

# Central Texas Spine Institute, LLP

An Association of Independent Medical Practices  
Specializing in Spinal Disorders and Pain Management

Neal H. Blauzvern, D.O.  
6818 Austin Center Blvd., Ste. 200  
Austin, Texas 78731  
(512) 795-9482

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Name

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Address

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Address

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City

State

Zip Code

Dear Patient:

The attached includes an information sheet, a form authorizing direct billing to the insurance company, a Pain Clinic questionnaire, and a form authorizing us to relay medical findings to your referring physician. ***It is very important that all of the forms are filled out completely at home before you come in for your appointment.*** If there are any questions regarding these forms please call our office and ask for assistance. This information is strictly confidential and will not be released to anyone without your permission.

Sincerely,

James M. Gdula  
Business Manager

attachments

Appointment Date \_\_\_\_\_

Time \_\_\_\_\_

**\* PLEASE ARRIVE AT THE OFFICE 30 MINUTES BEFORE YOUR APPOINTMENT WITH ALL FORMS COMPLETED. OTHERWISE, THE DOCTOR WILL NOT BE ABLE TO PROPERLY EVALUATE YOU, AND YOUR APPOINTMENT WILL HAVE TO BE RESCHEDULED.**



# PAIN EVALUATION QUESTIONNAIRE

Date \_\_\_\_\_

1. Name \_\_\_\_\_  
Last First Middle

2. Address \_\_\_\_\_  
No. Street City State Zip Code

3. Date of Birth \_\_\_\_\_  
Month/Day/Year

4. Current Marital Status:  Single  Married  Separated  Divorced  Widowed

5. Number of Children \_\_\_\_\_ Ages of Children \_\_\_\_\_

6. If you are married, what is your spouse's occupation (be specific): \_\_\_\_\_  
\_\_\_\_\_

**THE FOLLOWING QUESTIONS RELATE TO YOUR EMPLOYMENT. Please answer all questions that apply to you.**

7. Are you presently employed?  Full Time  Part Time  Housewife/Homemaker  
 Unemployed If unemployed, how long? \_\_\_\_\_

8. What is, or was, your specific occupation? Briefly describe what you do or what you did on your job.  
\_\_\_\_\_

9. If you are unemployed or employed part time, is this due to your present pain condition?

Yes  No

10. How long have you been working for your present employer? \_\_\_\_\_ years  
If unemployed, retired, disabled, etc., how long did you work for your last employer? \_\_\_\_\_ years

11. Do you enjoy your work?

All the time  Most of the time  Some of the time  Rarely or not at all

**IF YOUR PRESENT PAIN CONDITION WAS CAUSED BY YOUR JOB OR OCCURRED WHILE ON THE JOB OR WAS DUE TO AN ACCIDENT, PLEASE ANSWER THE FOLLOWING:**

12. Have you ever received compensation for your injury/illness?  Yes  No  Still waiting

13. If you have received compensation, do you feel that it has been satisfactory?  Yes  No

14. Are you now, or have you ever, been involved in a lawsuit regarding your pain?  Yes  No  
If yes, who are your attorneys? \_\_\_\_\_

Name \_\_\_\_\_

15. Have you attempted to return to work?  Yes  No  
If yes, did you attempt to work?  Full Time  Part Time

16. Compared to your abilities (including housewife) before your present condition, how do you see your present job abilities?

- Can do as much as before       Can do somewhat less than before  
 Can do much less than before       Cannot do job at all

17. Comparing how you were **BEFORE** you had your pain problem with your **PRESENT** condition, please answer the questions below:

#### SOCIAL ACTIVITIES

**Desire** for social activities:  Remains the same as before       Somewhat less than before  
 Very much less than before       No desire for such activities

**Ability** for social activities:  Remains the same as before       Somewhat less than before  
 Very much less than before       No ability for such activities

#### RECREATIONAL ACTIVITIES

**Desire** for such activities:  Remains the same as before       Somewhat less than before  
 Very much less than before       No desire for such activities

**Ability** for recreational activities:  Remains the same as before       Somewhat less than before  
 Very much less than before       No longer have the ability

18. Are you frequently confined to bed because of poor health?  Yes  No

19. What do **YOU** think is the cause of your pain? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

20. Since your pain condition began, which of the following people have you consulted for treatment and pain relief? Please also list the health care provider's name that you consulted.

