NORTHWEST
SPINE & PAIN MEDICINE

Dear: _____

We would like to welcome you as a new patient to Northwest Spine &Pain Medicine. The parking area is often quite busy; please allow yourself ample time to get to your appointment on time.

Your Physician has referred you to Northwest Spine and Pain Medicine.

Email: Medicalrecords@nwspm.com

Fax: 888-316-1928

South Hill Office: 3124 S. Regal Street, Spokane, WA 99223

Northside Office: 9425 N. Nevada St. Suite 300, Spokane, WA 99218

Coeur D'Alene: 509 W. Hanley Ave. Suite 101, Coeur D'Alene, ID 83814

- Due to the high volume of patients, if you are not on time for your appointment, with paperwork filled out, your appointment may need to be rescheduled.
- If your insurance requires a referral/authorization please make sure your **P**rimary **C**are **P**hysician (**PCP**) has certified your appointment with a written referral or phone call.
- Please bring all your current insurance information – for example: L&I, insurance card, referral information. If this information is not provided at the time of service, you may be rescheduled.
- All Co-pays must be paid at the time of service
- **IT IS CRUCIAL TO HAVE ALL DIAGNOSTIC STUDIES AT THE TIME OF YOUR APPOINTMENT OR YOU MAY BE RESCHEDULED.** If your films were done at Inland Imaging, Rockwood Clinic, Deaconess, Columbia Imaging, it is not necessary to call us as we have access to those images via the computer. If these have been done outside of Spokane, you will need to hand-carry them to your appointment.
- If you have paperwork for us to fill out, please allow 7 – 10 working days.
- **Please call the office with routine questions and requests during business hours Monday – Friday 8:00AM – 5:00PM.**
- Please allow 24 – 48 hours for medication refills. (THERE WILL BE NO MEDICATION REFILLS DURING WEEKEND AND NON-BUSINESS HOURS.)

We look forward to working with you. If you have any questions regarding your appointment, films, or insurance, please contact the assistant at (509) 464-6208.

Date: _____ Check- in Time: _____ Location: _____

Thank you.
Northwest Spine and Pain Medicine

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Name: (Last)_____(First)_____(MI)_____ Female☐ Male☐

Social Security No. _____ Age:_____DOB _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone: Home_____ Cell: _____

Work Number: _____ Employer: _____

Referring Doctor's full name: _____

Primary care Provider's full name: _____

Pharmacy Name: _____ Phone: _____ Location: _____

What are you being seen for today? _____

Is your pain work related? Yes ☐ No ☐ Claim #_____ Date of Injury_____

Is your pain due to a Motor Vehicle Accident? Yes ☐ No Who was at fault?_____

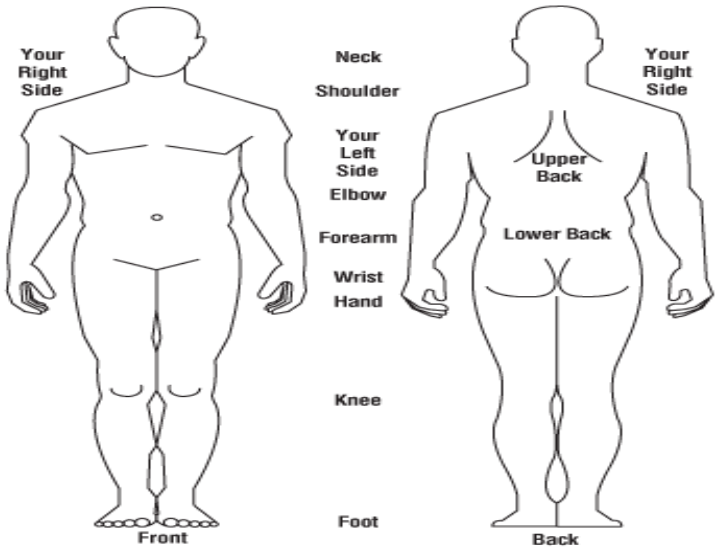
Please mark the severity of your pain on the following line:

On your **worst** days with one your **average** days with A On your **best** days with B

No pain 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-----10 Most Severe

PAIN DIAGRAM

Mark the areas on your body where you feel the described sensations. Please mark all affected areas.
Use the appropriate symbols: Numbness --- Pins/Needles OOO Burning XXX Stabbing /// Aching +++



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REVIEW OF SYSTEMS

Do you currently have or have you had in the past 2 weeks?

General: ☐Fever ☐Chills ☐Weight Loss ☐Weight Gain ☐Fatigue ☐Weakness

Vision: ☐Change in Vision ☐Pain With Light ☐Cataracts ☐Glaucoma ☐Recent Injury ☐Vision Loss ☐Eye Pain ☐Infections

Cardiovascular: ☐Chest pain ☐Heart murmur ☐Extremity(s) cool ☐History of heart attack ☐Ulcers on legs ☐Palpitations ☐Extremity(s) discolored ☐Leg pain walking ☐Swelling of Legs ☐High Blood Pressure ☐Thrombophlebitis

Gastrointestinal: ☐Abdominal Pain ☐Heartburn ☐Rectal Bleeding ☐Blood in Stools ☐Hepatitis ☐Excessive Hunger or Thirst ☐Hemorrhoids ☐Laxative Use ☐Swallowing Problems ☐Constipation ☐Nausea ☐Vomiting ☐Diarrhea ☐Liver Disease ☐Decreased Appetite ☐Gallbladder Disease ☐Vomiting Blood

Musculoskeletal: ☐Arthritis ☐Back Problems ☐Muscle Cramps ☐Restricted Motion ☐Joint Pain ☐Muscle Stiffness ☐Deformities ☐Weakness ☐Gout ☐Joint Stiffness ☐Paralysis

Psychiatric: ☐Depression ☐Anxiety ☐Disturbing Thoughts ☐Memory Loss ☐Psychiatric Disorders ☐Behavioral Change ☐Excessive Stress ☐Mood Changes ☐Disorientation ☐Hallucinations

Neurologic: ☐Loss of Consciousness ☐Dizziness ☐Headaches ☐Paralysis ☐Tingling ☐Numbness ☐Blackouts ☐Fainting ☐Memory Loss ☐Speech Disorders ☐Tremors ☐Burning ☐Head Injury ☐Strokes ☐Unsteady Gait

Endocrine: ☐Weakness ☐Cold Intolerance ☐Goiter ☐Weight Gain ☐Excessive Urination ☐Heat Intolerance ☐Sweats ☐Weight Loss ☐Fatigue ☐Increased Thirst ☐Thyroid Trouble

Hematologic/Lymph: ☐Anemia ☐Swollen Glands ☐Bleeding Easily ☐Lumps ☐Blood Clots

Ears, Nose, Throat, (Allergic/Immunologic): ☐Runny Nose ☐Recurrent Infections ☐Stuffy Nose ☐Frequent Colds ☐Discharge ☐Sinus Infection ☐Nose Bleeds ☐Hearing Aid ☐Ringing in Ears ☐Tonsils Enlarged ☐Lumps ☐Tenderness ☐Asthma ☐Bronchitis ☐Shortness of Breath ☐Cough ☐Coughing Blood ☐Positive TB Test ☐Wheezing

PAST MEDICAL HISTORY

Check the medical problems you currently have or have had in the past.

• