US Pain & Spine Institute™

NEW PATIENT

Date of visit: _____

Patient: _____ **Date of birth:**_____

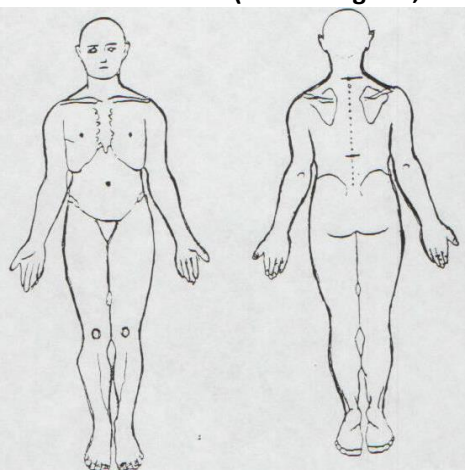
Pain/Chief Complaint: _____

Have you had this pain treated by (circle all that apply): Another Physician Urgent care center Emergency room Hospital

Were you referred to our clinic by another physician? If so, whom? _____

Medical records: _____ Have in hand today _____ Already faxed _____ Will request _____ No medical records

Where is it located: (shade diagram, mark worst spot with an X)



PAIN SCALE

Over the last week, rate:

	None										Worst
Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
Least Pain:	0	1	2	3	4	5	6	7	8	9	10
Usually:	0	1	2	3	4	5	6	7	8	9	10
Right Now:	0	1	2	3	4	5	6	7	8	9	10
Acceptable Level:	0	1	2	3	4	5	6	7	8	9	10

Office use only:

Weight: _____

Height: _____

Pulse: _____

Resp: _____

BP: _____ / _____

Pulse Ox: _____

Taken by:_____

Office use only: MODI ____/____ _____% SOAPP _____/20 No Low Mod/High

UA POC Required / Done BDI _____ GENE Pending / Done

Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

How would you describe your pain? (Circle all that apply) Sharp Dull Aching Burning Shooting Stinging Stabbing Throbbing Numb Tingling Pressure Nagging Gnawing Shocking Crampy

When did this pain begin? _____ **Onset?** Sudden Gradual

Frequency of pain? Constant Intermittent

When is pain at its worst? Mornings During the day Evening Night

Since your pain began, how has it changed? Worsening Improving Stayed the same

What makes the pain worse? (Circle all that apply)

Coughing Lifting Sitting Standing Walking Climbing stairs Lying down Other: _____

What makes the pain better? (Circle all that apply) Ice Heat Rest Lying supine Stretching NSAIDs Opioids Physical therapy Acupuncture Chiropractor Other: _____

Does your pain interfere with your: (Circle all that apply) General Activity Mood Walking Work Housework Activities of daily living Hobbies Relationships Sleep Life Enjoyment

Associated symptoms: (Circle all that apply) Depression Anxiety Sleep problems Weight gain Decreased libido Social withdrawal Loss of strength Loss of flexibility Fever Malaise Weight loss

Is this related to a specific injury? Yes No **When was the injury?** _____

Where did the injury occur? Home Work Auto Other: _____

What was the mechanism of the injury? Fall Bending Lifting Twisting Trauma Other: _____

Who has treated this pain?

PCP (name) _____ Phone number _____

Neurologist (name) _____ Phone number _____

Neurosurgeon (name) _____ Phone number _____

Orthopedic (name) _____ Phone number _____

Diagnostic testing and imaging

X-ray of the _____ Date: _____ Facility: _____
CT of the _____ Date: _____ Facility: _____
MRI of the _____ Date: _____ Facility: _____
EMG/NCV study of the _____ Date: _____ Facility: _____

Past Treatment: NSAIDs Opiods Muscle relaxants Steroids PT Chiropractor TENS unit Psychological

Past interventions	**Date**	**% pain relief (0-100%)**
Trigger Point Injection		
Joint Injection Joint _____		
Epidural injection Level(s)_____		
Facet Joint Injection Level(s)_____		
Radiofrequency Level(s)_____		
Vertebroplasty / Kyphoplasty Level(s)_____		
Discogram		
Spinal cord stimulator: trial / permanent implant Medtronics Boston Scientific St. Judes		
Intrathecal pump: trial / permanent implant		

Surgery **Date** **Surgeon**

_____
_____
_____

CURRENT MEDICATIONS:
Medication **Dose** **Frequency**

_____
_____
_____
_____
_____
_____
_____
_____
_____

Pharmacy Name: _____
Phone Number: _____

Do you take any blood thinners? Yes No
Who prescribes the blood thinner? _____
Any known drug allergies? Yes No
Medication **Allergic Reaction**

