MICHIGAN SPINE CLINIC

Dear

Your physician has referred you to our clinic for evaluation and treatment of your pain problem. In order to best serve you, it is necessary for us to learn as much as we can about you. Chronic pain is a complex problem that often affects a person's mood, family relationships and ability to participate in work and recreation. The following questionnaire requests information about many aspects of your life beyond pain. We have found that all of this information is necessary if we are to provide the best possible diagnosis and treatment plan. **PLEASE CAREFULLY READ AND ANSWER EACH AND EVERY QUESTION.**

Since this is your personal account of your pain problem, please answer the questions **BY YOURSELF** and not with the opinions or assistance of others. We will obtain information from family members at a later time. The information you provide is **STRICTLY CONFIDENTIAL**. This information will not be released to anyone else without your specific written permission. Thank you for your cooperation.

Sincerely,

The Staff of the Michigan Spine Clinic

PERSONAL DATA:

First Name: ________________________________ MI: ___

Last Name: ____

Address: ____
(Apt. No.)

City: ________________________ State: ___ Zip: _______

Home: (_____)_____________ Cell: (_____)_____________

Work: (_____)_____________

Date of birth: ____/_____/________ Age: ___

Sex: M / F (circle) Height: ______ Weight: ______

EMPLOYMENT DATA:

Employer Name: __________________________________

Employment Status: __Full-time __Part-time __Unemployed

__Self-employed __Retired __On active military duty

__On military reserve

Employer Address: ________________________________

City: _______________________ State: ___ Zip: _______

Emergency Contact: ________________________________

Relationship: ______________ Phone: (_____)__________

PHYSICIAN AND PHARMACY DATA:

Personal (family) Physician: ____ Phone: (_______)________________

Address: ____ City: __________________________ State: ___ Zip: ________
(Suite no.)

Referring Physician: ____ Phone: (_______)________________
(if different from above)

Address: ____ City: __________________________ State: ___ Zip: ________
(Suite no.)

Pharmacy Name: ____ Phone: (_______)________________

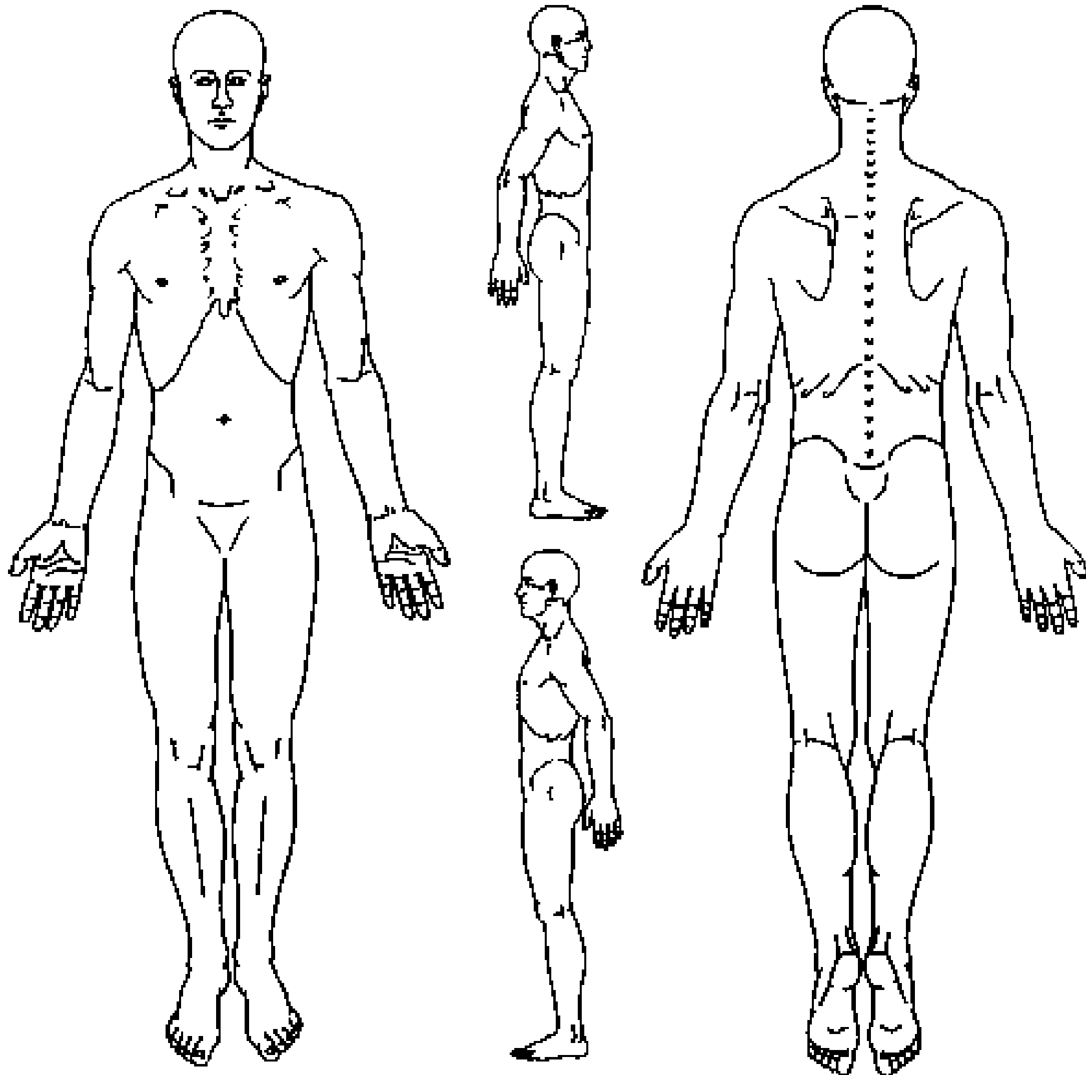
Address: ____ City: __________________________ State: ___ Zip: ________
(Suite no.)

