Double-Board Certified Interventional Pain Physicians

ACGME Fellowship Trained

Ashleigh Byrne, MD
Craig W. Davis, MD
Kelly Curran, PA-C
Kyle Harmer, PA-C
Troy Johnsen, PA-C
Jared Mathis, PA-C

main 801.569.5520 **referral coordinator** 801.352.5944 **fax** 801.352.5951

WEST JORDAN CLINIC
3181 W. 9000 S.
West Jordan, UT 84088

DRAPER CLINIC
11724 S. State St.
Draper, UT 84020

TOOELE CLINIC
Northpointe Medical Park
2326 N. 400 E.,
Bldg C, Ste. 203
Tooele, UT 84074

WASATCH CLINIC
1160 E. 3900 S., Ste. 1000
Salt Lake City, UT 84124

Appointment: Date: ____________ Time: ______________ Location: ____

Dear Patient,

Welcome to Granger Pain and Spine. We appreciate you choosing us for your medical care and treatment. Our goal is to treat your condition using a multidisciplinary approach, with a commitment to providing you the best possible care and service.

Opioid pain medications are NOT prescribed at the Initial Consultation Visit. Patient must agree to the Opioid Pain Contract and Initial Evaluation/Testing must be complete prior to any changes or prescribing of opioid medication prescriptions.

Please arrive 15-20 minutes prior to your scheduled appointment.

If your initial questionnaire is not completed prior to your arrival for this consultation, please plan to **arrive 40 minutes** early to complete this form.

Although we understand that sometimes you may be delayed, please notify our office immediately of any scheduling conflicts so that we may prevent any delay in your visit.

So that we may provide you the best possible treatment options we ask that on your first visit you please bring along with you the following:

1. A list of **ALL** current medications, as well as a list of past pain medications and allergies.
2. All pertinent and related lab work, X-Rays, MRI's and CT scans, both reports and imaging (on a disc preferably) if possible.
3. Any previous related medical records and doctor consults, if you have them.
4. Current and valid insurance cards and government issued photo ID.
5. Completed attached Initial Visit Patient Questionnaire.

On your first visit you can expect to have a thorough history and physical exam performed by an ACGME fellowship trained pain management physician. After the initial consultation, recommendations and treatment options will be discussed in detail.

If for some reason you cannot make your appointment, please contact us within 24-48 hours to reschedule. We look forward to seeing you soon.

Sincerely,

Granger Pain & Spine

GRANGER
PAIN & SPINE

Initial Visit Patient Questionnaire

Primary care physician: ______________________ Phone #: ______________

Referring physician (if not the same): ______________________ Phone #: ______________

Patient Information

Last name: ______________________ First name: ______________________ M.I.: ______

Birth date: ____

About Your Pain

Where is your worst pain? ____

____

Other pain problems? ____

Onset of Pain & Duration - When did your pain begin? Is this your first occurrence?

____

____

Timing of Pain - How often do you have your pain? (please check one)

- ☐ Constantly (100% of the time)
- ☐ Frequently (75% of the time)
- ☐ Intermittently (50% of the time)
- ☐ Occasionally (25% of the time)

Pain Quality - How would you describe the pain? (circle as many adjectives as are applicable)

Burning	Sharp	Cutting, dull	Throbbing
Cramping	Numbness	Aching	Pressure
Pins & needles	Shooting	Electric like	Other: ______________

Rate Your Pain Intensity

Please circle the number that best describes your pain **right now**:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain imaginable

Please circle the number that best describes your pain **on average for the last week**:

