Reset Form

SpineTeam Spokane | The Pain Center Diagnostic & Treatment | TeamRehab Spine & Extremity Specialists

PATIENT NAME _____ EMAIL: _____

STREET _____ CITY, STATE, ZIP _____

HOME PHONE _____ EMPLOYED: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Unemployed

WORK PHONE _____ EMPLOYER _____

CELL PHONE _____ EMPLOYER ADDRESS _____

DATE OF BIRTH _____ GENDER: ☐ M ☐ F SOCIAL SECURITY # _____

MARITAL STATUS ☐ Married ☐ Divorced ☐ Widowed ☐ Single SPOUSE EMPLOYED: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Unemployed

SPOUSE NAME _____ SPOUSE DATE OF BIRTH _____

SPOUSE WORK PHONE _____ SPOUSE'S SS# _____

EMERGENCY CONTACT _____ PHONE _____

(IF SPOUSE IS EMERGENCY CONTACT, PLEASE INCLUDE A SEPARATE PHONE NUMBER OTHER THAN HOME PHONE ABOVE)

COMPLETE INSURANCE IN FULL

MEDICAL INSURANCE - *If you want us to bill your insurance, **you must bring your card** to your first appointment, otherwise, services are payable in full at time of service. Deductibles & co-pays are always due at time of service.*

PRIMARY INSURANCE _____ POLICY HOLDER _____

POLICY NUMBER _____ GROUP # _____ RELATIONSHIP _____

DEDUCTIBLE _____ CO-PAY _____ BIRTH DATE _____

SECONDARY INSURANCE _____ POLICY HOLDER _____

POLICY NUMBER _____ GROUP # _____ RELATIONSHIP _____

DEDUCTIBLE _____ CO-PAY _____ BIRTH DATE _____

REQUIRED FOR WORKMAN'S COMP

DATE OF INJURY _____ STATE _____

CLAIMS ADJUSTOR _____

TELEPHONE _____

ATTENDING PHYSICIAN _____

ATTORNEY _____

REQUIRED FOR AUTOMOBILE ACCIDENT

DATE OF ACCIDENT _____ STATE _____

INSURANCE NAME _____

POLICY# _____

POLICY HOLDER _____

NOTE: THIRD PARTY INSURANCE REQUIRES LEIN OR PRE-PYMTS

PAYMENT AUTHORIZATION / ASSIGNMENT OF BENEFITS / MEDICARE BENEFITS / RECEIPT OF PRIVACY POLICY

I understand that professional services at SpineTeamSpokane are contingent upon my compliance with the recommended treatment plan.
I understand that I may not be allowed to reschedule an appointment that is canceled with less than 24 hours notice.
I have listed all medical insurance for which I am eligible to the best of my knowledge and will notify you of any changes in my health coverage.
I understand that regardless of insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I request that payment of authorized medical benefits be made on my behalf to SpineTeamSpokane or its authorized representative for any services furnished me by that physician/supplier.

FOR MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to SpineTeamSpokane or its authorized representative for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of SpineTeamSpokane's Notice of Privacy Practices. I understand that these practices are subject to change without notice and that a copy of the current policy is posted in the office at all times.

