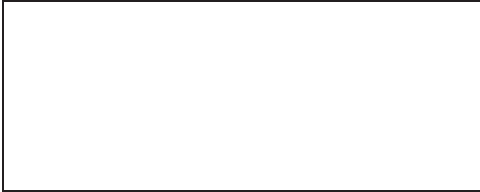
Back & Neck Pain Center

Experts in healing. Specialists in caring.



Patient Label

Name:____________________ **Home Phone:**____________

Address:____________________ **Cell Phone:**____________

DOB:____________ **Age:**____________ **Sex:** ❑ **Male** ❑ **Female**

Emergency Contact:____________________ **Phone #:**____________

Insurance Information

Primary Insurance:____________________ ID#:____________

Secondary Insurance:____________________ ID#:____________

Current Condition and Symptoms: ____

____

____

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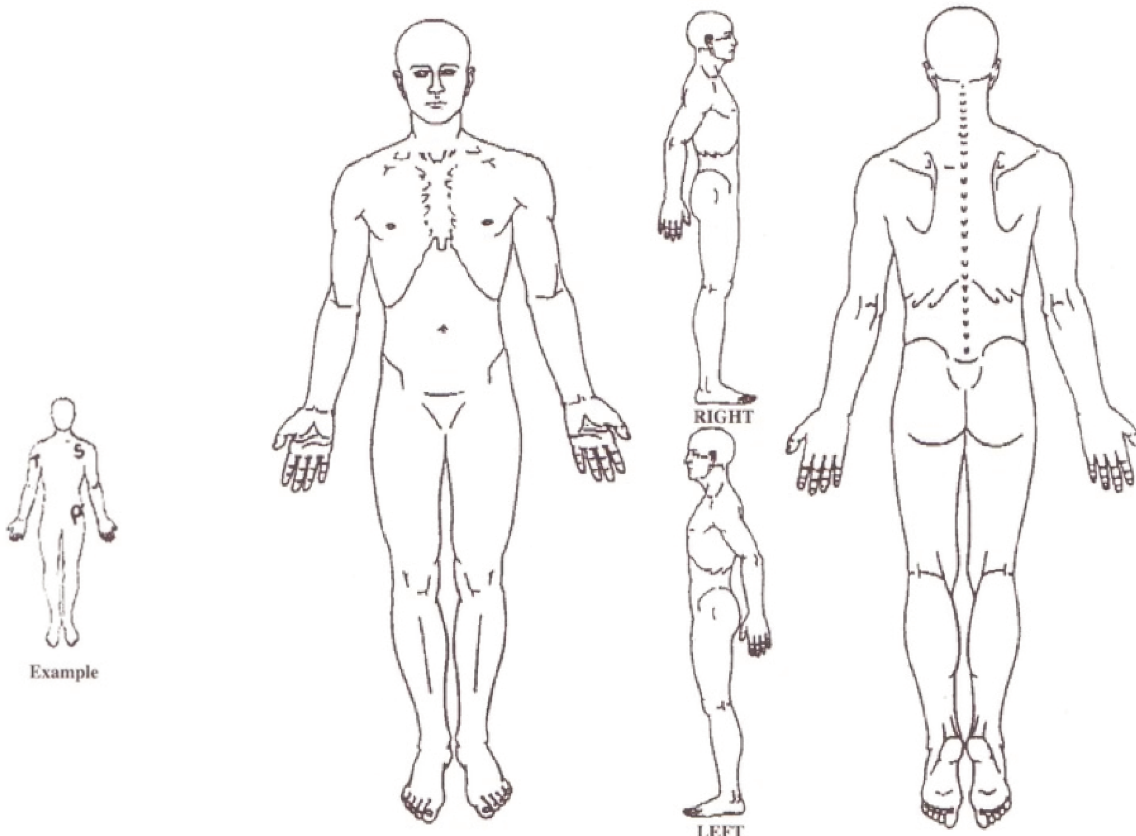
Use the letters to indicate the type and location of your sensations right now:

S=Stiffness B=Burning N=Numbness P=Sharp Pain T=Tingling D=Dull Pain

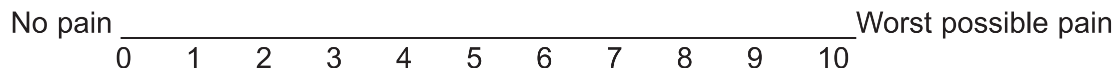


Patient Label

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:



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1. How would you rate your pain RIGHT NOW?