- |  |   |
|--|---|
| <input type="checkbox"/> Allergist/Immunologist                      | <input type="checkbox"/> Ophthalmologist (Eyes)                 |
| <input type="checkbox"/> Cardiologist                                | <input type="checkbox"/> Orthopedist (Bone, Joints and Muscles) |
| <input type="checkbox"/> Dermatologist                               | <input type="checkbox"/> Pediatrician (Children)                |
| <input type="checkbox"/> Ear, Nose or Throat (Otorhinolaryngologist) | <input type="checkbox"/> Plastic Surgeon                        |
| <input type="checkbox"/> Endocrinologist (Glandular Disorders)       | <input type="checkbox"/> Radiologist                            |
| <input type="checkbox"/> General Practice or Family Practice         | <input type="checkbox"/> Surgeon (General)                      |

Name \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> Internal Medicine (Internist) | <input type="checkbox"/> Psychologist                |
| <input type="checkbox"/> Neurologist (Nervous System)  | <input type="checkbox"/> Osteopath                   |
| <input type="checkbox"/> Obstetrician/Gynecologist     | <input type="checkbox"/> Dentist                     |
| <input type="checkbox"/> Neurosurgeon                  | <input type="checkbox"/> Clergyman                   |
| <input type="checkbox"/> Acupuncturist                 | <input type="checkbox"/> Chiropractor                |
| <input type="checkbox"/> Faith Healer                  | <input type="checkbox"/> Hypnotist                   |
| <input type="checkbox"/> Physical Therapy              | <input type="checkbox"/> Pain Clinic (Specify) _____ |
|  | <input type="checkbox"/> Other (Specify) _____       |

21. Have any doctors ever told you that your pain was imaginary or "all in your head"?  Yes  No

22. Under what circumstances did your pain begin:

- |   |   |
|---|---|
| <input type="checkbox"/> Accident at work             | <input type="checkbox"/> Following surgery                            |
| <input type="checkbox"/> Accident at home             | <input type="checkbox"/> Following illness                            |
| <input type="checkbox"/> Other accident               | <input type="checkbox"/> Pain just began; can't relate it to anything |
| <input type="checkbox"/> At work, but not an accident | <input type="checkbox"/> Other reasons or circumstances               |

23. Please describe the circumstances you checked above. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

24. When did you first experience the pain for which you are now seeking help? Date \_\_\_\_\_

25. In what part(s) of the body did the pain begin? (Name all parts) If it spread to other parts of the body, which parts?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

26. The following words represent pain of increasing intensity. How would you describe your pain?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Mild                   | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Distressing - Fairly Severe |
| <input type="checkbox"/> Very Severe - Horrible |  | <input type="checkbox"/> Unbearable - Excruciating   |

Name \_\_\_\_\_

27. Do you have trouble falling asleep because of pain?  
 Never     Sometimes     Usually     Always

28. Does pain wake you up while your are sleeping?  
 Never     Sometimes     Usually     Always

29. Do you take medicine to help you fall asleep?  
 Never     Sometimes     Usually     Always

30. If you take medicine for sleep, is the medicine prescribed or recommended by your doctor?  Yes  No  
Decided to take yourself?  Yes  No

31. What is the name of the sleep medicine you take? \_\_\_\_\_

32. What do you do (activities) that will bring on the pain or make the pain worse?  
\_\_\_\_\_

33. About how long after beginning this activity does it take for the pain to begin or become worse?  
\_\_\_\_\_

34. What do you do to decrease the pain? (Massage, medicine, lying down, relaxation, etc.)  
Describe exactly what brings relief: \_\_\_\_\_  
\_\_\_\_\_

35. How long does it take for these remedies to take effect? \_\_\_\_\_

36. How many times during the day do you usually have to lie down because of pain?  
\_\_\_\_\_

37. How many times during an average day do you have to stop what you are doing because of pain?  
\_\_\_\_\_

38. Do you have days when the pain is so bad that you spend the day in bed?     Yes     No  
If yes, about how often does this happen? \_\_\_\_\_

39. Please list **ALL** medications you are **NOW** taking for pain.

<u>Pain Medications</u>	<u>Dose</u>	<u>Frequency</u>	<u>Date Started</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name \_\_\_\_\_

40. Please list **ALL** the medications that you have tried previously for the pain.

<u>Pain Medications</u>	<u>Dose</u>	<u>Frequency</u>	<u>Date Started</u>	<u>Date Stopped</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

