DISC Patient Questionnaire

Please complete and bring with you to your appt on:_______________________ At:__________

***** If your X-rays or MRI were not done at Derry Imaging please bring disc.***

Part A: General Information

Name: ______________________Date of Birth________ Age_____ Height_______ Weight_______

Primary Care Physician: ____

Referring Physician: ____

Education: ☐ l -8 grades ☐ High School Graduate ☐ GED ☐ College Graduate

Marital Status: ☐ Single ☐ Married ☐ Divorced

With whom do you live? ____

Part B: Vocational Information

Current Occupation or last job: ____

Current Employment Status:

☐ Employed Full-Time ☐ Employed Part-Time ☐ Unemployed ☐ Retired

☐ Student ☐ Military ☐ Veteran

Part C: Compensation and Legal Information

Are you receiving compensation or disability payments now? ☐ Yes ☐ No

Are you presently involved in a lawsuit? ☐ Yes ☐ No

Is your pain the result of an accident? If yes, please describe briefly.

____

Part D: General Medical Information

Past Medical History: (check all that apply)

☐ Angina ☐ Arthritis ☐ Anxiety/Depressions ☐ Bladder/Kidney Problems

☐ Blood Clots/Bleeding Disorders ☐ Cancer ☐ COPD/Asthma

☐ CHF I Heart Failure ☐ Diabetes/ Thyroid ☐ Pacemaker ☐ Prostate Problems

☐ Reflex/Hiatal Hernia/Ulcer ☐ Seizures/Epilepsy ☐ Sexually Transmitted Disease

☐ Stroke/TIA ☐ Sleep Apnea/CPAP ☐ Visions/Hearing Problems

☐ Other ______________________________

Past Surgical History:

____

____

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____

Medications with Dosage and Frequency (including over-the-counter medications)

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____

____

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____

Allergies to medication (with reaction)

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____

Are you on blood thinners? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Part E: Emotional History

Have you ever experienced any physical, emotional, or sexual abuse? ☐ Yes ☐ No
(If yes, please explain):

____

____

____

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

(If yes, please explain)

____

____

____

Are you safe at home? ☐ Yes ☐ No

Is anyone threatening or hurting you in any way? ☐ Yes ☐ No

Part F: Pain History

Mark the location(s) of your pain with an "x" on the diagram. If whole areas are painful, shade in the painful area

Describe your pain: ____________________

____

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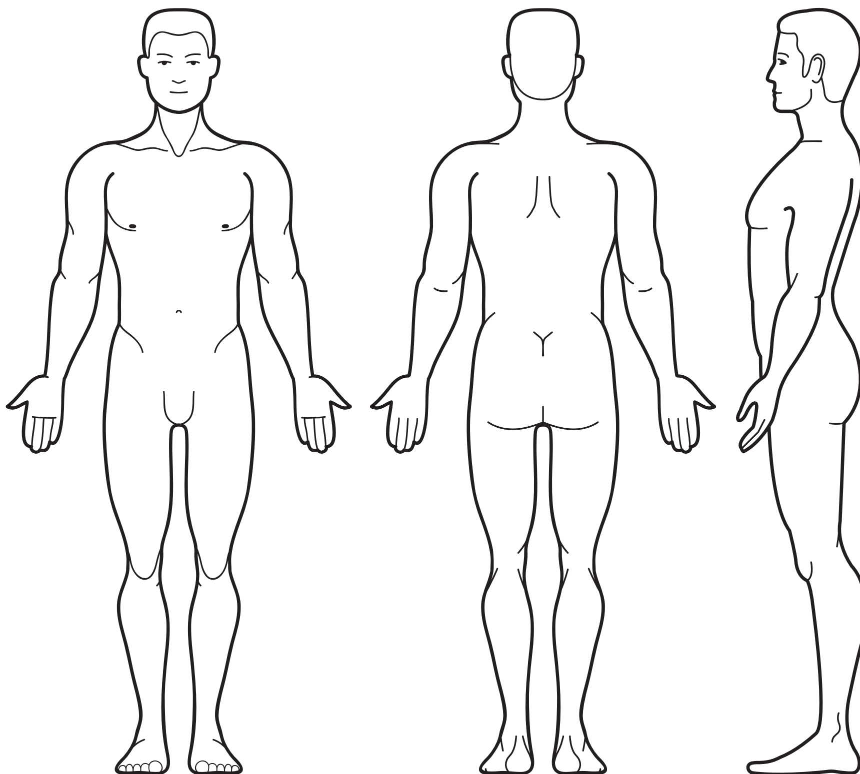
____

☐ Deep (inside) ☐ Superficial (on the skin) ☐ Constant (all the time)
☐ Intermittent (starts & stops)

☐ Aching ☐ Burning ☐ Shooting
☐ Stabbing ☐ Tingling ☐ Numb
☐ Weak ☐ Throbbing ☐ Other

Have you experienced any falls in the past 3 months? ☐ Yes ☐ No



Previous treatments tried for your pain:
(check all that apply. If helpful indicate by writing "yes" after the check box)

☐ Hospital bed rest ☐ Traction ☐ Surgery ☐ Nerve Block or injection

☐ TENS (electrical stimulator) ☐ Physical therapy (for how long?) ☐ Massage

☐ Home exercise & Stretching program ☐ Acupuncture ☐ Psychotherapy

☐ Chiropractic ☐ NSAIDS ☐ Muscle Relaxants ☐ Steroids ☐ Narcotics

☐ Membrane Stabilizers (Gabapentin, Lyrica, Topamax, Carbamazepine etc. ☐ Antidepressants ☐ Heat/Ice

Have you been to another Pain Center for injection or medication therapy? (Briefly describe)

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____

____

____

What is the main problem for which you are seeking treatment at the Interventional Spine and Pain Center?

____

____

How long have you had your current pain problem (in years and/or months?)

____

How did your current pain start? Was there a precipitating event?

____

How do the following affect your pain? (check one for each item)

	Decrease	**No Effect**	**Increase**
Bending forward	☐	☐	☐
Arching backward	☐	☐	☐
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Medication	☐	☐	☐

Are there other factors that make your pain:

Better? (please list) ____________________________

Worse? (please list) ____________________________

Rate your pain intensity on a scale from 0 to 10 with 0 =no pain / 10 = excruciating, incapacitating worst pain possible. Rate your pain during the past month or so since your injury. Circle the number for each question below.

Your pain at its worst	0	1	2	3	4	5	6	7	8	9	10
Your pain at its least	0	1	2	3	4	5	6	7	8	9	10
Your average pain	0	1	2	3	4	5	6	7	8	9	10

How often do you have your pain?

☐ Constantly (100% of the time

☐ Intermittently (30% to 60% of the time)

☐ Nearly constantly (60% to 95% of the time)

☐ Occasionally (less than 30% of the time)

Part G: Substance Use History

Have you ever been in treatment for abuse of alcohol, illicit drugs, or prescribed medications?

☐ No ☐ Yes If yes, where and when?

Are you currently using any of the drugs/substances listed below?
Next to each drug or substance checked, indicated if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol______________ Cocaine____________ Amphetamines _______________ Barbiturates _____________

Heroin ______________ Marijuana (indicate recreational or medicinal) ______________________

Other (specify) ____________________

Do you presently smoke cigarettes or use tobacco in any form? ☐ Yes ☐No

If not, did you ever smoke cigarettes or use tobacco in any form? ☐ Yes ☐No

How many packs do (did) you smoke a day? ____________________

For how many years? __________

Do you use any Marijuana based products for the treatment of your pain? ☐ Yes ☐No

Indicate whether topical, oral, or inhaled?

____