2. What is your typical or AVERAGE pain?

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

When did you first notice any symptoms? (Date of injury if known) ______________________________

How did your condition begin? ______________________________

Did you have an injury? ❑ Yes ❑ No. Explain______________________________

Is the pain keeping you from working? ❑ Yes ❑ No

Is this a workers compensation case? ❑ Yes ❑ No

Were you injured in a motor vehicle accident? ❑ Yes ❑ No

Is there a pending law suit? ❑ Yes ❑ No

Medications:

Include ALL prescription, over the counter, supplements and herbal products

Medication	Dosage	# Times Taken/Day	Reason for taking

Patient Label

Allergies: Do you have any allergies? (Including medication, food products, latex, etc.)
❑ Yes ❑ No, **If yes,** please describe allergen & reaction____

Have you ever had a reaction to any dye for a special test? ❑ Yes ❑ No, **If yes,** what type of test and reaction? ____

Surgical History:
Have you had any prior surgeries? ❑ Yes ❑ No, **If yes:**
Surgery______________________ Date ______________ Provider_______________Hospital_________________
Surgery______________________ Date ______________ Provider_______________Hospital_________________
Surgery______________________ Date ______________ Provider_______________Hospital_________________
Surgery______________________ Date ______________ Provider_______________Hospital_________________

Past Medical History:

- ❑ Diabetes
- ❑ Cancer
- ❑ Heart Attack
- ❑ Liver disease
- ❑ Bowel trouble
- ❑ Alcohol abuse
- ❑ Sexual/Psychological abuse
- ❑ Glaucoma
- ❑ Lupus
- ❑ Spine surgery
- ❑ Arthritis
- ❑ Stroke or TIA
- ❑ Hepatitis A, B or C
- ❑ Bleeding disorder
- ❑ Dialysis
- ❑ Drug abuse
- ❑ Psychiatric illness
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Other
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Seizures
- ❑ Kidney disease
- ❑ Asthma
- ❑ Chronic Bronchitis/Emphysema
- ❑ Fibromyalgia
- ❑ Depression/anxiety
- ❑ Epilepsy
- ❑ Osteoporosis

If you checked yes to any of the above, please explain:____
____
____
____
____

Family Medical History:

- ❑ Diabetes
- ❑ Cancer
- ❑ Heart Attack
- ❑ Liver disease
- ❑ Bowel trouble
- ❑ Alcohol abuse
- ❑ Sexual/Psychological abuse
- ❑ Glaucoma
- ❑ Lupus
- ❑ Spine surgery
- ❑ Arthritis
- ❑ Stroke or TIA
- ❑ Hepatitis A, B or C
- ❑ Bleeding disorder
- ❑ Dialysis
- ❑ Drug abuse
- ❑ Psychiatric illness
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Other
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Seizures
- ❑ Kidney disease
- ❑ Asthma
- ❑ Chronic Bronchitis/Emphysema
- ❑ Fibromyalgia
- ❑ Depression/anxiety
- ❑ Epilepsy

Patient Label

Imaging/tests:

Have you had any of the following imaging studies or tests for your current problem?

X-ray ❑ Yes ❑ No
CT Scan ❑ Yes ❑ No
MRI ❑ Yes ❑ No
Discogram ❑ Yes ❑ No
Bone Scan ❑ Yes ❑ No
EMG/Nerve Conduction ❑ Yes ❑ No
Sonogram ❑ Yes ❑ No
DEXA Scan ❑ Yes ❑ No

If you answered yes to any of the above tests, please tell us where you had them done, when you had them done, and what the results were if you know them.
If you have the disc with the images and/or the report please provide us with a copy.

