

# 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

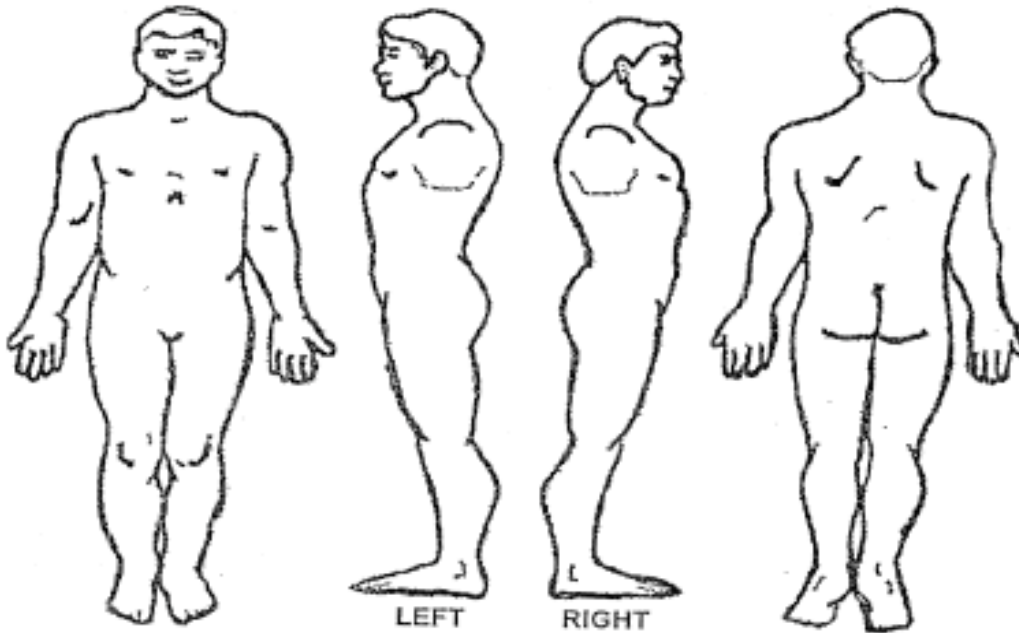
We would like to help you fulfill some concrete goals. It is important to set goals as well as define progress towards the goal. For many patients a complete return to perfect health will not be possible. We will work with you to define reasonable goals, and we will help you understand what you can expect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

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## 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 than 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 \_\_\_\_\_