GRANGER
PAIN & SPINE

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Appointment Details

Date: _____ Time: _____ Location: _____ Provider: Select Doctor _____

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.

If your initial questionnaire is not completed prior to your arrival for this consultation, please plan to **arrive 45 minutes early** to complete these forms.

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 the following with you:

1. A list of **ALL** current medications you are taking as well as a list of past pain medications and any medication allergies that you have
2. Current and valid insurance cards and government-issued photo ID
3. **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

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 (please check 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 check the number that best describes your pain **when it is bothering you:**

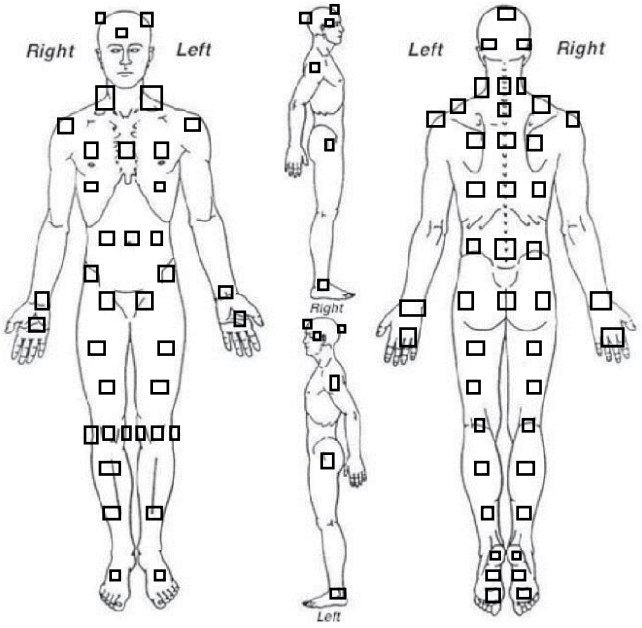
0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

No Pain Worst Pain Imaginable

Where Do You Hurt?

Check all that apply and use he diagram to show where the 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	◯	◯	◯
Endurance	◯	◯	◯
Sleep	◯	◯	◯

Past Interventions

Have you had **prior injections/procedures** for your pain issues? ☐ Yes ☐ No

Where/Which doctor? _____

_____

_____

When? _____

Have you participated in **Physical Therapy (PT)** for your pain issues? ☐ Yes ☐ No

If yes, did you complete a minimum of 4 visits over a 6-week period? ☐ Yes ☐ No

Where/Which PT office? _____

When? _____

Have you participated in **Chiropractic Care** for your pain issues? ☐ Yes ☐ No

If yes, did you complete a minimum of 4 visits over a 6-week period? ☐ Yes ☐ No

Where/Which chiropractor? _____

When? _____

Have you participated in a Physician or PT-directed **Home Exercise Program**? ☐ Yes ☐ No

When? _____

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		◯	◯	◯
☐ Aquatherapy		◯	◯	◯
☐ Heat treatment		◯	◯	◯
☐ Biofeedback		◯	◯	◯
☐ Other: _____		◯	◯	◯

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
Diclofenac	☐ Yes	☐ No
Celebrex	☐ Yes	☐ No
Acetaminophen/Tylenol	☐ Yes	☐ No

Opioids

Tramadol/Ultram	☐ Yes	☐ No
Oxycodone (Percocet)	☐ Yes	☐ No
Hydrocodone (Norco, Lortab, Vicodin)	☐ Yes	☐ No
Codeine (Tylenol #3)	☐ Yes	☐ No
Morphine	☐ Yes	☐ No
Hydromorphone (Dilaudid)	☐ Yes	☐ No
Fentanyl	☐ Yes	☐ No
Nucynta	☐ Yes	☐ No
Methadone	☐ Yes	☐ No
Butrans	☐ 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

Other

Beta Blockers	☐ Yes	☐ No
Medical Cannabis	☐ Yes	☐ No
Aimovig	☐ Yes	☐ No
Ajovy	☐ Yes	☐ No
Emgality	☐ Yes	☐ No
Botox	☐ Yes	☐ No
Oral Steroids	☐ 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

Current Medications Please list ALL medications you are currently taking:

Name of Medication	Dosage	Frequency

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

Do you take any anti-inflammatory medications such as 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 (check 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 ☐ Pacemaker; Type: _____

☐ Venous access device ☐ Intrathecal pump

☐ IUD

Do you have a history of dizziness or passing out with needles, intravenous (IV) placement, 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: _____
- ☐ Latex — Please describe: _____
- ☐ Rubber (band-aids, tape, balloons) — 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 (check all that apply)?

☐ Employed full-time	☐ Employed part-time	☐ Temporary disabled
☐ Permanently disabled	☐ Unemployed	☐ Homemaker
☐ Retired	☐ Student	☐ Unemployed due to pain

Has your employment status **been affected** by the present pain condition? ◯ Yes ◯ No

If yes, please explain: _____

_____

If disabled, what is the reason? _____

If unemployed, how long have you been out of work? _____ months, _____ years

What is 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 the approximate date and location of where performed, and results if known:

MRI: _____

CT: _____

X-Rays: _____

EMG/NCS: _____

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: _____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally, but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help, but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights, but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example, on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking*

- ☐ Pain does not prevent me from walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than ½ a mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ○ I can sit in any chair as long as I like
- ○ I can only sit in my favorite chair as long as I like
- ○ Pain prevents me from sitting more than 1 hour
- ○ Pain prevents me from sitting more than 30 minutes
- ○ Pain prevents me from sitting more than 10 minutes
- ○ Pain prevents me from sitting at all

Section 6 – Standing

- ○ I can stand as long as I want without extra pain
- ○ I can stand as long as I want, but it gives me extra pain
- ○ Pain prevents me from standing for more than 1 hour
- ○ Pain prevents me from standing for more than 30 minutes
- ○ Pain prevents me from standing for more than 10 minutes
- ○ Pain prevents me from standing at all

Section 7 – Sleeping

- ○ My sleep is never disturbed by pain
- ○ My sleep is occasionally disturbed by pain
- ○ Because of pain, I have less than 6 hours of sleep
- ○ Because of pain, I have less than 4 hours of sleep
- ○ Because of pain, I have less than 2 hours of sleep
- ○ Pain prevents me from sleeping at all

Section 8 – Sex Life (if applicable)

- ○ My sex life is normal and causes no extra pain
- ○ My sex life is normal, but causes some extra pain
- ○ My sex life is nearly normal, but is very painful
- ○ My sex life is severely restricted by pain
- ○ My sex life is nearly absent because of pain
- ○ Pain prevents any sex life at all

Section 9 – Social Life

- ○ My social life is normal and gives me no extra pain
- ○ My social life is normal, but increases the degree of pain
- ○ Pain has no significant effect on my social life apart from limiting my more energetic interests such as sports
- ○ Pain has restricted my social life and I do not go out as often
- ○ Pain has restricted my social life to my home
- ○ I have no social life because of pain

Section 10 – Traveling

- ○ I can travel anywhere without pain
- ○ I can travel anywhere, but it gives me extra pain
- ○ Pain is bad, but I manage journeys over 2 hours
- ○ Pain restricts me to journeys of less than 1 hour
- ○ Pain restricts me to short, necessary journeys under 30 minutes
- ○ Pain prevents me from traveling except to receive treatment

	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: 0

10. If you indicated 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: _____