Facility where tests were performed:______________________________

Date of the tests:______________________________

Results:______________________________

Habits:

Do you use tobacco? ❑ Yes ❑ No, **If yes,** what form? ____________ For how long? ____________
Have you ever smoked? ❑ Yes ❑ No, **If yes,** how many cigarettes per day? ____________
Do you use alcohol? ❑ Yes ❑ No, **If yes,** what type?____________ Frequency? ____________

Sleep Pattern:

Has your sleeping pattern changed due to your pain? ❑ Yes ❑ No
Does your pain wake you up at night? ❑ Yes ❑ No
Does your pain make it difficult to fall asleep? ❑ Yes ❑ No

Which of the following factors make your pain better or worse? Please check all that apply.

Bending forwards ❑ better ❑ worse
Bending backwards ❑ better ❑ worse
Sitting ❑ better ❑ worse
Standing ❑ better ❑ worse
Climbing stairs ❑ better ❑ worse
Exercise ❑ better ❑ worse
Reaching ❑ better ❑ worse
Coughing or straining ❑ better ❑ worse
Bowel movements ❑ better ❑ worse
Lying down ❑ better ❑ worse
Pushing shopping carts ❑ better ❑ worse
Sexual relations ❑ better ❑ worse
Relaxation ❑ better ❑ worse

Patient Label

Radiating Factors:
Mark which best describes the pain in your back/leg or neck/arm.

FOR BACK PAIN
❑ Back pain only no leg pain
❑ Back pain worse than leg pain
❑ Back pain and leg pain equal
❑ Leg pain worse than back pain
❑ Leg pain only no back pain
❑ Leg pain worsens when I bend backwards
❑ Leg pain worsens when I bend forwards

FOR NECK PAIN
❑ Neck pain only no arm pain
❑ Neck pain worse than arm pain
❑ Neck pain and arm pain equal
❑ Arm pain worse than neck pain
❑ Arm pain only
❑ Arm pain worsens when I look up
❑ Arm pain worsens when I look down

Pain Characteristics:
Do you have numbness, tingling, or pins and needles in your hands, feet, arms, or legs? ❑ Yes ❑ No,
If yes where? ______________________________

Do you have weakness of your muscles? ❑ Yes ❑ No, **If yes** where? ______________________________

Is the pain constant or intermittent? ❑ Consistant ❑ Intermittent

Is the pain sharp or dull? ❑ Sharp ❑ Dull

Describe the pain______________________________

Have you ever been in the emergency room or urgent care for the pain? ❑ Yes ❑ No

Have you experienced loss of bowel or bladder function? ❑ Yes ❑ No

Have you experienced severe weakness of your arms and legs? ❑ Yes ❑ No

Have you noticed extreme clumsiness, stumbling, or difficulty in walking? ❑ Yes ❑ No

Have you experienced numbness all over your body? ❑ Yes ❑ No

Have you experienced a recent fever or infection? ❑ Yes ❑ No

Is your pain unrelieved by rest, and/or when you go to sleep at night? ❑ Yes ❑ No

Please mark what other treatments you have tried? Where they helpful?

Pain Management and Treatment
❑ Epidural Injections Helpful? ❑ Yes ❑ No
❑ Facet Blocks Helpful? ❑ Yes ❑ No
❑ Sacroiliac Blocks Helpful? ❑ Yes ❑ No
❑ Trigger Point Injections Helpful? ❑ Yes ❑ No
❑ Radiofrequency Ablation Helpful? ❑ Yes ❑ No
❑ Pain Pump Helpful? ❑ Yes ❑ No
❑ Spinal Cord Stimulator Helpful? ❑ Yes ❑ No