PAIN DATA:

1. Please mark an **"X"** on the line which best represents how **SEVERE** your pain problem is**:**

NO PAIN ____ **MOST SEVERE PAIN YOU CAN IMAGINE**

2. **PLEASE SHOW WHERE YOUR PAIN IS. DOES THE PAIN TRAVEL?**



3. Please indicate your pain score on a scale of 0-10. **0 = No pain** and **10 = Worst pain you can imagine**

Your pain score at its **BEST** is: ______, at its **WORST** is: ______ and on **AVERAGE** is: _____

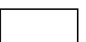
4. Are any of these symptoms associated with your pain? (Please check if any apply)

- ☐ Numbness
- ☐ Weakness
- ☐ Loss of bladder control
- ☐ Loss of bowel control

5. When is your pain worse?

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ No typical pattern

Note: All unmarked answers are negative.

The above has been reviewed by Dr. Haladjian 

6. Please check the **word(s) in each column** that best describes your average pain in the past month:

Intensity
- ☐ Excruciating
- ☐ Extremely strong
- ☐ Very strong
- ☐ Strong
- ☐ Moderate
- ☐ Mild
- ☐ Weak
- ☐ Very weak
- ☐ Just noticeable
- ☐ None
- ☐ Variable

Reaction
- ☐ Intolerable
- ☐ Miserable
- ☐ Distressing
- ☐ Uncomfortable
- ☐ Tolerable
- ☐ None

Sensation
- ☐ Piercing
- ☐ Stabbing
- ☐ Shooting
- ☐ Burning
- ☐ Grinding
- ☐ Throbbing
- ☐ Cramping
- ☐ Aching
- ☐ Stinging
- ☐ Squeezing
- ☐ Numbing
- ☐ Itching
- ☐ Tingling
- ☐ None
- ☐ Non-descriptive

7. How do the following affect your pain? (Please check one for each item)

	Pain is better	**Pain is worse**	**No difference**
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Lying down	☐	☐	☐
Cough or sneeze	☐	☐	☐
Lifting	☐	☐	☐
Bending forward	☐	☐	☐
Bending backward	☐	☐	☐
Turning	☐	☐	☐
Climbing stairs	☐	☐	☐
Going down stairs	☐	☐	☐
Medication	☐	☐	☐
Application of ice	☐	☐	☐
Application of heat	☐	☐	☐
Rest	☐	☐	☐
Weather changes	☐	☐	☐
Urination	☐	☐	☐
Bowel movement	☐	☐	☐
Traveling in a car	☐	☐	☐