41. Please list **ALL** other medications you take currently. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

42. Are you allergic to any medications? If so, please list them.

\_\_\_\_\_  
\_\_\_\_\_

43. Please list all Physical Therapy treatments you have received.

<u>Location</u>	<u>Treatments</u>	<u>Dates</u>	<u>Response</u>
_____	_____	_____	_____
_____	_____	_____	_____

44. Have you ever used a TENS unit? If so, what was your response?

<u>Dates Used</u>	<u>Response</u>
_____	_____
_____	_____

45. Have you ever had injections or nerve blocks for the pain? If so, what was the response?

<u>Treatment</u>	<u>Physician</u>	<u>Response</u>
_____	_____	_____
_____	_____	_____

46. Have you ever used any of the following techniques of pain control? If so, what was the response?

	<u>Dates</u>	<u>Location (Physician)</u>	<u>Response</u>
Biofeedback	_____	_____	_____
Hypnosis	_____	_____	_____
Relaxation Training	_____	_____	_____
Counseling	_____	_____	_____

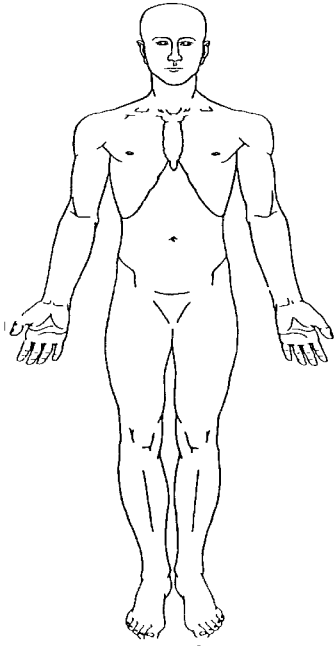
47. Have you ever had any operations for the pain? If so, what were the results?

\_\_\_\_\_  
\_\_\_\_\_

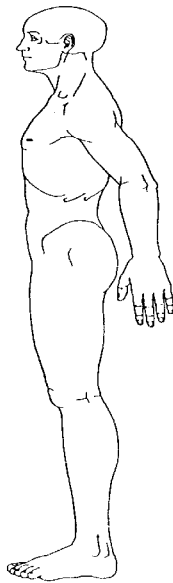


Name \_\_\_\_\_

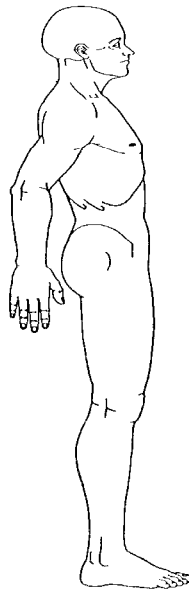
54. Please mark with an 'X' on these diagrams exactly where your pain or problems are located. Also, use an arrow to show where the pain goes, if the pain radiates to another part of your body.



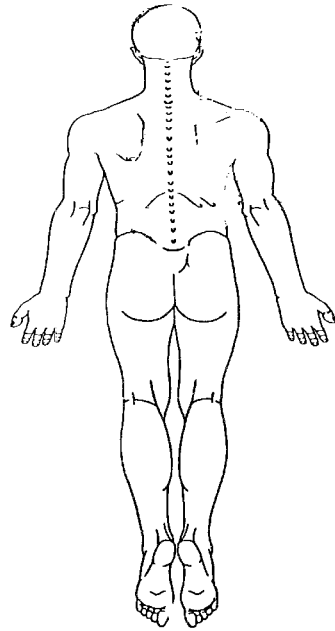
**FRONT**



**LEFT**



**RIGHT**



**BACK**

## **MISSED APPOINTMENT CHARGE**

**THERE WILL BE A \$50.00 NO-SHOW CHARGE TO ALL PATIENTS WHO DO NOT GIVE 24 HOUR NOTICE OF CANCELLATION. THIS INCLUDES PATIENTS WHO ARE MORE THAN 15 MINUTES LATE.**

**INSURANCE COMPANIES DO NOT COVER THIS CHARGE. IF YOU DO NOT SHOW OR DO NOT CANCEL, THIS FEE WILL BE YOUR RESPONSIBILITY.**

**ANYONE WITH A NO-SHOW FEE MUST PAY ON OR BEFORE YOUR NEXT VISIT IN ORDER TO SEE THE DOCTOR**

**PLEASE HELP US AND HELP YOURSELF BY BEING ON TIME TO YOUR APPOINTMENT.**

**THANK YOU!**

I have read the above and understand my responsibility.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date