Chiropractic Care
❑ Exercises Helpful? ❑ Yes ❑ No
❑ Physical Therapy Helpful? ❑ Yes ❑ No
❑ Massage Helpful? ❑ Yes ❑ No
❑ Electrical Stimulation (TENS) Helpful? ❑ Yes ❑ No
❑ Acupuncture Helpful? ❑ Yes ❑ No
❑ Heating pack Helpful? ❑ Yes ❑ No
❑ Ice pack Helpful? ❑ Yes ❑ No

Patient Label

Physical Therapy

❑ Exercises	Helpful? ❑ Yes ❑ No
❑ Physical Therapy	Helpful? ❑ Yes ❑ No
❑ Massage	Helpful? ❑ Yes ❑ No
❑ Electrical Stimulation (TENS)	Helpful? ❑ Yes ❑ No
❑ Acupuncture	Helpful? ❑ Yes ❑ No
❑ Heating pack	Helpful? ❑ Yes ❑ No
❑ Ice pack	Helpful? ❑ Yes ❑ No

Other

❑ Pilates	Helpful? ❑ Yes ❑ No
❑ Tai Chi	Helpful? ❑ Yes ❑ No
❑ Psychotherapy	Helpful? ❑ Yes ❑ No
❑ Aquatherapy	Helpful? ❑ Yes ❑ No
❑ Surgery	Helpful? ❑ Yes ❑ No
❑ Aromatherapy	Helpful? ❑ Yes ❑ No
❑ Relaxation/meditation	Helpful? ❑ Yes ❑ No
❑ Massage	Helpful? ❑ Yes ❑ No
❑ Yoga	Helpful? ❑ Yes ❑ No

If you checked YES to any of the above questions, please tell us which providers you have seen, and when the procedure or treatment was done

____

____

____

____

Patient Signature: ____ Date:__________ Time:__________

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Patient Label

BN7660

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if a person or organization authorized to receive my information is not a health plan or health care provider, the released information may be subject to redisclosure and may no longer be protected by federal privacy regulations.

Patient Name: ____ Date of Birth:______________________

Patient Address: ____

____

Phone #: _________________________________ MR#_________________________

Persons/Organizations authorized to disclose my information:

John T. Mather Memorial Hospital, Back & Neck Pain Center and Outpatient Treatment Provider

Specific description of information to be disclosed to outpatient treatment provider from Back & Neck Pain Center:

Consult note, clinical progress report, progress notes clinical summary and treatment request, provider, correspondence, imaging studies, diagnostic studies, laboratory results (inclusive of all dates while under care.)

Specific description of information to be disclosed from outpatient treatment provider to Back & Neck Pain Center:

Consult note, last 5 progress notes, list of all medications, imaging studies, diagnostic studies, laboratory results, hospital discharge reports (inclusive of all dates while under care.)

Description of the purpose of the disclosure of my patient information:

Coordination of treatment and navigation.

1. I understand that this authorization will expire on ____/____/________ or in 12 months from the date listed below.
2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form.
3. I understand that I may revoke this authorization at any time by notifying the providing organization disclosing my patient information in writing, but if I do, the revocation will not have any effect on actions the organization has already taken in reliance on this authorization.

This form MUST be completed before signing.

______________________________	______________	______________
(Signature of patient 18 years older / patient's representative)	Date	Time
______________________________	______________	______________
(Parent or Guardian)	Date	Time

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION TO AND FROM OUTPATIENT TREATMENT PROVIDER

Back & Neck Pain Center

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Patient Label

BN7655

I authorize contact from the Back & Neck Pain Center to **confirm my appointment and/or billing information** via: (Please select all that apply)

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Fax ☐ Email ☐ Any of the Above

I authorize **health information** to be provided to me via: (Please select all that apply)

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Fax ☐ Email ☐ Any of the Above

I authorize that a **message may be left with another member** of my household.

☐ Name of Person:________________________________ Relationship:________________________

☐ I **do not authorize** communication in any manner except in person.

