Phone: 907.563.8876
Fax: 907.762.6390
3801 University Lake Drive
Anchorage, AK 99508

Dear Patient:

Enclosed you will find a questionnaire regarding your past medical history and your current concerns. **We ask all our patients to please take the time to complete this questionnaire before your appointment. In the event you are unable to do so, we may need to reschedule your appointment.**

Some questions may not be relevant to your particular history, or you may not know the answer; however, please answer all questions to the best of your ability. This information will aid in the diagnosis and treatment of your medical problem.

We greatly appreciate your time and effort in filling out this form.

Your appointment is scheduled on _____ at _____ with _____, at the _____ facility. Please call our office, before your appointment, to pre-register. The phone number is (907) 563-8876.

Please bring this completed form, any old medical records, and any imaging studies (X-Rays, MRI, CT scan, etc.) you may have, to your appointment.
PLEASE DO NOT MAIL BACK!

Alaska Spine Institute Providers

Larry Levine, MD
Shawn Johnston, MD
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alaska spine institute

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3801 University Lake Drive, Suite 300
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This is a general questionnaire designed to obtain the maximum information possible about your condition. Many questions may not seem relevant to your particular history, or you may not know the answer; however, please answer to the best of your ability.
Thank you for taking the time to complete this questionnaire. This information will aid in the diagnosis and treatment of your problem.

Name: _____ Date: _____

Street Address: _____ SS#: _____ (optional)

City: _____ State _____ Zip _____ Home Phone: _____

Sex: _____ Age: _____ Birth Date: _____ Work Phone: _____

Cell Phone:_____

Are you right-handed or left-handed? Please circle one: Right Left Ambidextrous

Date of Injury: _____

Who is your general or primary doctor and what is their address?

_____

What other doctors have you seen?

Doctor	Address	Last Seen?

Please describe your problem in your own words, including dates when possible. (Use extra sheet if necessary):

