Please PRINT LEGIBLY to ensure we are able to properly identify information, to call you to schedule once received back. Please complete in Blue or Black Ink Only,

Your Name: _____ Your Date of Birth: _____

Referring Provider:_____

We would like to gather some information that will help with your evaluation. Please complete the following questionnaire as best you can. If there are questions you do not understand, you will be able to discuss this with your health care provider during the visit.

What condition do you need evaluated in the Montana Spine and Pain Center?

How long have you had the condition?

What caused the condition?

What symptoms are you currently experiencing?

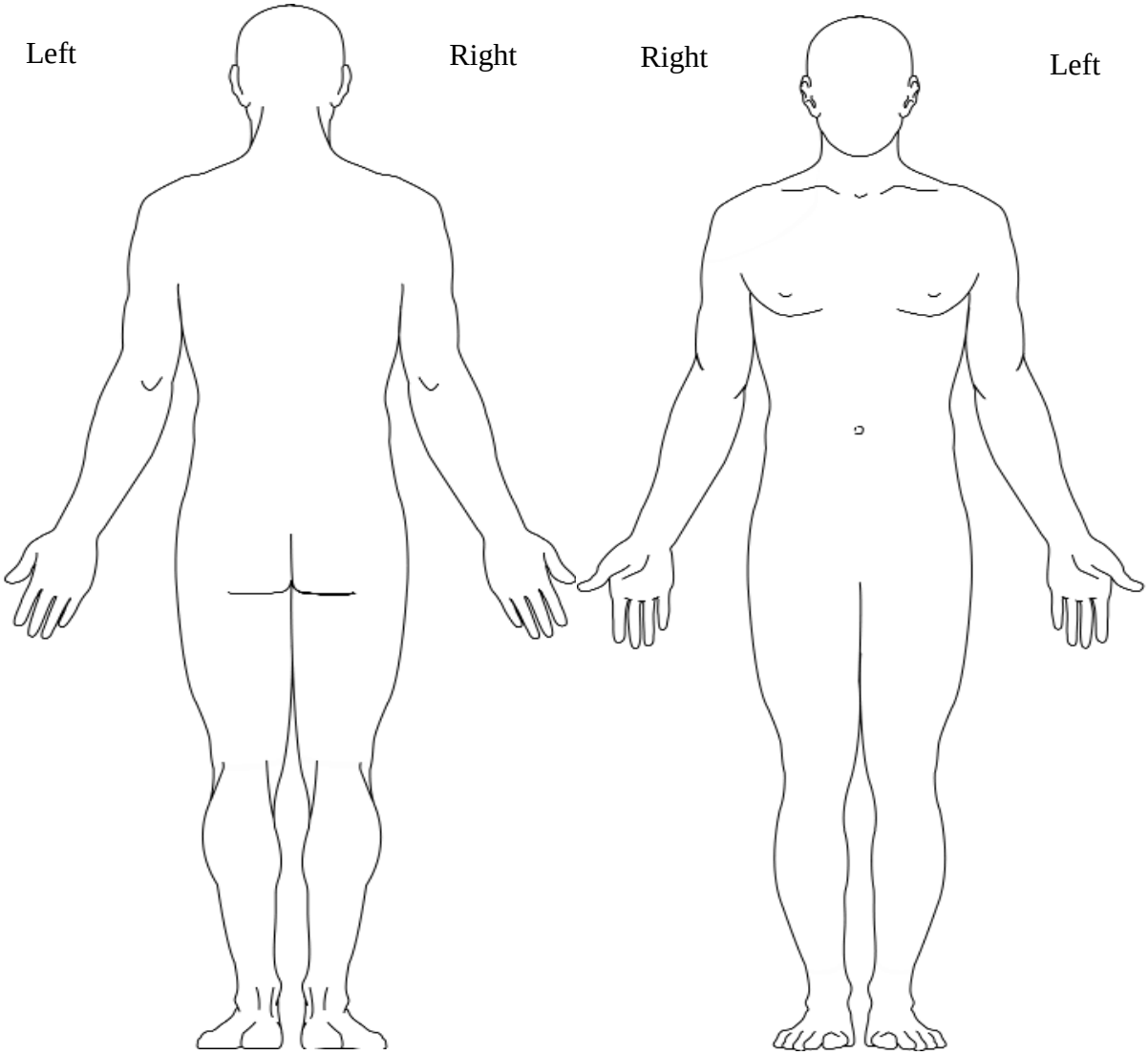
Pain Drawing

On the figures below, using the =, o, x, (, and / symbols, please mark the areas of your body where you feel:

Numbness ===== Stabbing //////// Burning xxxxx

Pins and Needles ooooo Aching ((((((

Please also place a checkmark "✓" on the area that hurts the most.



What test(s) have you had for your current problem?