Please fill-in the following communication methods of which you authorize the Back & Neck Pain Center to utilize:

Cell Phone #:______________________________ Home Phone #:______________________________

Work Phone #:______________________________ Fax #:______________________________

Email Address:____

____ ____________ ____________
(Printed Name of Patient) (Date) (Time)

____ ____________ ____________
(Signature of Patient/Legal Representative) (Date) (Time)

COMMUNICATION CONSENT

Back & Neck Pain Center

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Patient Label

Patient Name: ____ Date:__________ Time:__________
(print)

Please answer each section marking one box that most applies to you.

Section 1. Pain Intensity:
❑A. I have no pain at the moment.
❑B. The pain is very mild at the moment.
❑C. The pain is moderate at the moment.
❑D. The pain is fairly severe at the moment.
❑E. The pain is very severe at the moment.
❑F. The pain is the worst imaginable at the moment.

Section 2. Personal Care:
❑A. I can look after myself without causing extra pain.
❑B. I can look after myself normally but it causes extra pain.
❑C. It is painful to look after myself and I am slow and careful.
❑D. I need some help but manage most of my personal care.
❑E. I need help everyday in most aspects of self-care.
❑F. I do not get dressed, I wash with difficulty and stay in bed.

Section 3. Lifting:
❑A. I can lift heavy weights without extra pain.
❑B. I can lift heavy weights but it gives me extra pain.
❑C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
❑D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
❑E. I can lift very light weights.
❑F. I cannot lift or carry anything at all.

Section 4. Reading:
❑A. I can read as much as I want to, with no pain in my neck.
❑B. I can read as much as I want to, with slight pain in my neck.
❑C. I can read as much as I want to, with moderate pain in my neck.
❑D. I cannot read as much as I want because of moderate pain in my neck.
❑E. I can hardly read as much at all because of severe pain.
❑F. I cannot read at all.

Section 5. Headaches:
❑A. I have no headaches at all.
❑B. I have slight headaches, which come infrequently.
❑C. I have moderate headaches, which come infrequently.
❑D. I have moderate headaches, which come frequently.
❑E. I have severe headaches, which come infrequently.
❑F. I have headaches almost all the time.

Section 6. Concentration:
❑A. I can concentrate fully when I want to with no difficulty.
❑B. I can concentrate fully when I want to with slight difficulty.
❑C. I have a fair degree of difficulty in concentrating when I want to.
❑D. I have a lot of difficulty in concentrating when I want to.
❑E. I have a great deal of difficulty in concentrating when I want to.
❑F. I cannot concentrate at all.

Section 7. Work:
❑A. I can do as much work as I want to.
❑B. I can only do my usual work, but no more.
❑C. I can do most of my usual work, but no more.
❑D. I cannot do my usual work.
❑E. I can hardly do any work at all.
❑F. I cannot do any work at all.

Section 8. Driving:
❑A. I can drive my car without any neck pain.
❑B. I can drive my car as long as I want with slight pain in my neck.
❑C. I can drive my car as long as I want with moderate pain in my neck.
❑D. I cannot drive my car as long as I want because of moderate pain in my neck.
❑E. I can hardly drive at all because of severe pain in my neck.
❑F. I cannot drive my car at all.

Section 9. Sleeping:
❑A. I have no trouble sleeping.
❑B. My sleep is slightly disturbed (less than 1 hour sleepless).
❑C. My sleep is mildly disturbed (1-2 hours sleepless).
❑D. My sleep is moderately disturbed (2-3 hours sleepless).
❑E. My sleep is greatly disturbed (3-5 hours sleepless).
❑F. My sleep is completely disturbed (5-7 hours sleepless).

Section 10. Recreation:
❑A. I am able to engage in all my recreation activities with no neck pain at all.
❑B. I am able to engage in all my recreation activities with some pain in my neck.
❑C. I am able to engage in most, but not all, of my recreation activities because of pain in my neck.
❑D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
❑E. I can hardly do any recreation activities because of pain in my neck.
❑F. I cannot do any recreation activities at all.

NEPAIN DISABILITY INDEX

Score_____/_____