_____
_____
_____

Topical allergies: Iodine Latex Tape

Bowel Patterns **Usual frequency:** _____ Last BM: _____ Bowel Regimen: YES NO
Opioid Side Effects: (Circle all that apply) Constipation Dizziness Drowsiness Impaired mentation Sexual dysfunction Dry mouth Nausea Vomiting Pruritus Depression
Any history of: (Circle all that apply) Coagulation Disorder Depression Substance abuse Diabetes Hypertension Seizure Stroke Heart attack Kidney problems Liver problems Cancer Infections
Family History of: Substance abuse Chronic Pain Cancer Please elaborate: _____
Social History **Marital Status:** Married Single Separated Divorced Widow **#Children**: _____
Occupation: _____
Smoking (circle one): Never a smoker Former smoker Current some day smoker Current every day smoker
Alcohol use (circle one): Never drinks Socially History of Alcoholism Current Alcoholism
Illegal drug use (circle one): YES NO Formerly used illegal drugs If yes, please elaborate: _____
Have you ever abused prescription medications: YES or NO If yes, please elaborate: _____

FOR OFFICE USE ONLY

Problem List: **Plan:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

US Pain & Spine Institute™

SOAPP® Version 1.0 - SF

Name: _____ Date: _____

The following are some questions given to all patients at USPS Medical Associates, P.L.L.C. who are taking or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:
0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very Often

1. How often do you have mood swings? 0 1 2 3 4

2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4

3. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4

4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4

5. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

US Pain & Spine Institute™

The Revised Oswestry Disability Index

Patient name:_____Date:_____

SECTION 1-PAIN INTENSITY

0) The pain comes and goes and is very mild
1) The pain is mild and does not vary much
2) The pain comes and goes and is moderate
3) The pain is moderate and does not vary
4) The pain comes and goes and is very severe
5) The pain is severe and does not vary much

SECTION 2-PERSONAL CARE

0) I would not have to change my way of washing or dressing in order to avoid pain
1) I do not normally change my way of washing or dressing even though it causes some pain
2) Washing and dressing increases the pain, but I manage not to change my way of doing it
3) Washing and dressing increases the pain and I find it necessary to change my way of doing it
4) Because of the pain, I am unable to do some washing and dressing without help
5) Because of the pain, I am unable to do any washing and dressing without help

SECTION 3-LIFTING

0) I can lift heavy weights without extra pain
1) I can lift heavy weights, but it causes extra pain
2) Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g on a table)
3) Pain prevents me rom lifting heavy weights off the floor
4) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
5) I can only lift very light weights at the most

SECTION 4-WALKING

0) I have no pain while walking
1) I have some pain while walking, but it does not increase with distance
2) I cannot walk more than one mile without increasing pain
3) I cannot walk more than ½ mile without increasing pain
4) I cannot walk more than ¼ mile without increasing pain
5) I cannot walk at all without increasing pain

SECTION 5-SITTING

0) I can sit in any chair as long as I like
1) I can only sit in my favorite chair as long as I like
2) Pain prevents me from sitting more than one hour
3) Pain prevents me from sitting more than ½ hour
4) Pain prevents me from sitting more than 10 minutes
5) I avoid sitting because it increases pain right away

Total: _____/ _____= _____%
Total score / (# of sections completed x 5)

SECTION 6-STANDING

0) I can stand as long as I want without pain
1) I have some pain while standing , but it does not increase with time
2) I cannot stand for longer than one hour without increasing pain
3) I cannot stand for longer than ½ hour without increasing pain
4) I cannot stand for longer than 10 minutes without increasing pain
5) I avoid standing because it increases the pain right away

SECTION 7-SLEEPING

0) I get no pain in bed
1) I get pain in bed, but it does not prevent me from sleeping well
2) Because of pain, my normal night's sleep is reduced by less than ¼
3) Because of pain, my normal night's sleep is reduced by less than ½
4) Because of pain, my normal night's sleep is reduced by less than ¾
5) Pain prevents me from sleeping at all

SECTION 8-SOCIAL LIFE

0) My social life is normal and gives me no pain
1) My social life is normal, but increases the degree of pain
2) Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.)
3) Pain has restricted my social life and I do not go out very often
4) Pain has restricted my social life to my home
5) I have hardly any social life because of the pain

SECTION 9-TRAVELLING

0) I get no pain while traveling
1) I get some pain while traveling, but none of my usual forms of travel makes it any worse
2) I get extra pain while traveling, but it does not compel me to seek alternative forms of travel
3) I get extra pain while traveling, which compels me to seek alternative forms of travel
4) Pain restricts all forms of travel
5) Pain prevents all forms of travel except that done while lying down

SECTION 10-CHANGING DEGREE OF PAIN

0) My pain is rapidly getting better
1) My pain fluctuates, but is definitively getting better
2) My pain seems to be getting better, but improvement is slow at present
3) My pain is neither getting better nor worse
4) My pain is gradually worsening
5) My pain is rapidly worsening