

Western Rockies Interventional Pain Specialists

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(970) 270-2259

New Patient Form

PATIENT LABEL:

At present pain is a _____ Worst pain gets _____ Best pain gets _____ Acceptable level of pain _____

VITAL _____

SIGNS BP _____ P _____ R _____ T _____ O2 Sat _____ Ht. _____ Wt. _____

Patient Information below this line:

What is the primary reason for your visit today? _____

List other health care providers involved with your pain care: _____

My Pain Check List:

Location: Please mark the location of pain on the drawing

My pain starts:

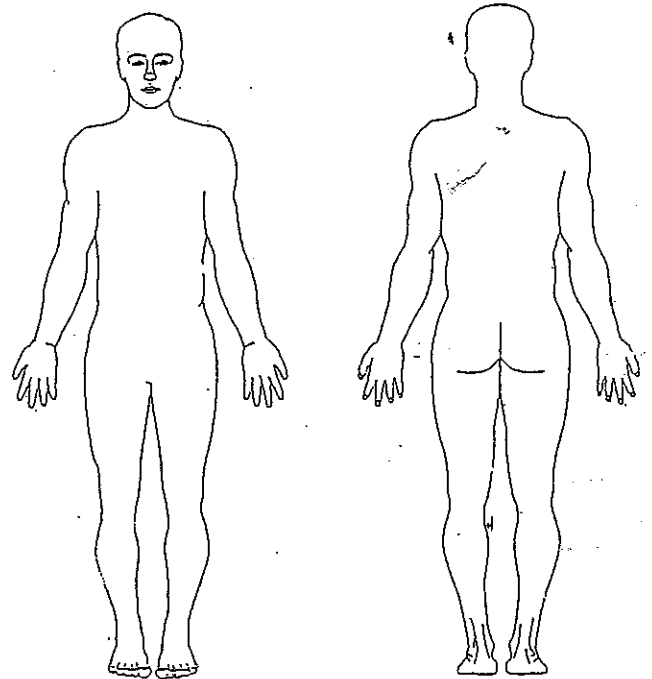
- | | |
|---|---|
| <input type="checkbox"/> suddenly | <input type="checkbox"/> sneaks up on me |
| <input type="checkbox"/> constantly present | <input type="checkbox"/> in certain positions |
| <input type="checkbox"/> at any time | <input type="checkbox"/> at certain times |
| <input type="checkbox"/> with certain motions | <input type="checkbox"/> when resting |
| <input type="checkbox"/> frequently | <input type="checkbox"/> occasionally |

The pain is:

- | | |
|--|---|
| <input type="checkbox"/> of short duration | <input type="checkbox"/> long lasting |
| <input type="checkbox"/> constant | <input type="checkbox"/> grows in intensity |
| <input type="checkbox"/> location specific | <input type="checkbox"/> radiating |
| <input type="checkbox"/> always equally strong | <input type="checkbox"/> varying |

The pain feels:

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> sharp | <input type="checkbox"/> dull |
| <input type="checkbox"/> burning | <input type="checkbox"/> aching |
| <input type="checkbox"/> stabbing | <input type="checkbox"/> pins and needles |



List activities limited by your pain: _____

Have you had any previous medical test or treatments for your pain? Yes/No

Test	Where	When	Treatments	Where	When	Helpful?
X-Ray			Spine Injection			Yes/No
MRI			Physical Therapy			Yes/No
CT SCAN			Chiropractor			Yes/No
EMG			Back Brace			Yes/No
Bone Density			Massage			Yes/No
Other			Other			Yes/No



LOW BACK PAIN SCALE

Date _____

Patient's Name _____

Please CIRCLE THE ONE NUMBER in each section which most closely describes your problem.
 PLEASE CHOOSE ONE NUMBER IN EVERY SECTION. Do not leave any section unanswered.