_____

_____

_____

_____

_____

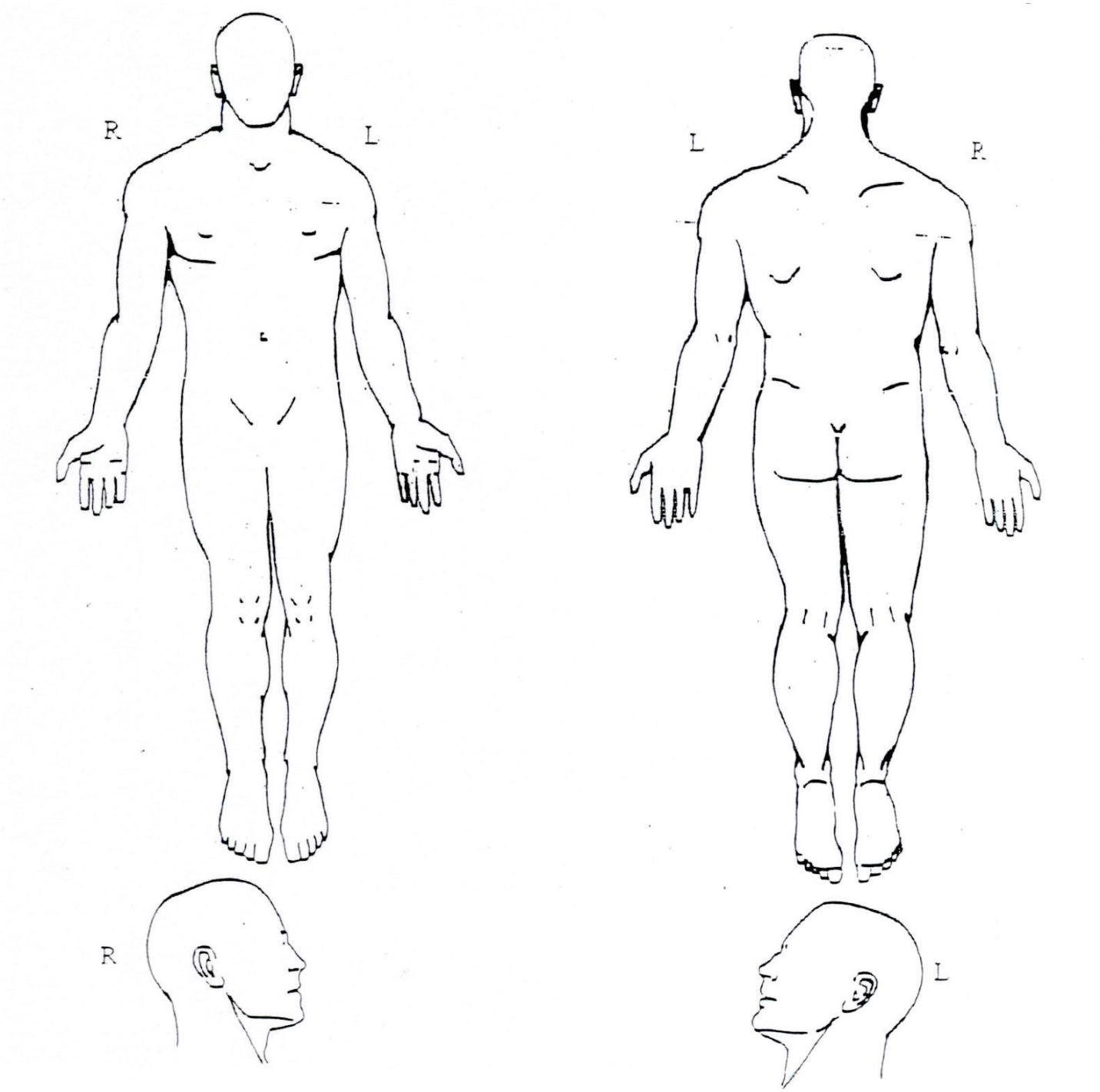
_____

_____

_____

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Include all affected areas.

	n		○○○		____		••••		xxxx		////
Numbness	n	Pins & Needles	○○○	Aching	____	Cramping	••••	Burning	xxxx	Stabbing	////



How long have you had your pain problem(s)? _____

Circle the word that describes your pain: Numbness Pins and needles Aching Cramping Burning Stabbing

Circle the number that corresponds to the severity of your pain. On the scale from 0 to 10, 0 means no pain and 10 is the most severe pain you can imagine.

0 1 2 3 4 5 6 7 8 9 10

Does you pain vary in intensity? ☐ Yes ☐ No

The WORST pain you ever have (from 0-10) is: _____

The LEAST pain you ever have (from 0-10) is: _____

What makes your pain worse? _____

Check items that decrease your pain:

☐ Rest/Bed	☐ Walking/Standing	☐ Sexual Activity	☐ Drugs/Alcohol
☐ Lying Down	☐ Being around people	☐ Physical Activity	☐ Time of Day

☐ Other: _____

List any physical activities you used to do frequently that you don't do any more because of pain: _____

_____

_____

Medications: List all the medicines that you have been taking recently. Include vitamins and nonprescription medicines as well as prescribed medicine. Indicate the amount you *usually* take in a day or a week.

Name of Medication	Dosage (# of mg)	How often?

Allergies and Reactions to Medicines or Other Substances

Medication / Other Substances	Type of Reaction

Adverse effects of sedation or anesthesia:_____

List medicines you have tried in the past for the pain: _____

Tests: List the tests you have had for this condition.

	Approximate date/year	Where done?
X-rays		
CT scan		
MRI		
EMG/NCV		
Other		

Previous Treatment and Results:

What have you been told is your diagnosis? _____

Have you ever had nerve blocks for your pain problem? ☐ Yes ☐ No How many? _____
Did any block produce pain relief? ☐ Yes ☐ No
What was the longest duration of pain relief following a nerve block? _____