8. Does pain interrupt your sleep? **YES** **NO** (please circle)

9. When did you first experience the pain for which you are now seeking help?

____

10. How did your pain begin?
- ☐ Accident at work
- ☐ Accident at home
- ☐ Car accident
- ☐ Other accident
- ☐ At work (not an accident)
- ☐ Following surgery
- ☐ Following illness
- ☐ Pain began without any trigger (cannot relate to anything)

Briefly describe the circumstances surrounding the onset of your pain:

____

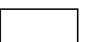
____

____

____

____

Note: All unmarked answers are negative.

The above has been reviewed by Dr. Haladjian 

11. Since your pain condition began, which of the following therapies have you received? (Check all that apply)

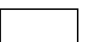
- ☐ Physical Therapy
- ☐ TENS (Transcutaneous Nerve Stimulation)
- ☐ Acupuncture
- ☐ Manipulation-chiropractor or osteopath
- ☐ Nerve blocks
- ☐ Operations
- ☐ Psychological/psychiatric counseling
- ☐ Family or marriage counseling
- ☐ Biofeedback and/or relaxation training

12. Please list all of the drugs, including nonprescription (over-the-counter) drugs, you have taken for your **PAIN** condition and indicate (by circling the appropriate number) how effective these drugs were.

Medication	**Dose**	**Frequency**	**Prescribed by**	**Effectiveness** **Not at All** ... **Very Effective**	**Check here if still taking**
				1 2 3 4 5	
				1 2 3 4 5	
				1 2 3 4 5	
				1 2 3 4 5	
				1 2 3 4 5	
				1 2 3 4 5	
				1 2 3 4 5	
				1 2 3 4 5	
				1 2 3 4 5	

13. Previous diagnostic studies related to your pain condition:

	When	**Where**	**Ordering Physician**
☐ MRI			
☐ EMG/NCV			
☐ CAT Scan			
☐ Myelogram			
☐ Bone scan			
☐ Arthrogram			
☐ Plain X-RAY			
☐ Diskogram			



14. Since your pain began, which doctors or other health professionals have you consulted? Please list their names, specialties and approximate dates in the order in which you saw them.

NAME	SPECIALTY	DATES

15. Are you currently receiving compensation for your pain problem? **YES** **NO** (please circle)
If yes, please check ALL the appropriate sources of compensation.

- ☐ Workers' Compensation
- ☐ No-fault Auto Insurance
- ☐ Social Security Disability
- ☐ Supplemented Security Income
- ☐ Sick Leave Disability Benefits
- ☐ Long-term Medical Disability

16. Are you involved in any legal action (e.g., court case) related to your pain? **YES** **NO** (please circle)
If yes, please indicate what type of legal action you are involved in.

- ☐ Suit for Workers' Compensation
- ☐ Suit for No-Fault Insurance
- ☐ Suit against a third party (Employer, driver of another automobile, owner of the company where you got hurt, a government agency, a doctor)
- ☐ Suit to increase your current compensation benefits

MEDICAL DATA:

1. Past medical history (Please check if you have had any of these medical conditions before)

Respiratory
- ☐ Asthma
- ☐ COPD/Emphysema

Renal
- ☐ Infections
- ☐ Kidney failure

Endocrine
- ☐ Diabetes
- ☐ Thyroid disorder

Blood Disorder
- ☐ Anemia
- ☐ HIV/AIDS

Cardiovascular
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ Blood clots in the leg
- ☐ Heart attack

Neurology
- ☐ Seizures
- ☐ Stroke (CVA)
- ☐ Mini Stroke (TIA)
- ☐ Paralysis
- ☐ Headaches

GI/Hepatic/Pancreatic
- ☐ Cirrhosis
- ☐ Pancreatitis
- ☐ Ulcer
- ☐ Gastritis
- ☐ Hepatitis

Rheumatoid/Connective Tissue Disorder
- ☐ Gout
- ☐ Arthritis
- ☐ Sceleroderma
- ☐ Ankylosing Spondylitis
- ☐ Fibromyalgia
- ☐ Lupus

