BLUE RIDGE
ORTHOPAEDIC &
SPINE CENTER

Daniel Heller, M.D.
Blue Ridge Orthopaedic Pain Management
(EVL1, HPK)

In order to provide you with the highest level of care possible, it is very important to know as much as possible about your clinical condition, your previous medical treatment/history and current medical condition.

It is necessary to have this information at your first appointment with the pain specialists. Please complete this **ENTIRE** document PRIOR to that first appointment, and bring it with you, along with your MRI films/CD and other diagnostic films.

Please do not be concerned if the questionnaire items do not match your symptoms or your situation exactly – just choose the items that are CLOSEST match. Or, you can change the items slightly to better match your symptoms – for example, if the item refers to back or leg pain and you are experiencing neck or arm pain, just write in the correct locations and then answer the questions for your specific situation.

In any case, you will have ample opportunity to describe your situation during your appointment.

Thank you for your time in working with us to address your painful condition.

Daniel Heller, MD

Patient Name: _____ Date of Appointment: ____/____/_____

1. Where are you having the most severe pain?

2. When did it start? _____

3. Is your pain? [ ] constant [ ] Intermittent

4. Is your injury/condition work/MVA related? [ ] Yes [ ] No [ ] Unsure

   If yes; date of injury: _____ / _____ / _____

5. Are you currently working? [ ] Yes [ ] No Retired? Disabled?

6. Indicate what activity, if any, seemed to CAUSE your current pain condition:

7. What makes your pain better? (Name 3 things if you can, i.e. standing, sitting, and changing position, certain medications, rest…)

8. What makes your pain worse? (Name 3 things if you can, i.e. standing, sitting, walking, lying down…)

9. Are you currently taking any prescribed pain medications? If so what medications and doses?

10. If you are taking pain medications are they helping?

11. Please name 3 things you are able to do that you would not be able to do without the help of the medications? (ie. sleep or rest, work, stand longer, sit longer, do heavy chores…)

11. **Previous Treatment**

Please indicate if you have received any of the following treatments for your Pain condition, when the treatment occurred, and whether the outcome was positive (+) or negative (-)

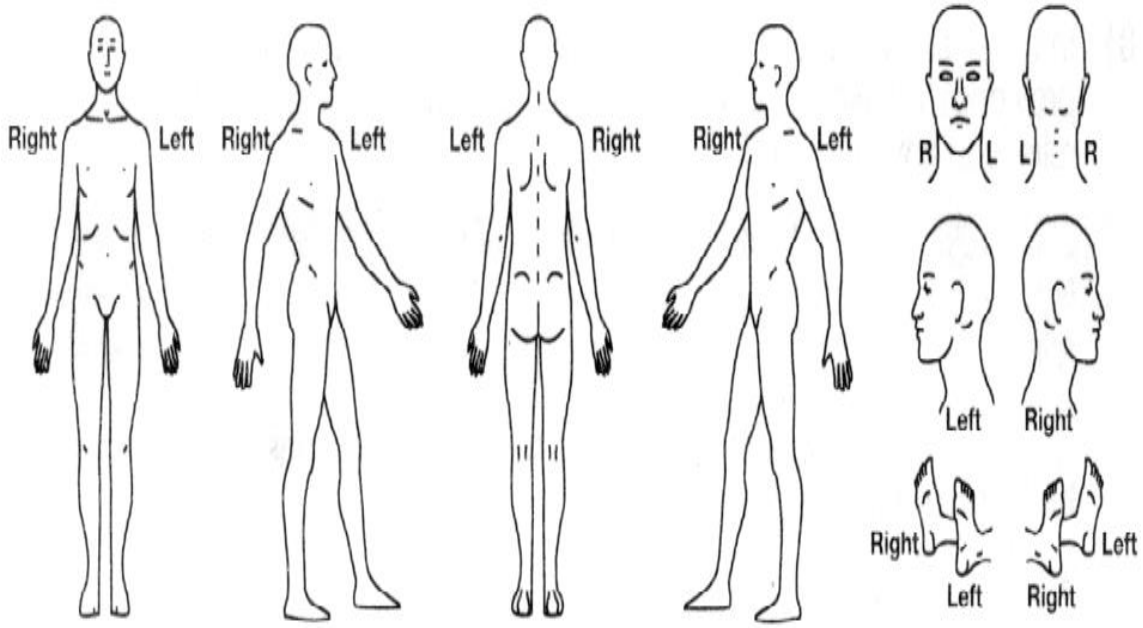
Treatment	Approximate Month & Year	Results (+ or -)
Surgery		
Physical Therapy		
Chiropractic treatment		
Injections guided by x-ray		
☐Epidural Steroid		
☐Facet Injection		
☐Sacroiliac Joint		
☐Hip Joint		
☐Other		

PAIN LINE: Draw a perpendicular line or arrow to indicate your usual level of pain

No PAIN 0 — Worst possible PAIN 10

|_____|

PAIN DIAGRAM: Please outline the area where you have pain



Patient Name: _____ Date of Appointment: ____/____/___

Account #: _____

Review of Systems: Please check [√] any of the following symptoms you are having:

Constitutional	**Cardiovascular**	**Gastrointestinal**
☐ unexplained weight loss/gain ☐ new weakness ☐ fevers/chills/night sweats ☐ NONE	☐ new chest pain/pressure/tightnes ☐ irregular heart rate/beat ☐ trouble breathing while lying ☐ high blood pressure ☐ NONE	☐ acid reflux ☐ history of stomach ulcer ☐ bloody or dark stools ☐ constipation ☐ nausea/vomiting ☐ hepatitis A/B/C ☐ NONE
Integumentary	**Ear/Nose/Throat**	**Musculoskeletal**
☐ new rash ☐ frequent bruising ☐ itching ☐ bleeding ☐ nail or hair changes ☐ hives ☐ sores that don't heal ☐ NONE	☐ vertigo/dizziness ☐ loss of hearing ☐ ringing in the ear ☐ nose bleed ☐ trouble swallowing ☐ NONE	☐ joint pain / stiffness ☐ joint redness and swelling ☐ muscle cramps ☐ new weakness ☐ NONE
Neurological	**Respiratory**	**Genitourinary**
☐ new headache ☐ blackouts or fainting ☐ tingling / numbness ☐ paralysis ☐ seizures ☐ memory loss ☐ NONE	☐ shortness of breath ☐ sleep apnea ☐ cough – new or chronic? ☐ tuberculosis ☐ NONE	☐ blood in the urine ☐ urgency to urinate ☐ loss of bladder control ☐ frequent urination ☐ new difficulty urinating ☐ NONE
Eyes	**Psychological**	**For Clinical Use only**
☐ blurry vision ☐ double vision ☐ cataracts ☐ glaucoma ☐ eye pain ☐ NONE	☐ depression ☐ anxiety ☐ thoughts of suicide, hurting yourself or anyone else ☐ trouble falling asleep ☐ NONE	**Ht.** _____ **Wt.** _____ **B/P** _____ **P** _____

Do you want me to arrange special treatment or counseling, for depression, anxiety, or if you are having any thoughts of hurting yourself or anyone else? Yes No NA

Have you ever had any problems with drug (including prescription) or alcohol abuse or misuse (including DUI or any drug or alcohol related charges or convictions)?

Findings were reviewed and confirmed with the patient

_____
Daniel S. Heller, MD