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SPINE & PAIN CENTER

Patient Information

First Name
Last Name
Date Of Birth
Today's Date
Address
Mobile Phone
Home Phone
City/State
Zip Code
Employer Name
Work Phone
Email
Primary Care Physician
PCP Phone
Date Of Birth
Gender
Referring Physician
Referring Phone

Emergency Information

Name
Phone
Relationship

Insurance Information

Primary Insurance
Subscriber Name
Subscriber DOB
Subscriber ID
Group Number

Secondary Insurance
Subscriber Name
Subscriber DOB
Subscriber ID
Group Number

If Applicable Chose one

- [ ] Workers Compensation Insurance
- [ ] Motor-Vehicle Accident Insurance
- [ ] Personal Injury

Insurance Name
Insurance Phone
Date of Injury
Insurance Address
City/State
Zip Code
Emloyer at the time of Injury
Date of Injury
Claim#
Adjustor's Name
Adjustor's Phone
Email
Attorney's Name
Attorney's Phone
Email

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Allergies

- [ ] Penicillin
- [ ] Sulfa
- [ ] IV Dye/Contrast
- [ ] Topical Iodine
- [ ] Shellfish
- [ ] Latex
- [ ] None
- [ ] Other ______

Current Medications

Medication	Dosage	Instructions

Past Medical History (check or list)

- [ ] Aneurysm
- [ ] Arthritis
- [ ] Asthma
- [ ] Blood Clots
- [ ] Hypertension
- [ ] Cancer
- [ ] Hyperlipidemia
- [ ] COPD
- [ ] Diabetes
- [ ] Fibromyalgia
- [ ] Heart Disease
- [ ] Osteoporosis
- [ ] Stroke
- [ ] Migraine
- [ ] Congestive Heart Failure
- [ ] Other ______

Family Medical History (Please distinguish relationship i.e.: Mother, Father, Sibling, Grandparents...)

______

Surgeries (Please list & Include Location, Date, Operating Physician)

______

Social History & Occupation

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Widowed
- [ ] Separated
- [ ] Engaged

Occupation ______

How did you find us?

- [ ] Google
- [ ] Facebook
- [ ] Word of mouth
- [ ] Billboard
- [ ] Reffered by MD
- [ ] Website
- [ ] News Media
- [ ] Other ______

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Tobacco/Alcohol/Supplements

Tobacco? ☐ Yes ☐ No

Frequency

Alcohol? ☐ Yes ☐ No

Frequency

Coffee/Tea/Soda ? ☐ Yes ☐ No

Frequency

Substance Abuse History (I.E. Marijuana, Cocaine, Narcotics, Amphetamines...) **Describe?**

