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Blue Ridge Orthopaedic Pain Management
Scheduling Coordinators
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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 you painful condition.

Daniel Heller, MD

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

Account #: _____

1. Where are you having the most severe pain? _____

2. What is the onset date of your current pain condition? _____

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?

If not, what was the last date you worked? ____ / ____ / ____

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

7. How long have you had this current pain?

___ Not sure ___ Weeks / months ___ Months / years

8. Please indicate where your current pain was located when it was first started:

___ Unknown ___ Lower Back ___ Lower Back & Legs
___ Upper Back ___ Neck ___ Neck and Arms
___ other (describe) _____

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

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

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

Account #: _____

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		
<input type="checkbox"/> Epidural Steroid		
<input type="checkbox"/> Facet Injection		
<input type="checkbox"/> Sacroiliac Joint		
<input type="checkbox"/> Hip Joint		
<input type="checkbox"/> Other		

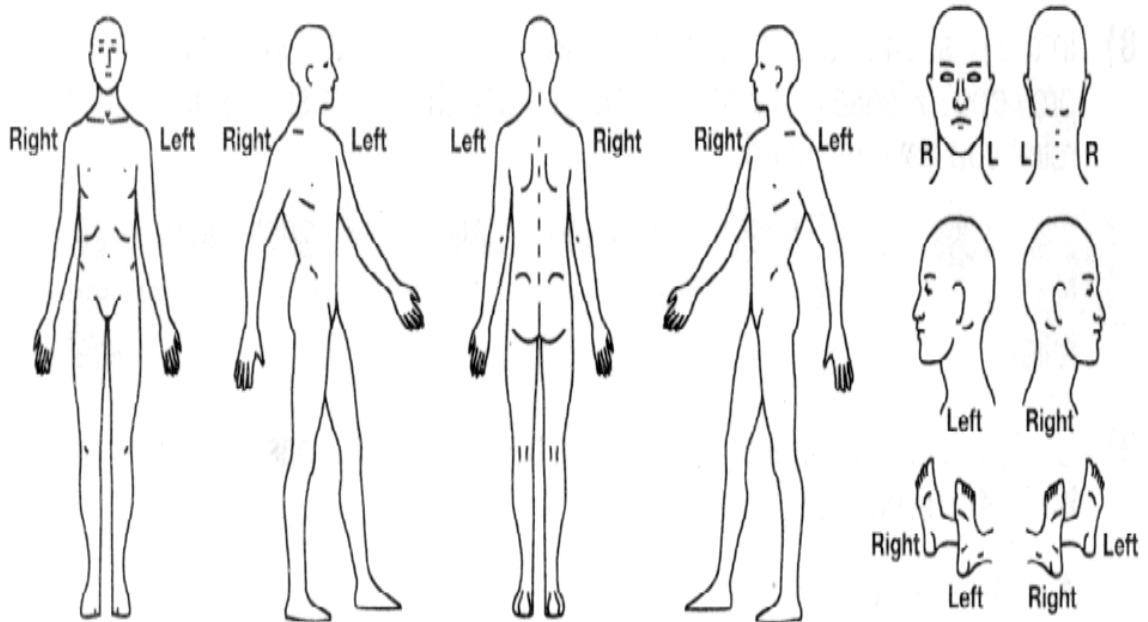
PAIN LINE: Draw a perpendicular line or arrow to indicate your usual level of pain

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:

<p>Constitutional</p> <p>unexplained weight loss/gain weakness night sweats fevers/chills loss of appetite fatigue trouble sleeping heat/cold intolerance excessive thirst NONE</p>	<p>Cardiovascular</p> <p>chest pain/pressure/tightness palpitations irregular heart rate leg pain with walking trouble breathing while lying high blood pressure low blood pressure NONE</p>	<p>Gastrointestinal</p> <p>acid reflux ulcer stomach pain/heart burns bloody or dark stools constipation diarrhea nausea/vomiting hepatitis A/B/C NONE</p>
<p>Integumentary</p> <p>rashes frequent bruising itching bleeding nail or hair changes hives sores that don't heal NONE</p>	<p>Ear/Nose/Throat</p> <p>vertigo/dizziness loss of hearing ringing in the ear ear ache or drainage nose bleed change in sense of smell sinusitis sore or bleeding gums trouble swallowing NONE</p>	<p>Musculoskeletal</p> <p>joint pain joint stiffness joint redness and swelling muscle cramps weakness NONE</p>
<p>Neurological</p> <p>headache blackouts and fainting tingling / numbness paralysis seizures memory loss NONE</p>	<p>Respiratory</p> <p>shortness of breath bronchitis pneumonia sleep apnea chronic cough tuberculosis NONE</p>	<p>Genitourinary</p> <p>blood in the urine painful urination urgency to urinate loss of bladder control frequent urination difficulty urinating NONE</p>
<p>Eyes</p> <p>blurry vision double vision cataracts glaucoma eye pain NONE</p>	<p>Psychological</p> <p>depression anxiety thoughts of suicide, hurting yourself or anyone else trouble falling asleep NONE</p>	<p>For Clinical Use only</p> <p>Ht. _____ Wt. _____ B/P _____ 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

Findings were reviewed and confirmed with the patient

Daniel Heller, MD