

# Western Rockies Interventional Pain Specialists

Kenneth C. Lewis, MD  
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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 \_\_\_\_\_  
SIGNNS 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:

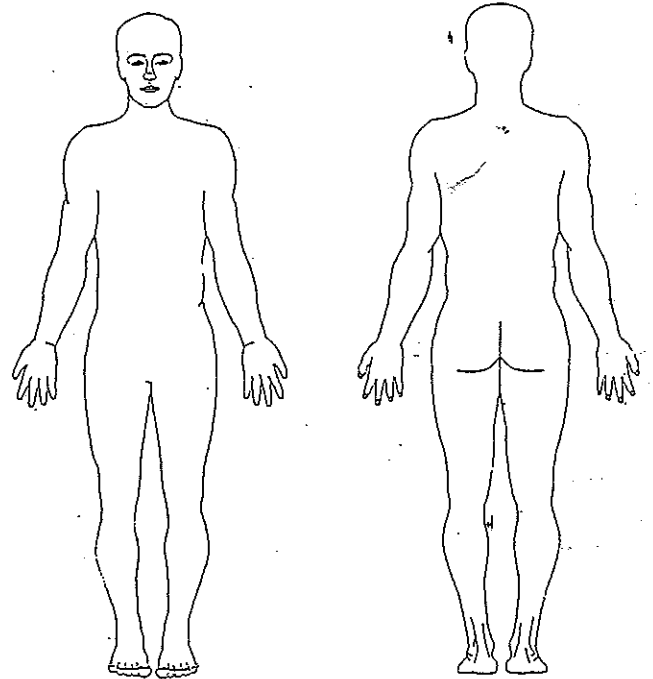
- |   |   |
|---|---|
| <input type="checkbox"/> suddenly             | <input type="checkbox"/> sneaks up on me      |
| <input type="checkbox"/> constantly present   | <input type="checkbox"/> in certain positions |
| <input type="checkbox"/> at any time          | <input type="checkbox"/> at certain 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



**NECK DISABILITY INDEX**

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. 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 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 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 self care.
- 5. I do not get dressed; I wash with difficulty and stay in bed.

**Section 7 – Work**

- 0. I can do as much work as I want to.
- 1. I can 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 can't do any work at all due to pain.

**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, but I can manage if conveniently positioned, e.g., on a table.
- 3. Pain prevents me from lifting heavy weights off the floor, 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 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 can't 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 can't drive my car at all due to pain.

**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 can't 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 due to pain.

**Section 9 – Sleeping**

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

**Section 5 – Headaches**

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

**Section 10 – Recreation**

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

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 Specialists**Kenneth 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](http://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