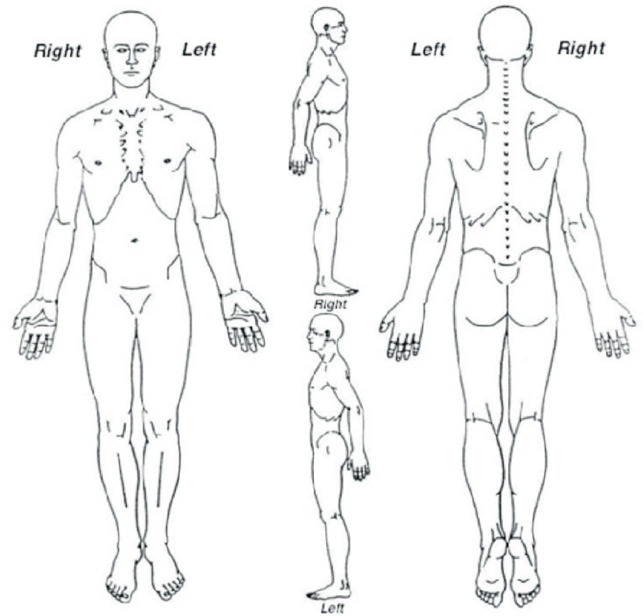
0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain imaginable

Where Do You Hurt? (Circle all that apply & use the diagram to show where pain is located)

Low back Mid back Knee
Neck Buttocks Legs
Hand/fingers Abdomen Hip
Wrist Foot Headaches
Chest wall Shoulder Pelvic

☐ I hurt everywhere
☐ Other: ___________________________________



Relieving and Aggravating Factors - How do the following affect your pain?
(please check one for each item)

	Improves	**Worsens**	**No Change**
Lying down			
Standing			
Sitting			
Walking			
Exercise (if applicable)			
Medication			
Relaxation			
Thinking about something else			
Coughing/sneezing			
Urination/bowel movements			
Functional limitations			
Endurance			
Sleep			

Functional Limitations

During the past month, indicate how your pain has interfered with:

Activity	Does not interfere	Occasionally interferes	Often interferes	Completely interferes
Going to work				
Household chores				
Doing yard work				
Shopping				
Socializing with friends				
Exercise or Recreation				
Having sexual				
Driving				
Sleeping				
Caring for self				

Endurance

How many blocks can you walk before having to stop secondary to pain? ____________ blocks

How long can you sit before having to get up and move about? ________ minutes ________ hours

How long can you stand before you have to sit down? ________ minutes ________ hours

How often during the day do you lie down because of pain (circle one)

Never Seldom Sometimes Often Constantly

Sleep

How many total hours of sleep time each night? ____________________

How many times do you awaken due to pain?____________________

How many times do you awaken for bathroom trips? ____________________

Past Procedures Date performed

- ☐ Epidural Steroid injection ____________________
- ☐ Nerve block ____________________
- ☐ Cortisone injection (location: ____________) ____________________
- ☐ Trigger point injection ____________________

Have you EVER been on any of the following medications? (Check "Yes" if you have been)
If so, where you there any side effects? (list in margin)

NSAIDs/anti-inflammatories

Ibuprofen/Motrin/Advil ☐ Yes ☐ No
Naproxen/Naprosyn/Aleve ☐ Yes ☐ No
Other: melaxicam ☐ Yes ☐ No
Diclotenac ☐ Yes ☐ No
Celebrex ☐ Yes ☐ No
Acetaminophen/Tylenol ☐ Yes ☐ No

Narcotics

Tramadol ☐ Yes ☐ No
Oxycodene (Percocet) ☐ Yes ☐ No
Hydrocodone ☐ Yes ☐ No
(Norco, Lortab, Vicodin)
Codeine (Tylenol #3) ☐ Yes ☐ No
Morphine ☐ Yes ☐ No
Hydromorphone (Dilaudid) ☐ Yes ☐ No
Fentanyl ☐ Yes ☐ No
Suboxone/Subutex ☐ Yes ☐ No
Other: ______________________________

Topicals (patches, creams, ointments, gels

OTC: Salonpas, Icy Hot, etc. ☐ Yes ☐ No
Lidoderm/Lidocaine ☐ Yes ☐ No
Voltaren, Pennsaid ☐ Yes ☐ No

Neuropathic agents/antidepressants/etc.