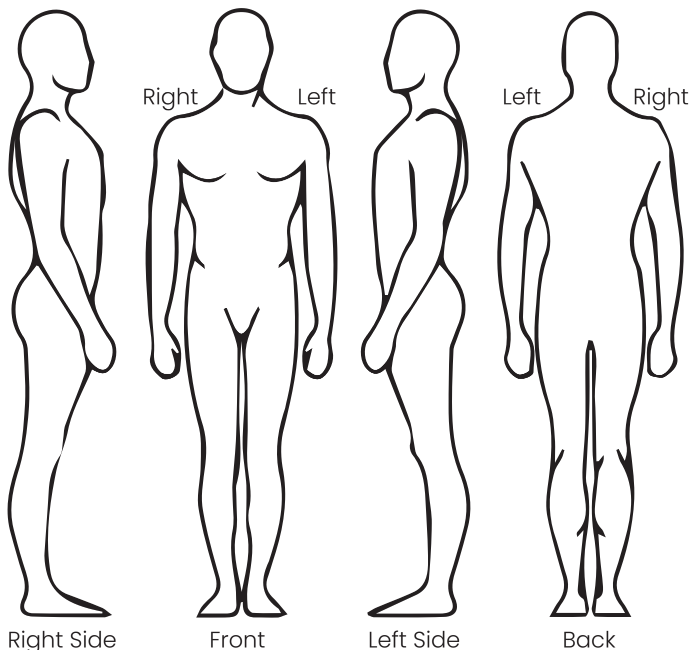
Mental Health History

☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ Other

Communicable Diseases (I.E. STD's, Hepatitis, HIV/AIDS...) **List:**

Pain Assessment

Mark the Areas of Pain



Check The Words That Best Describes Your Pain

☐ Dull
☐ Shooting
☐ Radiating
☐ Aching
☐ Sharp
☐ Burning
☐ Cramping
☐ Throbbing
☐ Other

☐ Tingling
☐ Pulling
☐ Unbearable
☐ Numb
☐ Electric
☐ Tearing
☐ Stabbing
☐ Pounding

Height (in)

Weight (lbs)

Pain Score (check your pain score below)

No Pain — Moderate Pain — Severe Pain

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Pain Assessment (Cont'd)

Are you Experiencing any Weakness? ☐ Yes ☐ No

What is the frequency of your pain? ☐ Constant ☐ Intermittent

Are you experiencing any Loss of Bowel/Bladder Control? ☐ Yes ☐ No

Are you, or could you be pregnant? ☐ Yes ☐ No

How Long has the pain been present?

____

How Did the Injury or Pain Occur?

____

Has your pain affected your daily activities or relationships with family or friends? ☐ Yes ☐ No

If Yes, Please Explain

____

Is there anything that worsens the pain?

☐ Bending	☐ Coughing	☐ Daily Activities	☐ Neck Movement	☐ Twisting
☐ Kneeling	☐ Lifting	☐ Lying Down	☐ House Work	☐ Prolonged Positions
☐ Sitting	☐ Standing	☐ Sneezing	☐ Stretching	☐ Getting Dressed
☐ Weather Changes	☐ Walking	☐ Stairs	☐ Other ________	

Is there anything that makes the pain better?

☐ Rest	☐ Bending Forward	☐ Twisting	☐ Massage	☐ Bending Backward
☐ Heat	☐ Ice	☐ Walking	☐ Laying	☐ Switching Positions
☐ Muscle Relaxant	☐ Opiods	☐ Stretching	☐ NSAIDs	

Does your Pain radiate? If Yes, Chose below ☐ Yes ☐ No

☐ Right Arm	☐ Left Arm	☐ Right Leg	☐ Left Leg	☐ Orbit
☐ Buttocks	☐ Shoulder Blades	☐ Other ________		

Have you missed work due to your condition? ☐ Yes ☐ No If so, what date? ________

Are you currently on work restrictions? ☐ Yes ☐ No

If yes, explain

____

Are you taking anti-coagulants or "blood thinners"? ☐ Yes ☐ No

If Yes, Please check below

☐ Plavix	☐ Coumadin	☐ Eliquis	☐ Xarelto	☐ Pradaxa
☐ Aspirin	☐ Other ________			

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Current/Previous Treatments

Have you tried Therapy (Physical, Chiropractic, Occupational, or Massage Therapy)? ☐ Yes ☐ No

If yes, list below the type of therapy, most recent visit, length of treatment, and length of relief

Have you tried a home exercise program? ☐ Yes ☐ No If yes, when did you start?

