Western Rockies Interventional Pain Specialists
Kenneth C. Lewis, MD
Thomas J. Scruton, PA-C

551 Kokopelli Blvd.
Fruita, CO 81521
(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.

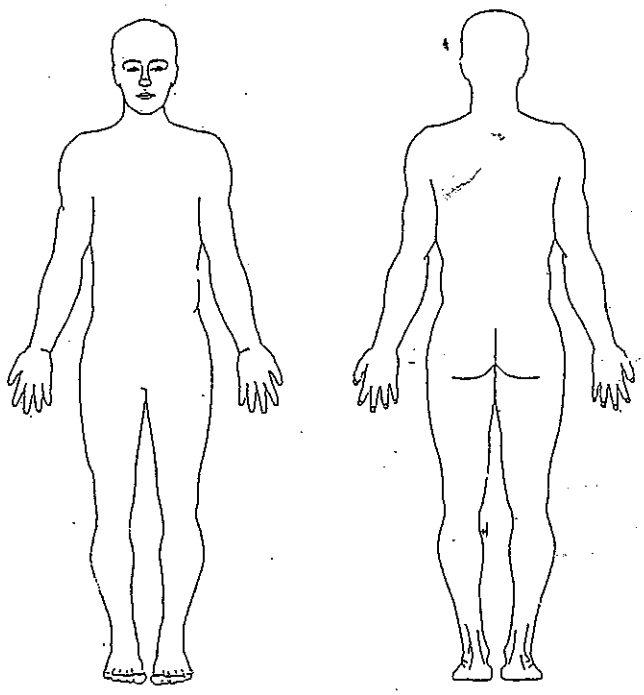
Patient Information below this line:

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:

____suddenly	____sneaks up on me
____constantly present	____in certain positions
____at any time	____at certain times
____with certain motions	____when resting
____frequently	____occasionally

The pain is:

____of short duration	____long lasting
____constant	____grows in intensity
____location specific	____radiating
____always equally strong	____varying

The pain feels:

____sharp	____dull
____burning	____aching
____stabbing	____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

Western Rockies

Pain Management.com

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Family Health West

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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

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Medication allergies: _____

_____

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

Last menstrual
Period_____

Psychiatric
__Poor sleep
__Depression
__Anxiety
__Stress
__Panic spells

Gastrointestinal
__Hard to swallow
__Heartburn
__Nausea / Vomiting
__Constipation
__Diarrhea
__Blood in stools
__Stomach pain

Reviewed by: Signature_____

WESTERN ROCKIES
INTERVENTIONAL PAIN SPECIALISTS
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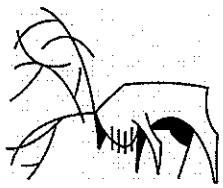

*I understand there will be a $50 charge billed to me, not my insurance company, for missed appointments or cancellations less than 24 hours in advance.

*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