	Have not had treatment	Lasting benefit	Temporary benefit	No help	Made worse
Operation/Dates:					
1. _____/_____	0	1	2	3	4
2. _____/_____	0	1	2	3	4
3. _____/_____	0	1	2	3	4
4. _____/_____	0	1	2	3	4
5. _____/_____	0	1	2	3	4
Nerve blocks:	0	1	2	3	4
Nerve stimulator (TENS):	0	1	2	3	4
Exercise program:	0	1	2	3	4
Physical therapy:	0	1	2	3	4
Biofeedback/hypnosis:	0	1	2	3	4
Acupuncture:	0	1	2	3	4
Heating pads, ultrasound, whirlpool, massage, etc.	0	1	2	3	4
Manipulations:	0	1	2	3	4
Pain management unit:	0	1	2	3	4
Other treatments (not counting medicines):					
_____	0	1	2	3	4
_____	0	1	2	3	4

General Medical History: Check any conditions you have ever had:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Gonorrhea
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Hepatitis/Liver Disease
- ☐ Herpes
- ☐ Hypertension/ high blood pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Illness
- ☐ Lung disease
- ☐ Ulcer
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Syphilis
- ☐ Thyroid trouble
- ☐ Other: _____

Previous Hospitalizations/Serious Illnesses/Injuries/Surgeries:

Year:	Diagnosis:	Operation (if any):

Have you had any similar injuries in the past? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Have you had any prior on-the-job injuries? ☐ Yes ☐ No

If yes, please describe the injury, list the date, and list the duration of time you were off work, if any.

Injury	Date	Time Loss

Was there an impairment rating or a legal settlement related to this injury? ☐ Yes ☐ No

Have you had any automobile accident injuries? ☐ Yes ☐ No If yes, please describe all injuries: _____

_____

_____

Is there a history of any of the following in a blood relative? (Please check box if yes)

☐ Alcoholism	☐ Breast Cancer	☐ Stroke	☐ Psychiatric Illness
☐ High blood pressure	☐ Chronic Pain	☐ Depression	☐ Heart Attack
☐ Migraine	☐ Disability	☐ Diabetes	☐ Colon Cancer

# of Brothers: _____ # of Sisters: _____

Father: ☐ Alive: age: _____ ☐ Deceased: age: _____, cause _____

Mother: ☐ Alive: age: _____ ☐ Deceased: age: _____, cause _____

Marital Status (check one or more): ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
☐ Remarried ☐ "Living Together"

How long? _____

Spouse's Occupation: _____

Number of children: _____ Ages: _____

Circle years of school completed: 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Tobacco use currently:_____ Number of cigarettes smoked daily:_____ Weekly?:_____

Previous smoker? ☐ Yes ☐ No Quit date: _____

Alcohol (amount per day or week): _____

Have you had a problem with alcohol? ☐ Yes ☐ No

Coffee, Tea, Cola beverages (cups, glasses per day):_____

Do you have trouble falling asleep? ☐ Never ☐ Sometimes ☐ Usually ☐ Always

Does pain frequently awaken you? ☐ Yes ☐ No

If yes, how many times per night? _____ When awakened, do you: ☐ Empty Bladder ☐ Take medicine
☐ Sit up a while ☐ Other, describe: _____

Do you easily return to sleep? ☐ Yes ☐ No

Sleep position: ☐ Back ☐ Stomach ☐ Right side ☐ Left Side

Living Arrangements: ☐ Apartment ☐ House ☐ Other _____ # of steps _____

Has pain interfered with your *desire* for a social life? ☐ No Interference ☐ Minimal change ☐ Considerable change ☐ Stops desire for social life

Has pain interfered with your *ability* for a social life? ☐ No Interference ☐ Minimal change ☐ Considerable change ☐ Completely prevents

Has pain interfered with your *desire* for hobbies/recreation? ☐ No Interference ☐ Minimal change ☐ Considerable change ☐ Stops desire for recreation

Has pain interfered with your *ability* for hobbies/recreation? ☐ No Interference ☐ Minimal change ☐ Considerable change ☐ Prevents recreation

Please list recreational activities/sports you enjoy.	Sports/Recreational activity:	Times per week:	Hours each time:
	_____	_____	_____
	_____	_____	_____

Has pain interfered with your sexual *desire*? ☐ No Interference ☐ Minimal change ☐ Considerable ☐ Stops desire for sex

Has pain interfered with you sexual ability? ☐ No Interference ☐ Minimal change ☐ Considerable ☐ Completely prevents sex