Neurontin/gabapentin ☐ Yes ☐ No
Lyrica ☐ Yes ☐ No
Cymbalta ☐ Yes ☐ No
Topamax/topiramate ☐ Yes ☐ No
Savella ☐ Yes ☐ No
Nortriptyline/Pamelor ☐ Yes ☐ No
Amitriptyline/Elavil ☐ Yes ☐ No
Effexor ☐ Yes ☐ No
Lamictal/lamotrigine ☐ Yes ☐ No

Muscle Relaxants

Cyclobenzaprine/Flexeril ☐ Yes ☐ No
tizanidine/Zanaflex ☐ Yes ☐ No
baclofen ☐ Yes ☐ No
Soma ☐ Yes ☐ No
Metaxolone/Skelaxin ☐ Yes ☐ No
Orphenadrine/Norflex ☐ Yes ☐ No
Methocarbamol/Robaxin ☐ Yes ☐ No

Triptans

Imitrex/sumatriptan ☐ Yes ☐ No
Maxalt/rizatriptan ☐ Yes ☐ No
Relpax/eletriptan ☐ Yes ☐ No
Zomig or Axert or Frova or Amerge
(circle which above) ☐ Yes ☐ No

Past Interventions - Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to best describe your relief

Treatment	Date (approx)	Excellent relief	Moderate relief	No relief
☐ Traction				
☐ Surgery				
☐ Acupuncture				
☐ TENS/E-stim				
☐ Physical therapy				
☐ Aquatherapy				
☐ Exercise				
☐ Heat treatment				
☐ Biofeedback				
☐ Chiropractic				
☐ Other				

Current Medications - Please list ALL medications you are <u>currently</u> taking.

Name of Medication	Dosage	Frequency

Do you take any blood thinners like Coumadin, warfarin, Plavix, Aggrenox or lovenox? ☐ Yes ☐ No

Do you take anti-inflammatory medications like aspirin, naproxen (Aleve), meloxicam (Mobic), diclofenac, ibuprofen (Motrin, Advil), etc? ☐ Yes ☐ No

Do you take Tylenol or Acetaminophen? ☐ Yes ☐ No

Past Medical History - Have you had any of the following health problems? (Please circle all that apply)

Heart disease
Angina
Heart attack/stents
Stroke
High blood pressure
Chronic cough
Asthma/Emphysema/COPD
Seizures or epilepsy
Cancer
Psychiatric disorders (anxiety, depression, bipolar, etc.)
Kidney disease
Liver disease
Arthritis
Bleeding problems
Glaucoma
Kidney stones
Diabetes
GERD/reflux

Please explain any medical conditions circled above: ______________________________

____

Other (please specify): ____

Do you have any implanted devices?

- ☐ Spinal cord stimulator
- ☐ Venous access device
- ☐ IUD
- ☐ Pacemaker (type): ____________________
- ☐ Intrathecal pump

Do you have a history of dizziness with needles, IV placement, medical procedures, etc? ☐ Yes ☐ No

If yes, please explain: ____

Do you have a history of “passing out” with needles, medical procedures, etc? ☐ Yes ☐ No

If yes, please explain: ____

Allergies - List all medication that you have allergies to, and your reactions to them.

Medication	Reaction When Taken

Do you have symptoms like red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following?

- ☐ Dye
- ☐ Iodine
- ☐ Medications: ____________________ Please Describe: ____
- ☐ Shellfish
- ☐ Foods: ________________________ Please Describe: ____
- ☐ Latex
- ☐ Rubber (band-aids, tape, spandex, balloons)
- ☐ Kiwis, chestnuts, bananas, avocado
- ☐ No Known allergy
- ☐ After doctor/dental visits (please describe)

ALL Surgeries - Approximate date and type of operations.

Surgery Type	Approximate Date

Family History - Have any blood relatives had any of the following health problems? (Please check all that apply and indicate the relation, such as parent, sibling, aunt, children, etc.)