Cancer
- ☐ Type:

2. Review of symptoms: Have you had any of the following symptoms in the **last 2 weeks**?

General
- ☐ Unexpected weight loss
- ☐ Fever

Gastrointestinal/Abdomen
- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Blood stool

Musculoskelatal
- ☐ Muscle weakness
- ☐ Swelling of extremities

Skin
- ☐ Rash

Endocrine
- ☐ Appetite change
- ☐ Cold intolerance

Hematologic/Hepatic
- ☐ Jaundice

Cardiopulmonary
- ☐ Chest pain
- ☐ Fast heart rate
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Require oxygen supplement

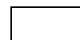
Neurological
- ☐ Headaches
- ☐ Dizziness

Genitourinary
- ☐ Urinary retention
- ☐ Blood in urine
- ☐ Abnormal menstrual cycle

Eyes
- ☐ Visual disturbance

Ear, Nose, Throat
- ☐ Ringing in the ears
- ☐ Hearing disturbance
- ☐ Bleeding gums

Note: All unmarked answers are negative.

The above has been reviewed by Dr. Haladjian 

3. Family History: Does any blood relative in your family have the following? (Please check, if yes to any)

- ☐ Rheumatoid arthritis
- ☐ Cancer
- ☐ Lupus
- ☐ Headaches
- ☐ Heart disease
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Blood disorder

4. Please list any major surgeries that you have had in the past:

Type of Surgery	When	Where	Surgeon

5. Are you currently taking any **blood thinners**? **YES** or **NO** (please circle)

If YES, please list out all blood thinners (anticoagulants) including aspirin:

Medication	Dose	Frequency	Prescribed by	For how long

6. Are you taking any **non-pain related medications**? **YES** or **NO** (please circle)

If YES, please list out all of the medications that you are currently taking:

Medication	Dose	Frequency

7. Are you allergic to any medications? **YES** or **NO** (please circle)

If YES, please list which medications: ____

____

8. Are you allergic to contrast dye? **YES** or **NO** (please circle)

9. Are you allergic to latex? **YES** or **NO** (please circle)

Note: All unmarked answers are negative.

The above has been reviewed by Dr. Haladjian ☐

SOCIAL HISTORY:

1. Marital Status (choose one): __Single __Married __Separated __Divorced __Widowed
2. Present living situation (if living with more than one individual, check primary head of household):

   __Alone __With spouse __With children __With parents __With friend __With other family member

3. Substance intake per day:

   Caffeine (coffee, tea, cola, etc.):____ Number of drinks _______

   Nicotine (cigarettes, cigar, pipe, etc.): ___________________________________ Pk/day______ Yrs ______

4. Alcohol intake (choose one):

   __None __Rarely(less than 1 drink per month) __Occasionally (less than 1 drink per week)

   __Regularly (2-3 times per week) __Daily __Former abuser

5. Have you used any of the following drugs? (Choose all that apply):

   __Marijuana __Amphetamines __Cocaine __Heroin __None of these __Other (please specify): ______________

   __Former abuser

   When was the last time you abused any of the above drugs? _____________________________

PSYCHOLOGICAL HISTORY:

Do you feel sad?	**__Always __Frequently __Occasionally __Rarely**
Do you feel helpless?	**__Always __Frequently __Occasionally __Rarely**
Do you feel hopeless?	**__Always __Frequently __Occasionally __Rarely**
Do you feel tense and worry all the time?	**__Yes __No**
Do you ever act in angry or aggressive ways? (for example: breaking objects, hitting other people)	**__Yes __No**
Do you have any history of mental health treatment by a psychiatrist, psychologist, or other mental health professional?	**__Yes __No**
Have you ever been hospitalized for psychiatric reasons?	**__Yes __No**
Do you have panic attacks?	**__Yes __No**
Are you a claustrophobic?	**__Yes __No**
Have you ever had any thoughts of wanting to die?	**__Yes __No**
Do you presently have any thoughts of harming or hurting anyone or yourself?	**__Yes __No**

Note: All unmarked answers are negative.

The above has been reviewed by Dr. Haladjian