Do you feel helpless to change your present condition? ☐ Never ☐ Sometimes ☐ Most of the time ☐ All of the time

Do you ever feel your condition is hopeless? ☐ Never ☐ Sometimes ☐ Most of the time ☐ All of the time

Do you think the pain is due to something more serious or different than doctors have told you? ☐ Yes ☐ No ☐ Not sure

Who do you work for currently? _____

Is this the same employer as at the time of injury? ☐ Yes ☐ No

Occupation: _____ How long in this position? _____

Brief description of usual job duties: _____

_____

Work status: ☐ Working full time ☐ Working part time ☐ Student ☐ Disabled ☐ Unemployed ☐ Retired

If disabled, (as worker/student/homemaker), date last worked: _____

If disabled, have you tried to return to work? ☐ Full time ☐ Part time ☐ No

Have you received disability income related to this condition?

☐ Yes, receive it now ☐ Yes, in the past ☐ No, never received it

Do we need to send our report to your lawyer? ☐ Yes ☐ No

What do *you* think is the cause of your symptoms? _____

Are there current or recent stressful situations in your life? ☐ Yes ☐ No ☐ Not sure

Does stress increase your pain? ☐ Yes ☐ No ☐ Have no stress

How often do you see a doctor? ☐ 3 times a month or more ☐ One or two times a month

☐ More than 3 times a year ☐ Yearly ☐ Rarely

Other than your pain problems, are you frequently ill? ☐ Yes ☐ No

What do you hope will be the result of this *evaluation*:

- ☐ Medical diagnosis (discover the cause of the pain)
- ☐ Determine the existence of a disability
- ☐ Recommendation for surgery
- ☐ Recommendation for medicines
- ☐ Recommendation for rehabilitation
- ☐ Other, describe: _____

If you are *treated* here, what are the results you **hope** for:

☐ Pain reduction ☐ Increased recreation ☐ Improved emotional well-being ☐ Other _____

☐ Return to work ☐ Elimination of drugs ☐ Increased socialization

If you are *treated* here, what are the results you **expect**? _____

_____

If your treatment here does not bring you relief, do you think you will try elsewhere? ☐ Yes ☐ No

How many *hours* per day (average) must you lie down or rest because of pain? _____

How many *times* per day (average) must you lie down because of pain? _____

How many *times* per day (average) must you stop what you are doing because of pain? _____

Please review the following list of medical problems and mark any that apply to you *now* or in the past. Please go over the list carefully. Medical problems that do not seem related to your current situation could result in a serious complication if you do not let us know about them.

Constitutional
- ☐ Recent weight gain: ____ lbs
- ☐ Recent weight loss: ____ lbs
- ☐ Fever or soaking sweats at night
- ☐ Fatigue
- ☐ Weakness/numbness of arms/legs
- ☐ Headaches ≥1-2 times per week
- ☐ Difficulty walking
- ☐ Loss of consciousness/convulsions

Eyes
- ☐ Vision problems not corrected by glasses
- ☐ Glaucoma
- ☐ Eye lens implant
- ☐ Eye prosthesis
- ☐ Contact lenses

Ears, Nose, Throat
- ☐ Chronic stuffy nose or nasal polyps
- ☐ Frequent nosebleeds
- ☐ Sinus problems
- ☐ Hay fever allergies
- ☐ Difficulty hearing
- ☐ Ear infections
- ☐ Hearing aid
- ☐ Chronic sore throat or tonsillitis
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Dentures or partial plates
- ☐ Capped teeth
- ☐ Loose teeth
- ☐ Orthodontic braces

Cardiovascular
- ☐ Heart murmur
- ☐ Prolapsed mitral valve
- ☐ Heart pacemaker
- ☐ Irregular heartbeat
- ☐ Palpitations or rapid pulse
- ☐ Fainting spells
- ☐ Chest pain or angina on exertion
- ☐ Chest pain or angina at night
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Swelling in feet or ankles
- ☐ Shortness of breath lying flat
- ☐ Shortness of breath at night
- ☐ Blood clots or pulmonary embolism
- ☐ High blood pressure
- ☐ Low blood pressure