SIGNATURE REQUIRED ✕ _____ **Date** _____

SPINETEAM Spokane

509.363.3100

THE PAIN CENTER Diagnostic & Treatment

1117 N Evergreen Rd Suite 2, Spokane, WA 99216

510 E Holland Ave, Spokane, WA 99218

FOR OFFICE USE ONLY

Date of Initial Evaluation

PATIENT INFORMATION

Name _____ Date of Birth _____ Age _____

Street _____ City _____ State _____

Phone #_____ ZIP _____

Is your condition: related to a **work** injury? ☐ NO ☐ YES, Date: _____

related to **auto accident**? ☐ NO ☐ YES, Date: _____

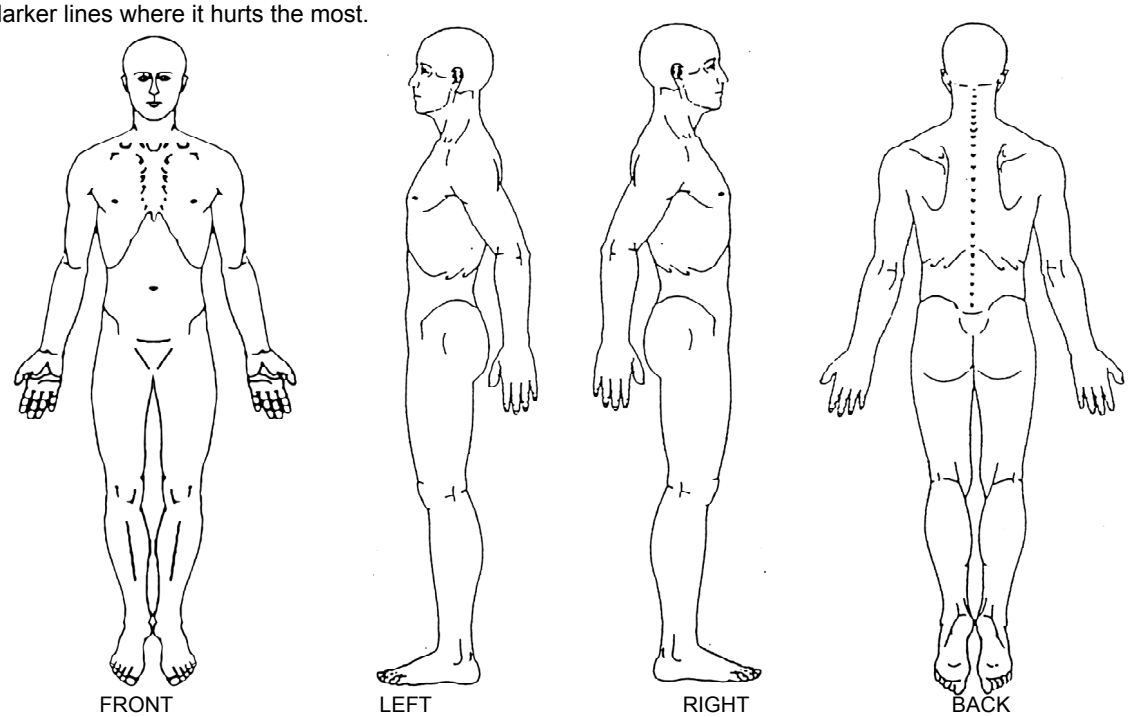
involved in a **lawsuit**? ☐ NO ☐ YES, Attorney: _____

Primary Care Physician _____ Date of last visit _____

Which doctor referred you? _____ Date of last visit _____

HISTORY

Where is your pain? Draw on the pictures below to show where your pain starts and where it spreads to. Use darker lines where it hurts the most.



FRONT LEFT RIGHT BACK

N + -
T + -
W + -

Which **one** problem would you like to focus on?

☐ Back ☐ Neck ☐ Shoulder(s)
☐ Leg(s) ☐ Headache ☐ Joint: _____
☐ Arm(s) ☐ Hand(s) ☐ Other:_____

Describe what the pain **feels** like (check all that apply)

☐ Sharp ☐ Radiating ☐ Other _____
☐ Dull ☐ Burning ☐ Other _____

Is the pain **constant**? ☐ YES ☐ NO - how often does it occur:_____
- is brought on by:_____
- lasts for how long: _____

Do you also experience:

	NO	YES: arms/hands	YES: legs/feet	YES: other
Weakness of muscles?	☐	☐	☐	☐ _____
Numbness (loss of feeling)?	☐	☐	☐	☐ _____
Tingling ("falling asleep")?	☐	☐	☐	☐ _____

