GRANGER
PAIN & SPINE

Double Board-Certified Interventional Pain Physicians
ACGME Fellowship Trained

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

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

WEST JORDAN CLINIC
9001 S. 3200 W.
Bldg. B, Ste. 3
West Jordan, UT 84088

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

Appointment: Date: _____ Time: _____ Location: _____

Dear Patient,

Welcome to Granger Pain & 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 with 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 completed prior to any changes or the prescribing of opioid medications.

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 to prevent any delay in your visit.

To ensure that we provide you with the best possible treatment options, we ask that on your first visit you please bring 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 lab work, x-rays, MRIs, and CT scans; both reports and imaging (on a disc preferably) if possible
3. Any previous related medical records, including provider consultation notes, if you have them
4. Current and valid insurance cards and government issued photo ID
5. Completed Initial Visit Patient Questionnaire (attached)

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

rev 2/2020

GRANGER PAIN & SPINE

Initial Visit Patient Questionnaire

Primary Care Provider: _____ Phone #: _____

Referring Provider (if not the same): _____ Phone #: _____

Patient Information

Last Name: _____ First Name: _____ MI: _____

DOB: _____

About Your Pain

Where is your worst pain? _____

_____

Other pain problems? _____

Onset of Pain and 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 and 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**:

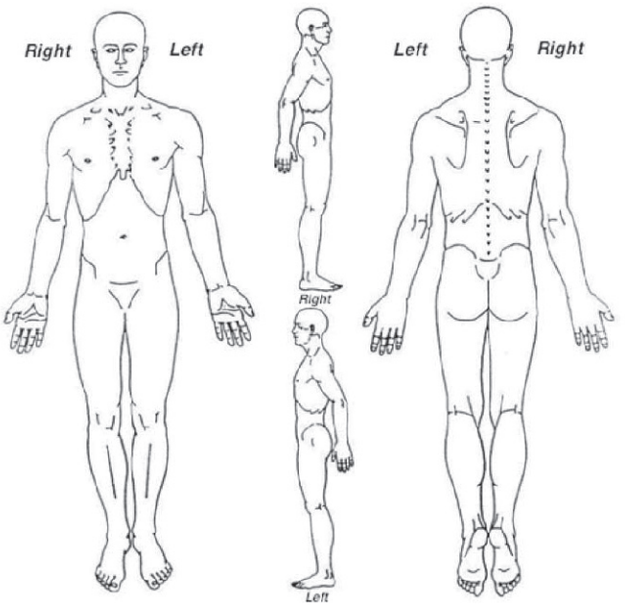
0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

Where Do You Hurt? - Circle all that apply and 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 indicate (with a ✓) improves, worsens, or no change for each item:

	Improves	Worsens	No Change
Lying down			
Standing			
Sitting			
Walking			
Exercise			
Medication			
Relaxation			
Thinking about something else			
Coughing/Sneezing			
Urination/Bowel movements			
Functional limitations			
Endurance			
Sleep			

Functional Limitations

During the past month, please indicate (with a ✓) how much 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 intercourse				
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 there any side effects (list in margin)?

NSAIDs/Anti-Inflammatories

Ibuprofen/Motrin/Advil	☐ Yes	☐ No
Naproxen/Naprosyn/Aleve	☐ Yes	☐ No
Meloxicam	☐ Yes	☐ No
Diclotenac	☐ Yes	☐ No
Celebrex	☐ Yes	☐ No
Acetaminophen/Tylenol	☐ Yes	☐ No

Narcotics

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

Other: _____

Topicals (e.g. patches, creams, ointments, or gels)

OTC (Salonpas, Icy Hot)	☐ 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, Axert, 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 currently taking:

Name of Medication	Dosage	Frequency

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

Do you take any anti-inflammatory medications like aspirin, naproxen (Aleve), meloxicam (Mobic), diclofenac, ibuprofen (Motrin or 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	Chronic cough	Kidney disease	Glaucoma
Angina	Asthma/Emphysema/COPD	Liver disease	Kidney stones
Heart attack/Stents	Seizures or epilepsy	Arthritis	Diabetes
Stroke	Cancer	Bleeding problems	GERD/Reflux
High blood pressure	Psychiatric disorders (e.g. anxiety, depression, or bipolar)		

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 medications 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 — Please describe: _____
- ☐ Iodine — Please describe: _____
- ☐ Medications — Please describe: _____
- ☐ Shellfish — Please describe: _____
- ☐ Foods — Please describe: _____
- ☐ Latex — Please describe: _____
- ☐ Rubber (band-aids, tape, balloons) — Please describe: _____
- ☐ Kiwis, chestnuts, bananas, avocado — Please describe: _____
- ☐ After doctor/dental visits — Please describe: _____
- ☐ No known allergy

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 (e.g. sibling, aunt, child):

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 - What is 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

If yes, please 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

If yes, please explain: _____

Have you ever thought 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 - What is your 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, for how long have you been off work?_____months _____years

Your current or former occupation(s): _____

Family Life - Please indicate your living arrangement (check one):

- ☐ Alone
- ☐ With friends
- ☐ With children
- ☐ With spouse/partner
- ☐ With spouse/partner and children

Previous Diagnostic Studies - Please indicate approximate date and location/where performed, and results 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
- ☐ Edema/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	Seldom	Sometimes	Often	Very Often
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 providers?	☐	☐	☐	☐	☐
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	Seldom	Sometimes	Often	Very Often
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 (e.g. going to class, work, or appointments)?	☐	☐	☐	☐	☐
3. In the past 30 days, how often have you had to go to someone other than your prescribing provider to get sufficient pain relief from medications? (e.g. another doctor, ER, friends, or 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 (e.g. having enough, taking them, or dosing schedule)?	☐	☐	☐	☐	☐
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 or screaming)?	☐	☐	☐	☐	☐
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 medication for symptoms other than 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 (circle the number associated with the frequency you experience each of the following)?

	Not at 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 (that you are a failure/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 cindicated any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all: _____
Somewhat difficult: _____
Very difficult: _____
Extremely difficult: _____