THE CENTER FOR SPINE HEALTH

Division of Radiology Associates of Northern Kentucky

Eric A. Brandser, M.D. | Kirk M. Doerger, M.D. | Darren R. Hurst, M.D.
Brian C. Lawler, M.D. | Attef A. Mikhail, M.D. | Sean D. Wells, M.D.

DATE: _____

PATIENT NAME_____
Last, First, MI

Date of Birth _____/_____/_____ AGE: _____ HEIGHT: _____ WEIGHT: _____

REFERRED BY: _____

Please circle when given choices AND fill in information when given blanks for all below:

HOW AND WHEN DID YOUR SYMPTOMS START?

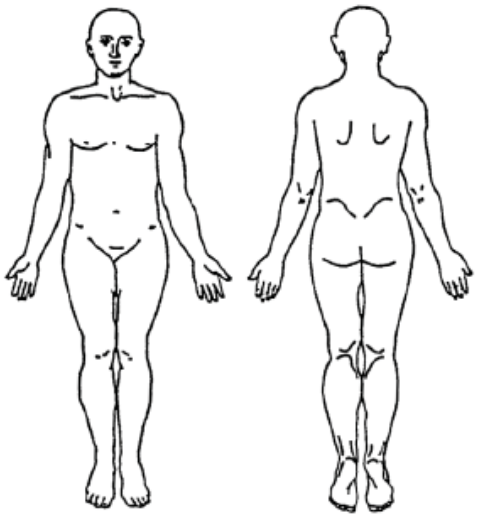
_____

_____

Work Injury? Yes No Motor Vehicle Accident? Yes No Date of Injury: _____

Where is Your Pain?

Please mark, on the drawings below, the areas where you feel pain. Write "E" if external or "I" if internal near the areas which you mark. Write "EI" if both external and internal.



Reprinted from Pain, Vol 1, Melzack R, The McGill Pain Questionnaire: major properties and scoring methods, 277-299, Copyright 1975, with permission from the *International Association for the Study of Pain.*

WHERE IS YOUR DISCOMFORT?

BACK	Right	Left
NECK	Right	Left

DOES IT RADIATE INTO THE ARM and/or LEG?

Right	Left

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PAIN PERCENTAGE:

NECK PAIN _____%
ARM PAIN _____%
BACK PAIN _____%
LEG PAIN _____%
TOTAL 100 %

PLEASE SCORE AND LOCALIZE YOUR PAIN (0 is No Pain/ 10 is Worst Pain Ever)
AVERAGE 0 1 2 3 4 5 6 7 8 9 10

ARE THE SYMPTOMS CONSTANT OR INTERMITTENT? _____

ACTIVITIES OR POSITIONS THAT MAKE THE PAIN WORSE? _____
_____

ACTIVITIES OR POSITIONS THAT MAKE THE PAIN BETTER?
_____

IS THERE WEAKNESS? _____

WHAT HAS BEEN YOUR TREATMENT SO FAR?

Physical Therapy Chiropractic Epidurals/Injections Surgery Pain Management

Please explain:_____

_____

_____

REVIEW OF SYSTEMS: Please Circle All That Apply:
Chest Pain Hypertension Fever Chills Nausea Loss of Bladder or Bowel Control

Diabetes Stroke Psychiatric Skin Shortness of Breath

ALLERGIES : Penicillin Iodine Contrast OTHER_____
_____

PRESENT MEDICATIONS: _____

_____

_____

PAST MEDICAL/ SURGICAL HISTORY: _____

_____

_____

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FAMILY HISTORY OF MEDICAL DISORDERS: _____

_____

_____

RECENT STUDIES: When and Where were the studies performed:

MRI_____

XRAY/CT_____

EMG_____

SOCIAL HISTORY: Single Married Divorced Separated Children In Home_____#

DISABLED: Yes No EMPLOYED Yes No Hours per week _____

OCCUPATION: _____

TOBACCO USE: Yes No CIGARETTES/Day x Years_____

ALCOLHOL USE: Yes No History of Substance Abuse/ Treatment Yes No

Have you ever signed a Pain Management Contract Yes No

_____ _____
Patient Signature Date

_____ _____
Doctor Signature Date