TDC
THE DOCTORS CLINIC

Interventional Spine/Pain

2200 NW Myhre Road • Silverdale, WA 98383 **(360) 830-1301**

Beno Kuharich, D.O.

Patient Information

Today's date:

Your name: Date of Birth: Age:

Referring Physician: _____ **Primary Care Physician:** _____

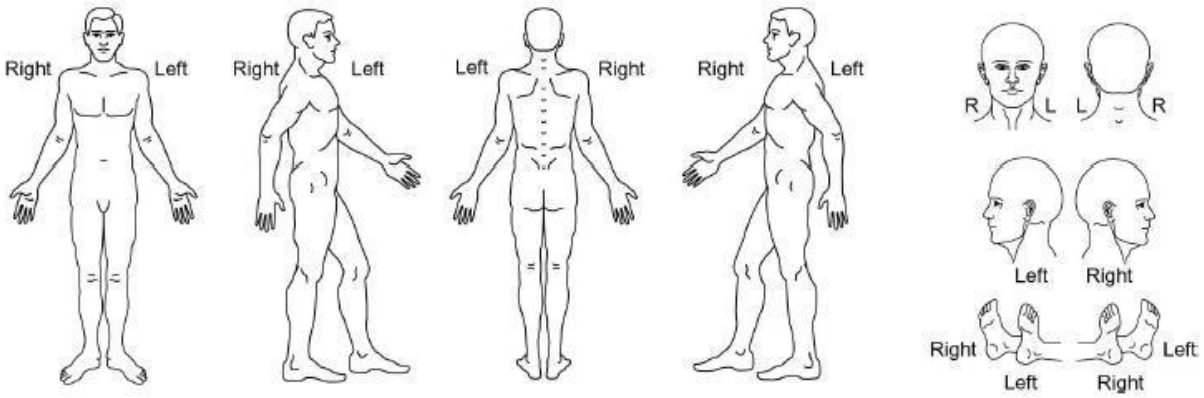
Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

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Pain Description **«PatientFullName»**

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp
☐ Cramping ☐ Numbness ☐ Spasm ☐ Throbbing
☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness

When is your pain at its worst?

☐ Mornings ☐Daytime ☐ Evenings ☐ Middle of the night
☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present
☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

Is your pain level affected by any of these daily living tasks:

	Yes	No		Yes	No
Bending Backward			Looking upward		
Bending Forward			Looking downward		
Changes in Weather			Rising from seated position		
Climbing Stairs			Sitting		
Coughing/Sneezing			Standing		
Driving			Walking		
Lifting Objects			Dressing		

What other factors worsen or affect your pain which is not mentioned above?

_____
_____

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Associated Symptoms

	No	Yes	Comments
Numbness/Tingling	☐	☐	Where?_____
Weakness in the arm/leg	☐	☐	_____
Balance Problems	☐	☐	_____
Bladder Incontinence	☐	☐	_____
Bowel Incontinence	☐	☐	_____
Joint Swelling/Stiffness	☐	☐	_____
Fevers/chills	☐	☐	_____

Please mark all of the following treatments you have used for pain relief: ☑

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Brace Support	☐	☐	☐
Hot Packs	☐	☐	☐
Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
TENS Unit	☐	☐	☐
Medications: _____	☐	☐	☐
ANSAIDS	☐	☐	☐
Tylenol	☐	☐	☐

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
☐ Joint Injection – Joint(s) _____
☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
☐ MILD (Minimally Invasive Lumbar Decompression) - _____
☐ Nerve Blocks – Area/Nerve(s) -_____
☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar
☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____
☐ Trigger Point Injections – Where_____
☐ Vertebroplasty/Kyphoplasty – Level(s) _____
☐ Other_____

Which of these procedures listed above have helped with your pain?

_____

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«PatientFullName»

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

☐MRI of the: _____ Date: _____
☐X-Ray of the: _____ Date: _____
☐CT Scan of the: _____ Date: _____
☐EMG/NCV study of the: _____ Date: _____
☐Other Diagnostic Testing: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

		Effective	**Not effective**
☐	Acupuncturist _____	☐	☐
☐	Internist _____	☐	☐
☐	Neurosurgeon _____	☐	☐
☐	Psychiatrist/Psychologist _____	☐	☐
☐	Chiropractor _____	☐	☐
☐	Orthopedic Surgeon _____	☐	☐
☐	Rheumatologist _____	☐	☐
☐	Physical Therapist _____ **How long were you treated _____**	☐	☐
☐	Neurologist_____	☐	☐
☐	Other _____	☐	☐

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Review of Systems «PatientFullName»

Mark the following symptoms that you currently suffer from:

Constitutional:

☐ Chills ☐ Difficulty sleeping ☐ Easy bruising
☐ Night Sweats ☐ Fatigue ☐ Fevers
☐ Insomnia ☐ Low sex drive ☐ Tremors
☐ Unexplained Weight Gain ☐ Weakness
☐ Unexplained Weight Loss

Eyes:

☐ Recent Visual changes

Ears/Nose/Throat/Neck:

☐ Dental Problems ☐ Earaches ☐ Hearing Problems
☐ Nosebleeds ☐ Sinus problems

Cardiovascular:

☐ Chest Pain ☐ Bleeding Disorder ☐ Blood Clots
☐ Fainting ☐ Palpitations ☐ Swelling in feet
☐ Shortness of breath during sleep

Respiratory:

☐ Cough ☐ Wheezing ☐ Shortness of breath

Gastrointestinal:

☐ Constipation ☐ Acid Reflux ☐ Abdominal Cramps
☐ Diarrhea ☐ Nausea/Vomiting ☐ Hernia

Musculoskeletal:

☐ Back Pain ☐ Joint Pains ☐ Joint Stiffness
☐ Joint Swelling ☐ muscle spasms ☐ Neck Pain

Genitourinary/Nephrology:

☐ Flank Pain ☐ Blood in Urine ☐ Painful Urination
☐ Decreased Urine Flow/Frequency/Volume

Neurological:

☐ Dizziness ☐ Headaches ☐ Tremors
☐ Numbness/Tingling ☐ Seizures

Psychiatric:

☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems
☐ Suicidal Thoughts ☐ Suicidal Planning
☐ Thoughts of Harming Others