Patient Name _____ (required for each page)

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To show your pain levels, place each letter (P, W, L, M) in the appropriate box on the graph below:

P = your present pain
W = the worst the pain gets
L = the least the pain gets
M = the pain you are at most of the time

0	1	2	3	4	5	6	7	8	9	10
No pain	Little bit		Little More		Even More			Whole Lot		Worst Pain Imaginable

WHEN did your pain begin? _____

HOW LONG 4+?_____

HOW did your pain begin? (check all that apply)

- ☐ Auto accident
- ☐ At home
- ☐ At work
- ☐ Bending
- ☐ Pulling
- ☐ Other/Explain _____
- ☐ Sports
- ☐ Fall
- ☐ Twisting
- ☐ No apparent cause

What makes your pain **WORSE**? (check all that apply)

- ☐ Standing
- ☐ Bending
- ☐ Exercise
- ☐ Other/Explain _____
- ☐ Walking
- ☐ Sitting/Driving
- ☐ Climbing Stairs
- ☐ Morning
- ☐ Night
- ☐ Touching Skin
- ☐ Stress / Worry
- ☐ Cold Weather

What makes your pain **BETTER**? (check all that apply)

- ☐ Medication
- ☐ Injections
- ☐ Alcohol
- ☐ Standing
- ☐ Sitting
- ☐ Walking
- ☐ Exercise
- ☐ Sleeping
- ☐ Lying Down -if so, hours per day NOT sleeping:_____
- ☐ Heat
- ☐ Bath / Shower

Have you had any **TREATMENTS** to help your pain?

	NO	YES, Helped	YES, but did NOT Help	WHERE and WHEN? (year only)
Surgery	☐	☐	☐	_____
Physical Therapy	☐	☐	☐	_____
Trigger Point Injections	☐	☐	☐	_____
Epidural Injections	☐	☐	☐	_____
TENS unit (Nerve stimulator)	☐	☐	☐	_____
Chiropractor	☐	☐	☐	_____
Counseling	☐	☐	☐	_____
Relaxation / Hypnosis	☐	☐	☐	_____
Medications	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

 # VISITS LAST 12MOS?____
WHY STOPPED-

Have you had any relavent **IMAGING** tests?

MRI	☐ NO	☐ YES	_____
XRAY	☐ NO	☐ YES	_____
BONE SCAN	☐ NO	☐ YES	_____
OTHER _____	☐ NO	☐ YES	_____

TYPICAL DAILY ACTIVITIES currently consist of: (check all that apply)

- ☐ Exercising
- ☐ Stretching
- ☐ Napping, #hrs: _____
- ☐ Sitting / Relaxing, #hrs: _____
- ☐ Walking, #hrs: _____
- ☐ Other _____
- ☐ Physical labor, #hrs: _____
- ☐ Employment, #hrs: _____

ACTIVITIES you used to able to do that you **cannot** do now because of the pain:

1) _____
2) _____
3) _____
4) _____

SPECIFIC MOVEMENTS:

How much do you **SLEEP** at night? _____ hrs

Do you have trouble **falling** asleep?	☐ YES	☐ NO
Do you have trouble **staying** asleep?	☐ YES	☐ NO
Does the pain **wake** you up?	☐ YES	☐ NO

Patient Name _____ (required for each page)

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CURRENT PAIN MEDICATION you take **NOW**:

Name of pill	Dose	How Many Qty# / Day	How Often (# hours)	How Long (#mos/yrs)	Does it Help? YES	NO	Last time taken:
					☐	☐	-
					☐	☐	-
					☐	☐	-
					☐	☐	-

PAST PAIN MEDICATIONS you are **not** currently taking:

Name of pill	Dose	Qty# / Day	Why did you stop taking this medicine? (side effects, didn't work, etc.)	WHY STOPPED-

OTHER CURRENT MEDICATIONS you are taking **NOW** (**not** pain pills):

Name of pill	Dose	For What?	Who prescribed?	Last time taken:
				-
				-
				-
				-
				-

ALLERGIES to medications: no known drug allergies ☐

What happens if you take it? (rash, vomitting, swelling, etc.)