❑ X-Rays When:	❑ CAT scan When:	❑ MRI Scan When:
❑ Bone Scan When:	❑ Electrical Tests When:	❑ Injections When:
❑ Blood Tests When:	❑ Discogram When:	❑ Other: When:

Which of the following treatments have you tried in the past for the condition?(Check all that apply)

❑ Anti-Inflammatory Medications
❑ Muscle Relaxants
❑ Antidepressants
❑ Anti-seizure Medications
❑ Trigger Point Injections
❑ Surgery
❑ Other:

❑ Chiropractic
❑ Narcotic Pain Medications
❑ Acupuncture
❑ TENS Unit
❑ Spinal Injections
❑ Pain Program

❑ Massage
❑ Yoga
❑ Meditation/Relaxation
❑ Pain Pump
❑ Spinal Stimulator
❑ Physical Therapy

What are your major concerns about your health?

What goals do you hope to accomplish at the Montana Spine and Pain Center?

Pain Questions

On a scale of 0-10, with 10 being the worst what is your present pain level?

Please Circle your response: 0 1 2 3 4 5 6 7 8 9 10

Does the pain keep you awake at night? ❑ Yes ❑ No

Is pain worsened when you cough or sneeze? ❑ Yes ❑ No

Do you stumble when you walk? ❑ Yes ❑ No

Have you noticed your hands are clumsy? ❑ Yes ❑ No

Do you have trouble controlling your bladder? ❑ Yes ❑ No

Do you have trouble controlling bowel movements? ❑ Yes ❑ No

Do you have weakness anywhere? ❑ Yes ❑ No

Do you have numbness anywhere? ❑ Yes ❑ No

Do you have numbness in your crotch area? ❑ Yes ❑ No

Have you had any of the following?

- ❑ Serious injuries
- ❑ Fever, chills or weight loss
- ❑ IV drug abuse
- ❑ Cancer
- ❑ Recent infection
- ❑ Organ transplant

What positions, movements or activities aggravate your pain?

What do you do to relieve your pain?

Past and Current Medical Care

What other medical conditions do you currently have? (Please check the box only for those conditions that have been formally diagnosed by a health care provider)

❑ Heart Disease	❑ Seizures	❑ Asthma	❑ Cancer
❑ Diabetes	❑ Gout	❑ High Blood Pressure	❑ Stomach Ulcers
❑ Sleep Apnea	❑ Thyroid Problems	❑ Rheumatoid Arthritis	❑ Osteoarthritis
❑ Liver Disease	❑ Anemia	❑ Hepatitis	❑ Kidney Disease
❑ Lung Disease	❑ Head Injury	❑ Depression	❑ Panic/Anxiety attacks
❑ Suicide attempt	❑ Schizophrenia	❑ Psychiatric hospitalization	❑ OCD (Obsessive Compulsive Disorder)
❑ Posttraumatic stress disorder	❑ Bipolar disorder (Manic Depression)	❑ ADD or ADHD (Attention Deficit\Hyperactivity Disorder)	❑ Other:

Have you ever experienced abuse? ❑ Yes ❑ No

If yes, what kind? ❑ Physical ❑ Emotional ❑ Sexual

If yes, when ? ❑ Childhood/adolescence ❑Adult ❑ Both

Do you feel safe at home? ❑ Yes ❑ No

	Past	Current
❑ Psychiatrist		
❑ Clinical Psychologist		
❑ Clinical Social Worker		
❑ Clinical Counselor		
❑ Other Mental Health Professional		

What surgical procedures have you had in the past?

Procedure	**Year**

What is your preferred Pharmacy?_____

Please provide a list *ALL* medications you are currently taking and attach them OR write them below. (Include supplements or over the counter medications).

Medication Name	Strength	Number of pills	Schedule	Name of prescriber	Why do you take it?
Example: glyburide	*10 mg*	*2*	*twice daily*	*Dr. Strong*	*diabetes*

What pain medications have you tried in the past that have not worked?

Medication	Why it did not work

Do you have any allergies to medications?

Medication	Reaction

If there is any history of spine, neurologic or muscle disease in your family please provide details below.

