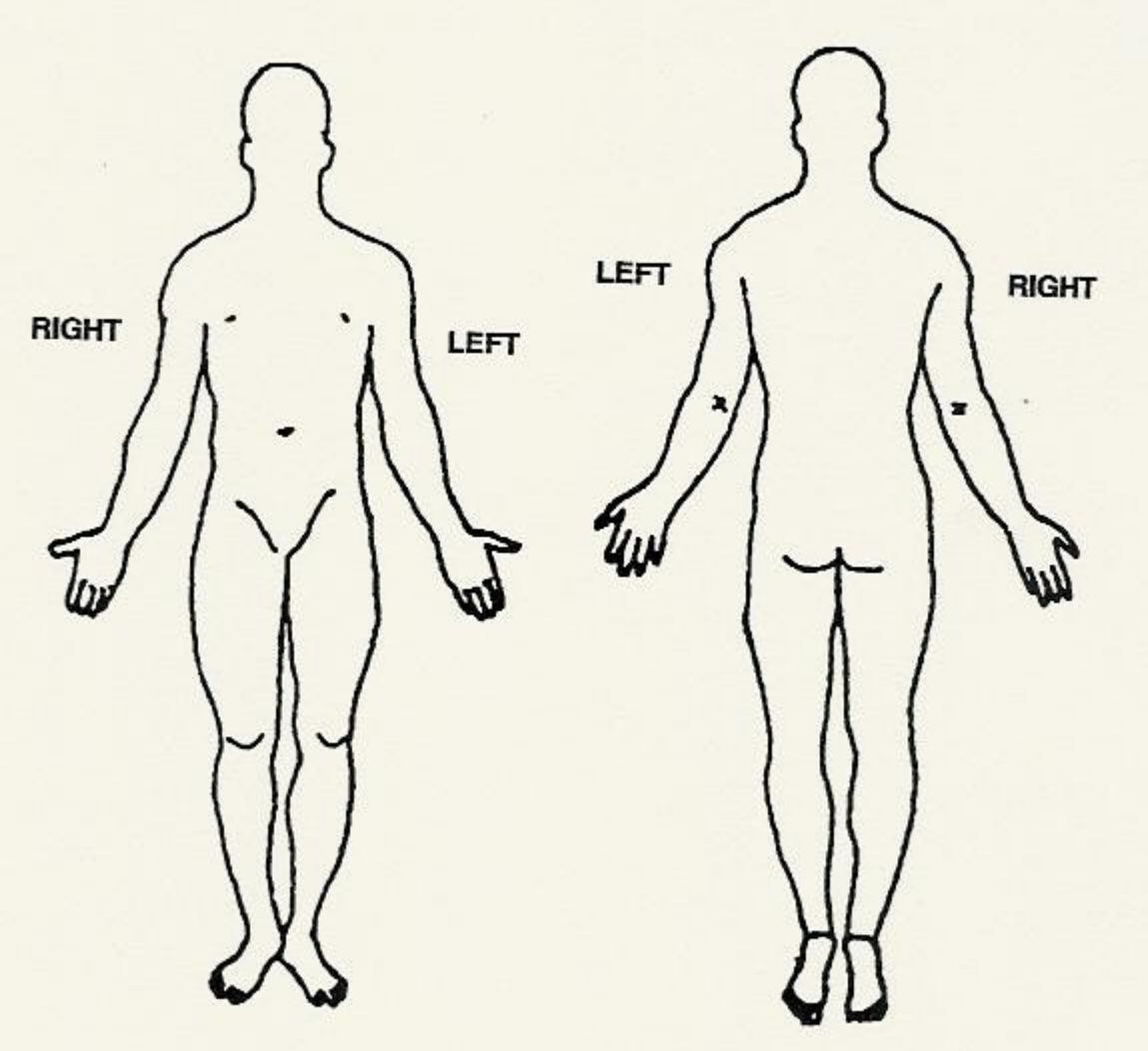
Other: _____

## 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 circle & check one that describes below)**

| | **Date of Accident/Reason** |
|---|---|
| __ Pain Just Started By Itself | _____ |
| __ Injury or Accident at Work/ Home | _____ |
| __ Following Surgery | _____ |
| __ Motor Vehicle Accident | _____ |
| __ Other Reason (specify): _____ | |

5. **WHAT DOES YOUR PAIN FEEL LIKE? Please circle <u>any</u> of the words below which describes the <u>character</u> 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 <u>pattern</u> of you pain:**

brief/momentary, steady/constant, periodic/intermittent

7. **Which activities/body positions (e.g. walking, bending, etc.) WORSEN your pain?**

_____

**Which activities/body positions (e.g. sitting, lying down, etc.) IMPROVE your pain?**

_____

8. **Which symptoms are associated with your pain (check <u>all</u> 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
__ 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
__ Other: _____