_____ _____

_____ _____

Do you have any of the following **medical problems**? (check all that apply)

☐ Heart	☐ Strokes / TIA's	☐ Nausea / Vomiting	☐ Achy muscles
☐ High Blood Pressure	☐ Pacemaker	☐ Constipation / Diarrhea	☐ Headaches
☐ Chest Pains	☐ Seizures	☐ Stomach Disorders	☐ Eyes, vision, spots
☐ Lung	☐ Diabetes	☐ Insomnia	☐ Bright lights hurt
☐ Breathing Problems	☐ Cancer	☐ Too much sleep, fatigue	☐ Depression
☐ Asthma	☐ Bleeding Disorders	☐ Muscle Spasms	☐ Anxiety
☐ Kidney	☐ Blood Thinness	☐ Numbness: _____	☐ Mental Disorder
☐ Liver	☐ Arthritis	☐ Weakness: _____	☐ Bowel or Bladder
			☐ Other _____

List all previous **surgeries**:

Name of Surgery	What year?	Where was it done?

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Women Only - Are you pregnant or planning to be in the near future? ☐ NO ☐ YES, when?_____

Are you currently **working**? ☐ NO ☐ YES Occupation: _____

Do any of the following medical problems **run in your FAMILY**? (check all that apply)

☐ Heart Problems	☐ Strokes / TIA's	☐ Sleeping Disorders	☐ Stomach Disorders
☐ High Blood Pressure	☐ Seizures	☐ Depression	☐ Headaches
☐ Breathing Problems	☐ Diabetes	☐ Anxiety	☐ Vision Disorders
☐ Cancer	☐ Bleeding Disorders	☐ Other _____	

Have you ever **smoked** regularly? ☐ NO ☐ YES If yes, how much per day? _____
how many years? _____
when did you quit? _____

Have you ever drank **alcohol** regularly? ☐ NO ☐ YES If yes, how much per day? _____
how many years? _____
when did you quit? _____

PATIENT SIGNATURE DATE PHYSICIAN DATE

SPINETEAM Spokane

THE PAIN CENTER Diagnostic & Treatment

PAIN QUESTIONNAIRE (REVISED OSWESTRY)

Please Read: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel more than one statement may relate to you, but **PLEASE CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 – Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing, even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Due to pain I am unable to do some washing and dressing without help.
F. Due to pain I am unable to do any washing or dressing without help.

SECTION 3 –Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weight off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
E. Pain prevents me from lifting heavy weights, but I manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 – Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking ¼ mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

SECTION 6 – Standing
A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain
D. I cannot stand for longer than ½ hour without increasing pain
E. I cannot stand for longer than 10 minutes without increasing pain.
F. I avoid standing because it increases the pain right away.

SECTION 7 – Sleeping
A. Pain does not prevent me from sleeping well.
B. I can sleep well only by using medications.
C. Even when I take medications I have less than 6 hours sleep.
D. Even when I take medications I have less than 4 hours sleep.
E. Even when I take medications I have less than 2 hours sleep.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
D. Pain restricts my social life and I do not go out very often.
E. Pain restricts my social life to my home.
F. I have hardly any social life due to pain.

SECTION 9 – Traveling
A. I can travel anywhere without extra pain
B. I can travel anywhere but it gives me extra pain.
C. Pain is bad but I manage journeys over 2 hours.
D. Pain is bad but I manage journeys less than 2 hour.
E. Pain restricts me to short necessary journeys under 30 minutes.
F. Pain prevents me from traveling except to the doctor or hospital.

SECTION 10 – Changing Degree of Pain
A. My pain is rapidly getting better
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Signature _____

Date _____