Nature of Relationship	Nature of Disease Process
Example: Father	*Degenerative Disc Disease, Herniated Disc*

Function and Demographic Questions

What it your highest level of education?_____

What is your occupation? _____

Are you retired? ❑ Yes ❑ No

Are you currently receiving Social Security disability benefits? ❑ Yes ❑ No

Are you currently receiving another type of disability benefit? ❑ Yes ❑ No

Have you missed work due to this episode of pain? ❑ Yes ❑ No

How much? _____
When did you last work?_____

Are you currently off work due to this episode pain? ❑ Yes ❑ No

How many hours per week do you currently spend involved in work or school related activities? _____

Are you currently involved in any type of legal action related to this episode pain? ❑ Yes ❑ No

If so, who is your attorney and where is the office located? _____

_____

What is your preferred style of learning:

❑ Visual ❑ Demonstration ❑ Explanation

❑ Written ❑ Audio ❑ Other _____

Do you have any cultural, religious or spiritual concerns you would like us to address? ❑ Yes ❑ No

If so, what?_____

Personal Habits

Smoking Status: ❑ Current Every Day Smoker ❑ Current Some Day Smoker ❑ Former Smoker ❑ Never Smoker	Smokeless Tobacco: ❑ Current User ❑ Former User ❑ Never Used	Alcohol Use ❑ Yes ❑ No
Start Date: Quit Date:	Quit Date:	Drinks/Week: _____Glasses of wine _____Cans of beer _____Shots of liquor
Types: ❑ Cigarettes ❑ Pipe ❑ Cigars ❑ E-Cigarettes	Types: ❑ Snuff ❑ Chew	
Packs/Day:		
Years:		

Do you currently use recreational drugs (including THC)? ❑ Yes ❑ No

What substance? When?

_____ _____

_____ _____

_____ _____

Do any members of your family have a history of alcohol abuse?	❑ Yes	❑ No
Do any members of your family have a history of using illegal drugs?	❑ Yes	❑ No
Do any members of your family have a history of prescription drug abuse?	❑ Yes	❑ No
Do you have a history of alcohol abuse?	❑ Yes	❑ No
Have you ever used illegal drugs?	❑ Yes	❑ No
Have you ever abused prescription drugs?	❑ Yes	❑ No
Have you ever been in drug or alcohol treatment?	❑ Yes	❑ No
If Yes: When?_____ Where?_____		

Review of Systems

A review of systems allows us to be more thorough in our evaluation and help prevent missing any information that may affect your pain. Please check the boxes next to any symptoms listed below which you have ***recently*** been experiencing on a ***frequent*** basis.

Constitution	Head, Ears, Nose, Throat	Respiratory	Cardiovascular	GI
□ Activity Change	□ Ear pain	□ Stop breathing during sleep (apnea)	□ Chest pain	□ Abdominal pain
□ Chills	□ Hearing loss	□ Difficulty breathing when flat	□ Leg Swelling	□ Blood in stool
□ Fatigue	□ Nosebleeds	□ Chest tightness	□ Irregular Heartbeat	□ Constipation
□ Fever	□ Ringing in ears	□ Shortness of breath		□ Diarrhea
□ Unexpected Weight Change	□ Trouble Swallowing	□ Wheezing		□ Nausea
				□ Rectal pain
				□ Vomiting

Eyes	Endocrine	Urinary System	Musculoskeletal	Skin
□ Eye pain	□ Cold intolerance	□ Difficulty urinating	□ Joint Pain	□ Color change
□ Light sensitive	□ Heat intolerance	□ Urinary Frequency	□ Gait problem	□ Rash
□ Blurry Vision	□ Excessive thirst	□ Urinary Urgency	□ Joint swelling	□ Open Wound
	□ Excessive Hunger		□ Muscle cramps	
			□ Neck stiffness	

Allerg/Immuno	Neurological	Hematologic	Psychiatric
□ Environmental allergies	□ Dizziness	□ Bruises/bleeds easily	□ Confusion
□ Food allergies	□ Facial asymmetry		□ Decreased concentration
	□ Headaches		□ Depressed
	□ Light-headedness		□ Hallucinations
	□ Numbness		□ Nervous/anxious
	□ Seizures		□ Self-injury
	□ Speech difficulty		□ Sleep disturbances
	□ Fainting		□ Suicidal ideas
	□ Tremors		
	□ Weakness		

The Keele STarT Back Screening Tool

Thinking about the **last 2 weeks** check your response to the following questions	**Disagree**	**Agree**
1 My back pain has spread down my leg(s) at some point in the last 2 weeks	☐	☐
2 I have had pain in the shoulder or neck at some time in the last 2 weeks	☐	☐
3 I have only walked short distances because of my back pain	☐	☐
4 In the last 2 weeks, I have dressed more slowly than usual because of my back pain	☐	☐
5 It's not really safe for a person with a condition like mine to be physically active	☐	☐
6 Worrying thoughts have been going through my mind a lot of the time	☐	☐
7 I feel that my back pain is terrible and it's never going to get any better	☐	☐
8 In general I have not enjoyed all the things I used to enjoy	☐	☐

9 Overall, how bothersome has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very Much	Extremely
☐	☐	☐	☐	☐

Pain Disability Questionnaire

Instructions: This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by circling ONE number in each section for the statement which best applies to you *today*.

Fill out **Back** or **Neck** section. If you are experience both back and neck pain, complete **both** sections.

