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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: \_\_\_\_\_

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: \_\_\_\_\_

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):**

Neurosurgeon/Ortho Spine: \_\_\_\_\_

Physiatrist / Rehabilitation Specialist: \_\_\_\_\_

Orthopaedic Surgeon: \_\_\_\_\_

Neurologist: \_\_\_\_\_

Pain Medicine Specialist: \_\_\_\_\_

Rheumatologist: \_\_\_\_\_

Chiropractor: \_\_\_\_\_

Other: \_\_\_\_\_

### **PAIN HISTORY**

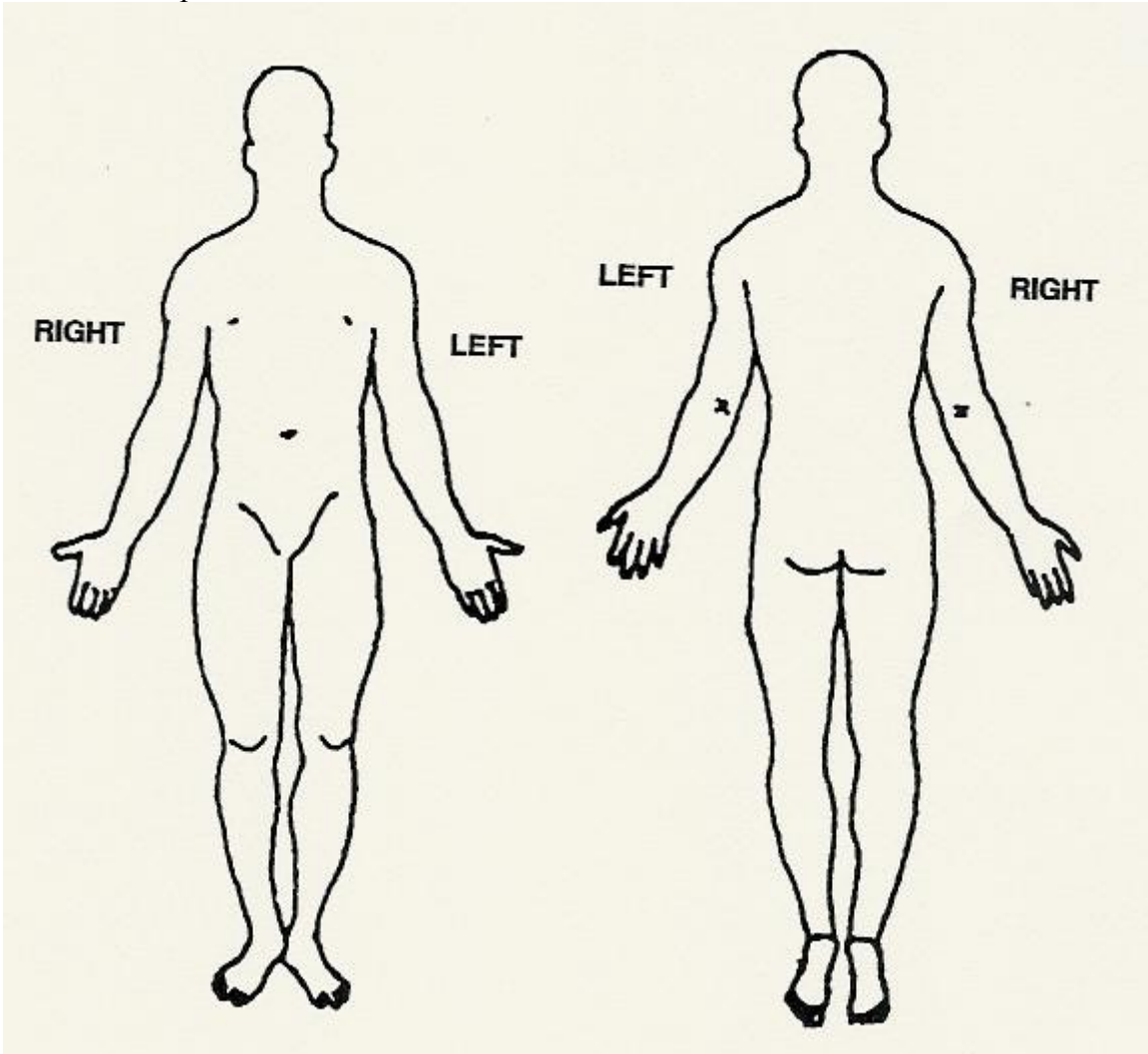
**1. PLEASE DESCRIBE YOUR PAIN PROBLEM Where is your pain? Where does the pain spread or radiate? (Example – “Low back pain that radiates down the back of my left leg to the heel”):**

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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”)

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3-4. **HOW** did your pain begin? (Please circle & check one that describes below)

- |   | <u>Date of Accident/Reason</u> |
|---|--------------------------------|
| <input type="checkbox"/> Pain Just Started By Itself      | _____                          |
| <input type="checkbox"/> Injury or Accident at Work/ Home | _____                          |
| <input type="checkbox"/> Following Surgery                | _____                          |
| <input type="checkbox"/> Motor Vehicle Accident           | _____                          |
| <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:**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
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:**

brief/momentary, steady/constant, periodic/intermittent

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

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

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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 pain?)

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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 <input type="checkbox"/> No <input type="checkbox"/>	_____
<input type="checkbox"/> Anti-Inflammatory Meds	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
<input type="checkbox"/> Muscle Relaxants	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
<input type="checkbox"/> Bedrest	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
<input type="checkbox"/> Physical Therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
<input type="checkbox"/> Exercise	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
<input type="checkbox"/> TENS (electrical stim)	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

**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 \_\_\_\_\_ 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?
<input type="checkbox"/> Single- Never Married	_____ years
<input type="checkbox"/> Married/Domestic Partner	_____ years
<input type="checkbox"/> 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)

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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)

- |   | <u>Ordered Provider</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. \_\_\_\_\_

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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. In addition, I will be financially responsible for appointments or procedures missed if I do not give 24 hours' notice to the clinic. The fee billed is \$25 for office visit, and \$150 for procedures.

**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. Any request for completion of FMLA and/or medical documents, will require a prepaid fee of \$25.00. 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, Gulfstream Laboratory and Monitoring Concepts. 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, Mark LeDoux, and John Michels

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

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Print Patient Name/ Signature  
Date

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Witness (Providers M.A.)  
Date