Health Problem	Affected Relative
☐ Alcohol or drug abuse	
☐ Allergies	
☐ Anesthesia problems	
☐ Arthritis	
☐ Asthma	
☐ Blood disease	
☐ Cancer	
☐ Diabetes	
☐ Genetic problems	
☐ Gastrointestinal disease	
☐ Genitourinary	
☐ Heart disease	
☐ High blood pressure/hypertension	
☐ High lipids	
☐ Psychiatric problems	
☐ Stroke	
☐ Thyroid problems	
☐ Other	

Education - Your highest level of education achieved? High school College Other: ____________

Legal Issues

Are you currently involved in litigation related to your pain? ☐ Yes ☐ No

Have you ever been arrested or had other legal problems? ☐ Yes ☐ No

Explain: ____________

Have you filed a workers compensation claim related to your pain? ☐ Yes ☐ No

Psychological Treatment

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problems, including your current pain complaint? ☐ Yes ☐ No

Explain: ____________

Have you ever though about, planned, or attempted suicide? ☐ Yes ☐ No

Substance Abuse

Do you drink alcohol? If yes, how many drinks per day? ____________ Per week? ____________

Do you have a history of alcoholism? ☐ Yes ☐ No

Have you ever had a DUI/DWI? ☐ Yes ☐ No

Do you have a history of heroin, cocaine, or amphetamine abuse, or addictions to other substances? ☐ Yes ☐ No

If yes, which ones? ____________

Have you ever been in a detoxification program for drug abuse? ☐ Yes ☐ No

Alcoholics Anonymous? ☐ Yes ☐ No Narcotics Anonymous? ☐ Yes ☐ No

Other: ____________

If you are clean and sober from above, how long have you been abstinent? ____________ years

Do you or did you ever smoke cigarettes or use tobacco? ☐ Yes ☐ No

How many years have you or did you smoke? ____________ years

How many packs per day do you or did you smoke? ____________ packs a day

Have you quit using tobacco, and if so when? ____________

Employment

Current employment status? (please circle all that apply)

Employed full time	Employed part time	Temporarily disabled
Permanently disabled	Unemployed	Homemaker
Retired	Student	Unemployed due to pain

Your employment status **HAS** been affected by the present pain condition? ☐ Yes ☐ No

Your employment status **HAS NOT** been affected by the present pain condition? ☐ Yes ☐ No

If disabled, reason: ______________________________

If unemployed, how long have you been off work? (if employed, do not answer) _______ months ______ years

Your current or former occupation(s): ______________________________

Family Life

Living Arrangements – "I currently Am" (check one)

Living ☐ Alone.

Living ☐ With friends.

Living ☐ With children.

Living ☐ With spouse/partner.

Living ☐ With spouse/partner and children.

Previous Diagnostic Studies - please indicate approximate date and location/where performed and result if known.

MRI:
CT:
X-Rays:
EMG/NCS:
Laboratory Data:

Review of Systems - Please check any of the following signs or symptoms that you are currently experiencing.

General

- [ ] Sedation/difficulty awakening/fatigue
- [ ] Fever/chills
- [ ] Weakness
- [ ] Abnormal weight change

ENT

- [ ] Eye pain
- [ ] Dry mouth
- [ ] Double vision
- [ ] Tearing
- [ ] Vision changes
- [ ] Hearing loss
- [ ] Nasal congestion
- [ ] Tinnitus/ringing in the ears
- [ ] Dizziness
- [ ] Sore throat

Respiratory

- [ ] Cough
- [ ] Difficulty breathing
- [ ] Shortness of breath

Cardiovascular

- [ ] Syncope/fainting
- [ ] Edeme/swelling in the legs or arms
- [ ] Palpitations
- [ ] Chest pain

Gastrointestinal

- [ ] Heartburn
- [ ] Nausea/vomiting
- [ ] Abdominal pain
- [ ] Constipation
- [ ] Diarrhea
- [ ] Incontinence (losing control of your stool without knowing)

Genitourinary

- [ ] Pain with urination
- [ ] Urinary retention
- [ ] Urinary incontinence (losing control of your urine without knowing)

Skin

- [ ] Rash
- [ ] Flushing
- [ ] Pruritis/itching
- [ ] Hair/nail changes

Neurologic

- [ ] Headache
- [ ] Seizure
- [ ] Dizziness
- [ ] Coordination problems/ataxia
- [ ] Cognitive impairment/confusion
- [ ] Frequent falls