List below the type of exercise, duration(minutes), and frequency (times per week)

Have you had previous Injection Therapy? ☐ Yes ☐ No

If yes, list below (Type of Injection, Date, Length of relief)

Have you had any of the following Imaging/tests to evaluate your pain? (check all that apply)

☐ MRI ☐ X-Ray ☐ CAT Scan ☐ Bone Scan ☐ EMG/Nerve Conduction
☐ Vascular Studies ☐ Ultrasound ☐ FCE ☐ PET ☐ None

Other

Please list when the test was performed, facility, and area tested:

Review of Systems

Constitutional	Yes	No
Chills	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No
Weight Change	☐ Yes	☐ No

Gastrointestinal	Yes	No
Abdominal pain	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No

Cardiovascular	Yes	No
Chest pain	☐ Yes	☐ No
Claudication	☐ Yes	☐ No
Edema	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No

Hematology	Yes	No
Bleeding	☐ Yes	☐ No
Bruising	☐ Yes	☐ No
Anemia	☐ Yes	☐ No

Musculoskeletal	Yes	No
Back Pain	☐ Yes	☐ No
Joint Stiffness	☐ Yes	☐ No
Limb Pain	☐ Yes	☐ No

Neurologic	Yes	No
Dizziness	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

256-646-7246
256-304-5333
www.reliefspineandpaincenter.com
1403 Old Water Works Rd SW, Fort Payne AL 35968

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Previous Medications Tried (at any point in the past)

- [ ] Ibuprofen
- [ ] Tylenol
- [ ] Diclofenac
- [ ] Tylenol #3/4
- [ ] Celebrex
- [ ] BC powder
- [ ] Advil/Aleve
- [ ] Tramadol
- [ ] Roxicodone
- [ ] Morphine
- [ ] Hydromorphone
- [ ] Nucynta
- [ ] Butrans
- [ ] Fentanyl Patch
- [ ] Belbuca
- [ ] Oxycodone
- [ ] Celexa/citalopram
- [ ] Wellbutrin
- [ ] Remeron
- [ ] Zyprexa/olanzapine
- [ ] Trintellix/vortioxetine
- [ ] Wellbutrin
- [ ] Remeron
- [ ] Roxicodone
- [ ] Paxil/paroxetine
- [ ] Zoloft/Sertraline
- [ ] Naproxen
- [ ] Hysingla
- [ ] Buprenorphine
- [ ] Effexor/venlafaxine
- [ ] Fioricet
- [ ] Cymbalta
- [ ] Meloxicam
- [ ] Hydrocodone
- [ ] Methadone
- [ ] Trintellix/vortioxetine
- [ ] Wellbutrin
- [ ] Remeron
- [ ] Roxicodone
- [ ] Paxil/paroxetine
- [ ] Percocet
- [ ] Lexapro
- [ ] Luvox
- [ ] Prozac/Fluoxetine
- [ ] Other

Opioid Risk Tool (ORT)

Instructions Please mark "Yes" or "No" for each question, depending on if it applies to you.

Question	Yes	No
Has there been a family history of alcohol abuse?	☐ Yes	☐ No
Has there been a family history of illegal drug use?	☐ Yes	☐ No
Has there been a family history of recreational drug use?	☐ Yes	☐ No
Has there been a personal history of alcohol abuse?	☐ Yes	☐ No
Has there been a personal history of illegal drug use?	☐ Yes	☐ No
Has there been a personal history of recreational drug use?	☐ Yes	☐ No
Are you aged between 16 - 45 years?	☐ Yes	☐ No
Has there been a history of preadolescent sexual abuse?	☐ Yes	☐ No
Has there been a personal history of Attention Deficit Disorder (ADD or ADHD), bipolar, or schizophrenia?	☐ Yes	☐ No
Has there been a personal history of depression?	☐ Yes	☐ No

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Patient Health Questionnaire-9 (PHQ-9)

Instructions Over the last 2 weeks, how often have you been bothered by any of the following issues? Please check the response that best describes your experience.

Questions	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, like reading the newspaper or watching TV	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐

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Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

No Disability ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Total Disability**

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Total Disability**

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Total Disability**

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Total Disability**

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Total Disability**

Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

No Disability ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Total Disability**

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping, and breathing.

No Disability ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Total Disability**

My signature confirms that the answers in this packet are accurate and stated to the best of my ability.

Pain Disability Index Total

(For clinic use)

Patient Signature

Date

Guardian Signature (if under 18)

Date