Bend Spine and Pain Specialists

Confidential Health Questionnaire

Patient Name _____ Date_____

Date of birth _____ Marital status: S M D W Sex: M F Referring Provider_____

Work related? _____ MVA? _____ Legal action in progress? _____

Chief Complaint _____

Pain Duration _____ Pain region _____

When did Pain begin? _____ Onset Severity 0(none) – 10(worst) _____

Description _____

Numbness? Where _____

Weakness? Where _____

Paresthesia? (pins and needles) Where? _____

Made worse by _____

Made better by _____

Any associated symptoms _____

Circle the Number that describes your **pain at its worst** over the last month.

0 1 2 3 4 5 6 7 8 9 10

Circle the Number that describes your **pain at its best** over the last month.

0 1 2 3 4 5 6 7 8 9 10

At what level of pain do you think **you could function** with on a daily basis?

0 1 2 3 4 5 6 7 8 9 10

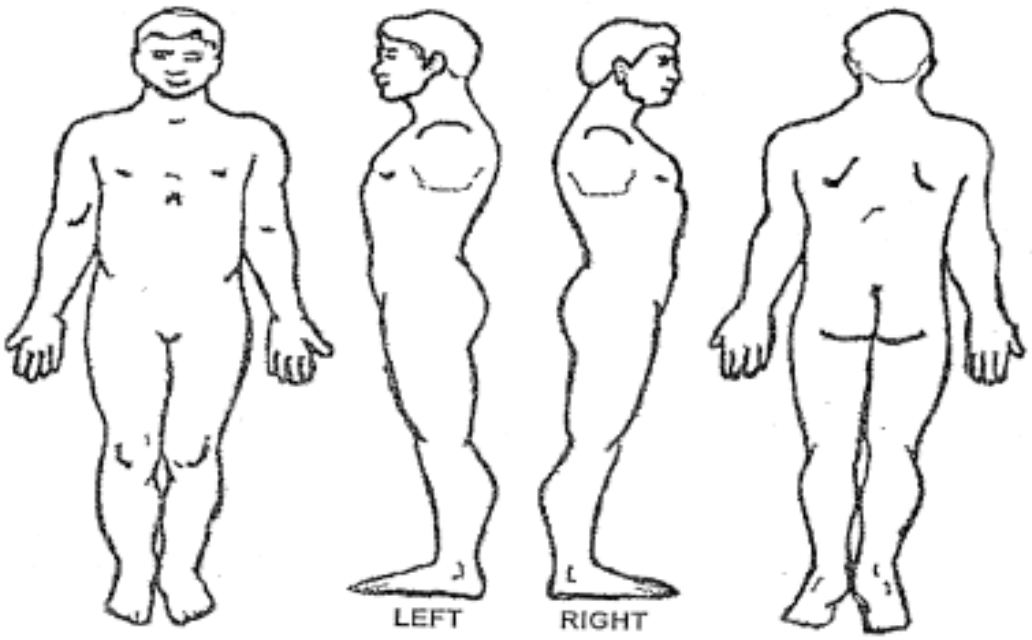
Setting Goals

We would like to help you fulfill some concrete goals. It is important to set goals as well as define progress towards the goal. For many patients a complete return to perfect health will not be possible. We will work with you to define reasonable goals, and we will help you understand what you can expect from treatment.

What are your goals for treatment? Be specific (return to work, care of home or family, shopping, activities, sex, self care, recreation, social activity).

1. _____
2. _____
3. _____

Pain Diagram On the diagram below, mark the area where you have pain.



Prior Treatment

What prior treatments have you had in the past? For example TENS, PT, opioid pain medication, injections. What percentage of relief did you experience? For what duration?

Treatment	% relief	How long improved?

Prior Tests - Have you had any of the following studies?

	Body area	Date	Facility
X-rays			
MRI			
CT			
EMG			
Other			

Medication - What are your current medications?	Dose	Frequency	Years

Patient Name _____ Date _____

Allergies

Do you have any allergies or bad reactions to medications?

_____

_____

_____

_____

Medical History

Prior Medical Problem	Years

Prior Hospitalizations

Reason for hospitalization	Date

Prior Surgeries

Type of Surgery	Surgeon	Date

Review of systems

Have you **recently** experienced?

Fever or Chills	Sweats	Loss of appetite	Fatigue	Double vision
Vision loss	Eye discharge	Eye pain	Ear ache	Ear discharge
Loss of hearing	Nose bleeds	Sore throat	Chest pain	Chest pressure
Palpitations	Irregular heart beat	Shortness of breath	Wheezing	Fainting
Edema in legs/hands	Cough	Excessive sputum	Coughing blood	Nausea
Constipation	Abdominal pain	Vomiting	Blood in the stools	Black tarry stools
Jaundice	Diarrhea	Painful urinating	Blood in urine	Incontinence
Frequent urgency	Muscle cramp	Muscle weakness	Joint swelling	Muscle/joint pain
Rash	Itching	Skin lesion	Paralysis	Seizures
Tremor	Vertigo	Difficulty with speech	Anxiety	Depression
Hallucinations	Suicidal thoughts	Addiction	Heat/cold intolerance	Excess thirst
Abnormal bruising /bleeding		Enlarged lymph nodes	Allergy	HIV

Weight change: gained _____ lbs or lost _____ lbs

Patient Name _____ Date _____

Psychiatric History

Do you have a psychological diagnosis? _____

Have you often been bothered by feeling down, depressed, or hopeless? _____

Have you been bothered by little interest or pleasure in doing things? _____

Substance Abuse History - Are you currently using? How often?

Marijuana _____ Medical Marijuana _____ Cocaine _____

Meth _____ Barbiturates _____ Heroin _____

Pills not prescribed to you?_____ Other drugs _____

Do you smoke or use tobacco? _____ How much _____Years _____

Alcohol _____ Number of drinks/day _____

Have you had more that 5 drinks in one setting within the past 3 months? _____

Ever thought you should cut down on your alcohol/drug use? _____

Have people annoyed you, criticizing your alcohol/drug use? _____

Ever felt guilty about your alcohol/drug use? _____

Ever have an "eye-opener" first thing in the morning? _____

Ever get arrested or in trouble, miss work because of alcohol/drug use? _____

Social History

Are you employed? _____ What do you do? _____

Are you married? _____ Children? _____What is your education level? _____

Hobbies _____

Family History - Who in your family has:

Alcoholism _____ Substance Abuse _____

Depression _____ Cancer _____

Heart Disease _____ Stroke _____

Diabetes _____ Hypertension _____

Quality of life Scale – How well do you Function?

0 I stay in bed all day

1 I sometimes get out of bed and move about the house

2 I get out of bed in the morning, but I don't get dressed, I stay at home all day

3 I get dressed in the morning, minimal activity at home

4 I do simple chores around the house only

5 I am able to fulfill all daily home responsibilities, I get out socially occasionally

6 I can do chores inside and outside the house, I am out frequently

7 I work or volunteer part time and I'm active at least 5 hours a day

8 I work or volunteer full time, fulfill all obligations, chores, and responsibilities

9 I work or volunteer full time and exercise occasionally

10 I work or volunteer full time and exercise regularly

Patient Name _____ Date _____