Section 1 – Pain Intensity

- 0. The pain comes and goes and is very mild.
- 1. The pain is mild and does not vary much.
- 2. The pain comes and goes and is moderate.
- 3. The pain is moderate and does not vary much.
- 4. The pain comes and goes and is severe.
- 5. The pain is severe and does not vary much.

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

- 0. I would not have to change my way of washing or dressing in order to avoid pain.
- 1. I do not normally change my way of washing or dressing even though it causes some pain.
- 2. Washing and dressing increase the pain but I manage not to change my way of doing it.
- 3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- 4. Because of the pain, I am unable to do some washing and dressing without help.
- 5. Because of the pain, I am unable to do any washing and dressing without help.

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 from lifting heavy weights off the floor.
- 3. Pain prevents me from lifting heavy weights off the floor, but I can manage if conveniently positioned, e.g., on a table.
- 4. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- 5. I can only lift very light weights at most.

Section 4 – Walking

- 0. I have no pain on walking.
- 1. I have some pain on walking but it does not increase with distance.
- 2. I cannot walk more than 1 mile without increasing pain.
- 3. I cannot walk more than ½ mile without increasing pain.
- 4. I cannot walk more than ¼ mile without increasing pain.
- 5. I cannot walk at all without increasing pain.

Section 5 – Sitting

- 0. I can sit in any chair as long as I like.
- 1. I can sit only in my favorite chair as long as I like.
- 2. Pain prevents me from sitting more than 1 hour.
- 3. Pain prevents me from sitting more than ½ hour.
- 4. Pain prevents me from sitting more than 10 minutes.
- 5. I avoid sitting because it increases pain immediately.

Section 6 – Standing

- 0. I can stand as long as I want without pain.
- 1. I have some pain on standing but it does not increase with time.
- 2. I cannot stand for longer than 1 hour without increasing pain.
- 3. I cannot stand for longer than ½ hour without increasing pain.
- 4. I cannot stand for longer than 10 minutes without increasing pain.
- 5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping

- 0. I get no pain in bed.
- 1. I get pain in bed but it does not prevent me from sleeping well.
- 2. Because of pain, my normal nights sleep is reduced by less than one-quarter.
- 3. Because of my pain, my normal nights sleep is reduced by less than one-half.
- 4. Because of my pain, my normal nights sleep is reduced by less than three-quarters.
- 5. Pain prevents me from sleeping at all.

Section 8 – Social Life

- 0. My social life is normal and gives me no pain.
- 1. My social life is normal but it increases the degree of pain.
- 2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- 3. Pain has restricted my social life and I do not go out very often.
- 4. Pain has restricted my social life to my home.
- 5. I have hardly any social life because of the pain.

Section 9 – Traveling

- 0. I get no pain when traveling.
- 1. I get some pain when traveling but none of my usual forms of travel make it any worse.
- 2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- 3. I get extra pain while traveling which compels me to seek alternative forms of travel.
- 4. Pain restricts me to short necessary journeys under ½ hour.
- 5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain

- 0. My pain is rapidly getting better.
- 1. My pain fluctuates but is definitely getting better.
- 2. My pain seems to be getting better but improvement is slow.
- 3. My pain is neither getting better or worse.
- 4. My pain is gradually worsening.
- 5. My pain is rapidly worsening.

Please rate the OVERALL severity of your pain by circling a number below:

※ no pain 0 1 2 3 4 5 6 7 8 9 10 unbearable pain ※

PHYSICIAN'S USE	
ODI _____ %	PAIN /10

Western Rockies Interventional Pain SpecialistsKenneth C. Lewis, MD
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Are you taking any blood thinners such as coumadin, aggrenox, plavix or aspirin? Yes/No

Are you allergic to contrast dye, iodine, shellfish or latex? Yes/No

List and indicate type of reaction: _____

List Medications:

Name	Dosage/Frequency

Previous Surgery:

Type of Surgery	Year	Reason

General Medical:

Heart problems Explain: _____	Yes/No	High blood pressure Explain: _____	Yes/No
Lung problems Explain: _____	Yes/No	Cancer Explain: _____	Yes/No
Liver disease Explain: _____	Yes/No	Ulcers Explain: _____	Yes/No
Kidney problems Explain: _____	Yes/No	Diabetes Explain: _____	Yes/No
Any disease of the nerves or muscles Explain: _____	Yes/No	Stroke Explain: _____	Yes/No
Drug or alcohol problems Explain: _____	Yes/No	Any previous fractures? Describe: _____	Yes/No
Psychiatric treatment Explain: _____	Yes/No	Any other serious injuries? Describe: _____	Yes/No
Other: _____			

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Social History: please check or complete as appropriate

Tobacco products _____ Smoking _____ How many packs a day _____ years used _____

Alcoholic beverages a day _____ Caffeinated beverages a day _____ Recreational drugs _____

Marital: Single _____ Married _____ Previous _____ Divorced _____ Widow/er _____

Children number and ages _____

Highest level of education achieved _____ Occupation _____

Current/last employment _____ Amount of time at current/last job _____

Family History: please list any known conditions affecting your biologic parents and relatives

Mother: Alive Yes/No. Age _____ Condition _____

Father: Alive Yes/No. Age _____ Condition _____

Other family conditions _____ Unknown _____

General:

How did you find out about us? (please circle) Phone Book, Internet, Friend, Family, News Paper

Do you need assistance getting to our office for visits?

I hereby consent to WRIPS medical and imaging records from previous providers as needed.

Patient's Signature: _____

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Patient Name: _____ Date: _____

REVIEW OF SYSTEMS

Check all that apply.

Constitutional

- Fever
- Chills
- Night sweats
- Weight loss
- Loss of appetite

Allergy / Immune

- Drug allergy
- Seasonal allergy
- Food allergy
- Iodine allergy
- Transplant

Neurologic

- Paralysis
- Tremors
- Spasticity
- Seizures
- Muscle atrophy
- Double vision
- Balance problems

Hemo / Lymphatic

- Anemia
- Excessive bleeding
- Lymphoma
- Leukemia
- Cancer
- Lymph node swelling
- Blood thinners

CV / Respiratory

- Shortness of breath
- Wheezing
- Coughing up Blood
- Chest pains
- Palpitations
- Leg swelling

HEENT

- Loss of vision
- Eye redness
- Dizziness
- Glaucoma
- Blurred vision
- Hearing loss

Musculoskeletal

- Joint stiffness / swelling
- Muscle pain / swelling
- Fatigue
- Fractures
- Walking problems
- Pelvic pain

Skin / Integumentary

- Rash
- Ulcer
- Eczema
- Hives
- Psoriasis

Endocrine

- Obesity
- Thyroid disorder
- Diabetes
- Menopause
- Menstrual irregularity
- Addison's Disease

Genitourinary

- Bladder control
- Blood in urine
- Dribbling
- Sexual difficulty
- Bowel control
- Pain urinating
- Pregnant

Psychiatric

- Poor sleep
- Depression
- Anxiety
- Stress
- Panic spells

Gastrointestinal

- Hard to swallow
- Heartburn
- Nausea / Vomiting
- Constipation
- Diarrhea
- Blood in stools
- Stomach pain

Last menstrual
Period _____

Reviewed by: Signature _____

WESTERN ROCKIES

INTERVENTIONAL PAIN SPECIALISTS

Kenneth C. Lewis, MD

Board Certified Anesthesiologist Specializing In Pain Management

www.WesternRockiesPainManagement.com

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*I understand there will be a \$50 charge billed to me, not my insurance company, for missed appointments or cancellations less than 24 hours in advance.

*I understand that a patient who receives medical services at Western Rockies Interventional Pain Specialists will receive 2 bills:

- 1) Family Health West will send the patient a bill for Outpatient Procedure Center charges (room, staff, equipment, supplies).
- 2) Western Rockies Interventional Pain Specialists will send the patient a separate bill for physician charges.

Print Name

Date

Signature