Back Pain – lumbar, hips or legs

Section 1- Pain Intensity
0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment
3. The pain is fairly severe at the moment
4. The pain is very severe at the moment
5. The pain is the worst imaginable at the moment

Section 2- Personal Care (washing, dressing etc.)
0. I can look after myself normally without causing increased pain
1. I can look after myself normally but it increases my pain
2. It is painful to look after myself and I am slow and careful
3. I need some help but manage most of my personal care
4. I need help every day in most aspects of self-care
5. I do not get dressed; I wash with difficulty and stay in bed.

Section 3- Lifting
0. I can lift heavy weights without increased pain
1. I can lift heavy weights but it causes increased pain
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned
3. Pain prevents me from lifting heavy weight, but I can manage light to medium weights if they are conveniently positioned
4. I can lift very light weights
5. I cannot lift or carry anything at all

Section 4 – Walking
0. Pain does not prevent me walking any distance
1. Pain prevents me from walking more than 1 mile
2. Pain prevents me from walking more than ¼ mile
3. Pain prevents me from walking more than 100 yards
4. I can only walk with crutches or a cane
5. I am in bed most of the time and have to crawl to the toilet

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 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. Pain prevents me from sitting at all

Section 6 – Standing
0. I can stand as long as I want without increased pain
1. I can stand as long as I want but it increases my pain
2. Pain prevents me from standing for more than 1 hour
3. Pain prevents me from standing for more than ½ hour
4. Pain prevents me from standing for more than 10 mins
5. Pain prevents me from standing at all

Section 7 – Sleeping
0. My sleep is never disturbed by pain
1. My sleep is occasionally disturbed by pain
2. Because of pain I get less than 6 hours sleep
3. Because of pain I get less than 4 hours sleep
4. Because of pain I get less than 2 hours sleep
5. Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)
0. My sex life is normal and causes no increase in pain
1. My sex life is normal but causes some increase in pain
2. My sex life is nearly normal but is very painful
3. My sex life is severely restricted by pain
4. My sex life is nearly absent because of pain
5. Pain prevents any sex life at all

Section 9 – Social life
0. My social life is normal and does not increase my pain
1. My social life is normal but increases my level of pain
2. Pain prevents me from participating in more energetic activities (ex. sports, dancing etc.)
3. Pain prevents me from going out very often
4. Pain has restricted my social life to my home
5. I have hardly any social life because of my pain

Section 10 – Travelling
0. I can travel anywhere without increased pain
1. I can travel anywhere but it increases my pain
2. My pain restricts travel over 2 hours
3. My pain restricts my travel over 1 hour
4. My pain restricts my travel to short necessary journeys under ½ hour
5. My pain prevents all travel except for visits to the doctor./therapist or hospital

Neck Pain – neck, shoulder or arms

Section 1 -Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Section 2- Personal Care (washing, dressing etc.)

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally, but it causes extra pain.
2. It is painful to look after myself, and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of my self-care.
5. I do not get dressed; I wash with difficulty and stay in bed.

Section 3- Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned for example on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift only very light weights.
5. I cannot lift or carry anything.

Section 4- Reading

0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want to with slight pain in my neck.
2. I can read as much as I want to with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I can hardly read at all because of severe pain in my neck.
5. I cannot read at all.

Section 5- Headaches

0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all the time.

Section 6- Concentration

0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7- Work

0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Section 8- Driving

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive at all because of severe pain in my neck.
5. I cannot drive my car at all.

Section 9- Sleeping

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

Section 10- Recreation

0. I am able to engage in all of my recreational activities with no neck pain at all.
1. I am able to engage in all of my recreational activities with some pain in my neck.
2. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
3. I am able to engage in a few of my usual recreational activities because of pain in my neck.
4. I can hardly do any recreational activities because of pain in my neck.
5. I cannot do any recreational activities at all.

Please provide any additional information you would like us to be aware of in the space below:

Patient Signature: _____ Date:_____

Thank you for providing us with this information. It is very useful in allowing us to make a thorough evaluation of your pain problem.

Please return completed form. *You can mail, fax, or drop off at the clinic.*

Montana Spine & Pain Center
500 W Broadway, 3rd Floor
Missoula, MT 59802
FAX: (406) 329-5697

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Physical Findings

Pain behavior: ❑ None ❑ Mild ❑ Moderate ❑ Severe
Gait: ❑ Normal ❑ Spastic ❑ Antalgic ❑ Heel/Toe_____ Squat_____

Cervical Spurling _____ Hoffman _____

Range of motion
Palpation
Reflexes
Sensory
Motor

Thoracolumbar SLR_____ Figure 4 _____ Hip Exam _____

Range of motion
Palpation
Reflexes
Sensory
Motor

Synthesis

This document was reviewed on _____ at _____
Date *Time*
by: _____
Signature