Respiratory
- ☐ Asthma or wheezing
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Chronic cough
- ☐ Change in amount of phlegm
- ☐ Change in color of phlegm
- ☐ Coughing up blood
- ☐ Collapsed lung
- ☐ Tuberculosis exposure
- ☐ Blueness of your fingernails

Gastrointestinal
- ☐ Ulcers
- ☐ Hiatal hernia or frequent heartburn
- ☐ Ulcerative colitis
- ☐ Diverticulitis
- ☐ Colostomy or other 'ostomy'
- ☐ Hepatitis or yellow jaundice
- ☐ Liver cirrhosis
- ☐ Gallbladder problems
- ☐ Vomiting blood
- ☐ Black, tarry bowel movements
- ☐ Blood in bowel movements
- ☐ Change in bowel habits

Genitourinary
- ☐ Kidney stones
- ☐ Kidney infections
- ☐ Kidney failure
- ☐ Dialysis
- ☐ Prostate problems
- ☐ Bladder infections
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Do you lose your urine at times

Musculoskeletal
- ☐ Fractures or broken bones
- ☐ Arthritis
- ☐ Difficulty opening mouth wide
- ☐ Scoliosis
- ☐ Spinal column deformity

Integumentary/Dermatologic
- ☐ Skin rash or sores
- ☐ Itching
- ☐ Color change, pigmentation, nodules
- ☐ Pressure ulcers

Neurologic
- ☐ Seizures or convulsions
- ☐ Epilepsy
- ☐ Stroke
- ☐ Brain aneurysm or hemorrhage
- ☐ Multiple Sclerosis
- ☐ Nerve Injury or Numbness

Psychiatric
- ☐ Depression
- ☐ Anxiety or panic attacks
- ☐ Mental disorder

Endocrine
- ☐ Diabetes
- ☐ Insulin use
- ☐ Low blood sugar or hypoglycemia
- ☐ Thyroid problems
- ☐ Steroid use

Allergic/Immunologic
- ☐ Herpes exposure
- ☐ AIDS exposure
- ☐ Street drug use

Hematologic
- ☐ Abnormal bleeding problems
- ☐ Anemia or low blood count
- ☐ Blood transfusion
- ☐ Hemophilia
- ☐ Sickle cell anemia

Lymphatic
- ☐ Swollen glands or masses in neck, axillae, groin
- ☐ Lymphedema

Others
- ☐ Sexual problems
- ☐ Muscular dystrophy
- ☐ Myasthenia gravis
- ☐ Malignant hyperthermia
- ☐ Bad reaction to local anesthetic
- ☐ Down syndrome
- ☐ Cancer or tumor
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Recent acute illness
- ☐ Recent hospitalization
- ☐ Recent surgical operation

Use the back of this page to list any problems not already covered that you consider important

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For women only:

Are you pregnant? ☐ Yes ☐ No
Are menstrual periods normal? ☐ Yes ☐ No
☐ Any vaginal discharge
☐ Bleeding between periods
☐ Bleeding after menopause

Number of pregnancies: _____
Number of deliveries: _____
Date of last menstrual period: _____
Approx date of last pap smear: _____

I have carefully reviewed this checklist and completed it to the best of my knowledge. Date: _____

_____ _____

Signature of Patient, Parent, or Guardian ***Relationship to patient, (if not self)***

1.) Family History of Substance Abuse: Mark each box that applies

Alcohol	☐
Illegal drugs	☐
Prescription drugs	☐

2.) Personal History of Substance Abuse:

Alcohol	☐
Illegal drugs	☐
Prescription drugs	☐

3.) Age (mark box if between 16 and 45) ☐

4.) History of Preadolescent Sexual Abuse ☐

5.) Psychological Disease

Attention deficit disorder, Obsessive compulsive disorder, Bipolar, Schizophrenia	☐
Depression	☐

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _ . 8_. 9_. 10_. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _. 8_. 9_. 10_. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _ . 8_. 9_. 1 0_. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _ . 8_. 9_. 1 0_. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _ . 8_. 9_. 10_. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _. 8_. 9_. 10_. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _ . 8_. 9_. 10_. Worst Disability

Signature _____ **Please Print** _____

Date _____