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.

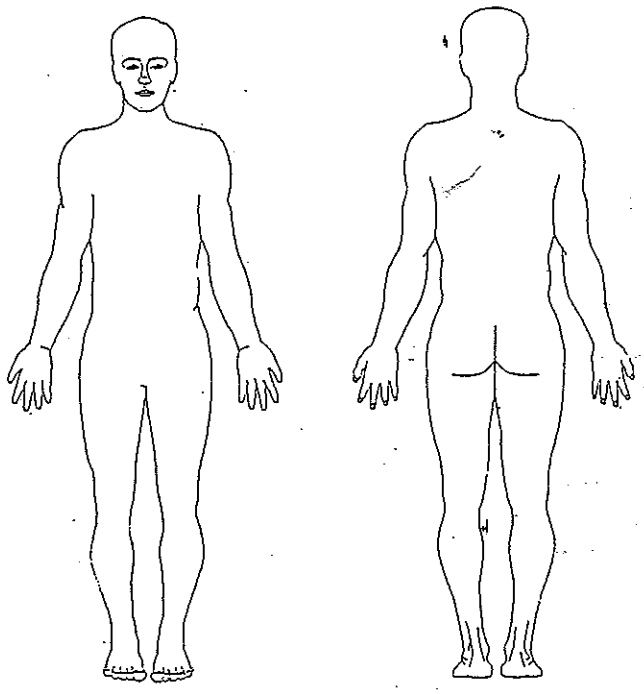
Patient Information below this line:

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

The pain is:

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

The pain feels:

____sharp
____burning
____stabbing
____dull
____aching
____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

@ Family Health West

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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 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 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 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 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 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 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 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 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 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

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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