Psychological

- [ ] Feeling high
- [ ] Depression
- [ ] Anxiety
- [ ] Feeling suicidal

Musculoskeletal

- [ ] Joint pain
- [ ] Stiffness

Endocrine

- [ ] Heat or cold intolerance
- [ ] Sweating
- [ ] Unusual thirst
- [ ] Unusual hunger
- [ ] Unusual sweating
- [ ] Excessive urination

Hematologic

- [ ] Unusual bruising
- [ ] Excessive bleeding

Height: ____________________

Weight: ____________________

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?	☐	☐	☐	☐	☐
2. How often have you felt the need for higher doses of medication to treat your pain	☐	☐	☐	☐	☐
3. How often have you felt impatient with your doctors?	☐	☐	☐	☐	☐
4. How often have you felt that things are just too overwhelming that you can't handle them?	☐	☐	☐	☐	☐
5. How often is there tension in the home?	☐	☐	☐	☐	☐
6. How often have you counted pain pills to see how many are remaining?	☐	☐	☐	☐	☐
7. How often have you been concerned that people will judge you for taking pain medication?	☐	☐	☐	☐	☐
8. How often do you feel bored?	☐	☐	☐	☐	☐
9. How often have you taken more pain medication than you were supposed to?	☐	☐	☐	☐	☐
10. How often have you worried about being left alone?	☐	☐	☐	☐	☐
11. How often have you felt a craving for medication?	☐	☐	☐	☐	☐
12. How often have others expressed concern over your use of medication?	☐	☐	☐	☐	☐
13. How often have any of your close friends had a problem with alcohol or drugs?	☐	☐	☐	☐	☐
14. How often have others told you that you had a bad temper?	☐	☐	☐	☐	☐
15. How often have you felt consumed by the need to get pain medication?	☐	☐	☐	☐	☐
16. How often have you run out of pain medication early?	☐	☐	☐	☐	☐
17. How often have others kept you from getting what you deserve?	☐	☐	☐	☐	☐
18. How often, in your lifetime, have you had legal problems or been arrested?	☐	☐	☐	☐	☐
19. How often have you attended an AA or NA meeting?	☐	☐	☐	☐	☐
20. How often have you been in an argument that was so out of control that someone got hurt?	☐	☐	☐	☐	☐
21. How often have you been sexually abused?	☐	☐	☐	☐	☐
22. How often have others suggested that you have a drug or alcohol problem?	☐	☐	☐	☐	☐
23. How often have you had to borrow pain medications from your family or friends?	☐	☐	☐	☐	☐
24. How often have you been treated for an alcohol or drug problem?	☐	☐	☐	☐	☐

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	☐	☐	☐	☐	☐
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appts.)	☐	☐	☐	☐	☐
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the ER, friends, street sources)	☐	☐	☐	☐	☐
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	☐	☐	☐	☐	☐
5. In the past 30 days, how often have you seriously thought about hurting yourself?	☐	☐	☐	☐	☐
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	☐	☐	☐	☐	☐
7. In the past 30 days, how often have you been in an argument?	☐	☐	☐	☐	☐
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc)?	☐	☐	☐	☐	☐
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	☐	☐	☐	☐	☐
10. In the past 30 days, how often have you been worried about how you're handling your medications?	☐	☐	☐	☐	☐
11. In the past 30 days, how often have others been worried about how you're handling your medications?	☐	☐	☐	☐	☐
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	☐	☐	☐	☐	☐
13. In the past 30 days, how often have you gotten angry with people?	☐	☐	☐	☐	☐
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	☐	☐	☐	☐	☐
15. In the past 30 days, how often have you borrowed pain medication from someone else?	☐	☐	☐	☐	☐
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress?)	☐	☐	☐	☐	☐
17. In the past 30 days, how often have you had to visit the Emergency Room?	☐	☐	☐	☐	☐

GRANGER PAIN & SPINE

Patient Health Questionnaire

Name: ______________________________ Date: ______________

Over the past 2 weeks, how often have you been bothered by any of the following problems? (use “√” to indicate your answer)

	Not a all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so figity or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thought that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	______ +	______ +	______
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying score card)	TOTAL:			

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, ore get along with other people?	
	Not difficult at all ______
	Somewhat difficult ______
	Very difficult ______
	Extremely difficult ______

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