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 pain?)**

_____

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

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

**PRIOR TREATMENTS (continued):**

| | Helpful? | WHEN did you receive this treatment? |
|---|---|---|
| __ Chiropractic Therapy | Yes__ No__ | _____ |
| __ Traction | Yes__ No__ | _____ |
| __ Cortisone Injections | Yes__ No__ | _____ |
| __ Epidural Injections | Yes__ No__ | _____ |
| __ Other Nerve Blocks | Yes__ No__ | _____ |
| __ Surgery | Yes__ No__ | _____ |
| __ Psychotherapy | Yes__ No__ | _____ |
| __ Biofeedback | Yes__ No__ | _____ |

__ 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)**

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

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

Year _____ Surgery _____
Year _____Surgery_____
Year _____ Surgery _____
Year _____Surgery_____

## 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. 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?** _____

20-21. **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/vitamin E?** __ Yes __ No

**If yes, list: _____**

**SOCIAL HISTORY**

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

| | **How Long?** |
|---|---|
| __ Single- Never Married | _____years |
| __ Married/Domestic Partner | _____years |
| __ Divorced/ Widowed | _____ years |

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

__ I Live Alone
__ With My Parents
__ With Spouse/Domestic Partner
__ With Children (ages? _____)
__ with Others (Significant Other, Roommate, etc.)

25. **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

26. **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
__ Consider myself a heavy drinker

27. **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

28. **What is your employment status? (Please check one)**

__ Retired
__ Able to work but currently unemployed
__ Homemaker
__ Student
__ Working Part Time
__ Working Full Time
___ Involved in ongoing legal, disability or worker's compensation case

29. **What is (was) your occupation or job title? (Please describe)**

_____

30. **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

**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)**

| | Ordered Provider |
|---|---|
| __ Blood Tests | _____ |
| __ X-Rays | _____ |
| __ MRI Scan | _____ |
| __ CT scan | _____ |
| __ EMG / Nerve Conduction Studies | _____ |
| __ Bone Scan | _____ |
| __ other? _____ | _____ |

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

_____
Patient Signature Date


# Patient Responsibility Form

**INSURED:** Your co-pay, in accordance with your insurance plan, is due at check in. Once we receive payment from your insurance you will be billed for any balance owed.

**UNINSURED:** if you are a new patient $350.00 will be due at the time of check in. If you are an established patient $125.00 will be due at time of check in. Any balance owed is due after your visit with your physician, payable at the front check in/out desk.

**No show, cancellation and late patient policy:** If you need to cancel an appointment we ask that you do so within 24 hours of your scheduled appointment time. If there are three or more scheduled appointments in which you do not keep without prior cancellation or if there are repeated scheduled appointments in which you arrive late consecutively, you could be subject to dismissal from our practice.

**Updated Information:** You will be asked when you check in at every visit to provide a picture ID, verify your personal information and make any changes so that your account can be updated. It is your responsibility to inform us of any demographic and insurance changes. If you have two or more insurance carriers, please advise us and provide us with a copy of both cards. This is also to help with processing and expediting insurance claims.

**NOTE**: Interventional Spine and Pain does not provide disability evaluation or approval. We ask that all new patients/referrals make the practice aware if they have retained the services of an attorney ( Letter of Protection)/(LOP) or have been involved in a MVA (motor vehicle accident), as our practice does not treat patients under these situations and ask that this be brought to our attention **PRIOR** to scheduling.

**Patient Consent to Treatment:** I, knowing that I am suffering from a condition requiring diagnostic, medical, or interventional/ surgical treatment, do hereby voluntarily consent to such procedures and care and to such diagnostic, medical and/or office based interventional/surgical treatments under the general and specific instructions of the physicians of Interventional Spine and Pain, their assistants or their designee as in necessary in their judgement. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by the physicians and healthcare providers of Interventional Spine and Pain, P.A...This form will be in effect from this day forward unless I sign a revocation.

**Patients Initials**: _____ **Date**: _____

**Disclosure of Physicians Interest**: This is to inform you of the financial relationship with the following companies/surgical centers: Park Cities Surgery Center, Ambulatory Surgical Institute of Dallas, Walnut Hill Medical Center, Southwest Laboratory, Liberty Medical Diagnostics Center, Select Pain Procedure Center of Richardson, and MedCore. Our investment interest have absolutely no bearing on our decisions about the appropriate treatment for our patients, including our decisions regarding your care. However, in the interest of full, disclosure, we want you to know about our relationship with these companies, and give you the opportunity to ask us any questions you may have about that relationship and/or decision to use these companies.

Thank you,

Drs. Pablo Zeballos and Mark LeDoux

I have read and understand the above financial disclosure between these companies and our physician's providers.

_____
_____
Print Patient Name/ Signature
Date

_____
_____
Witness (Providers M.A.)
Date

_____
_____
Provider Signature
Date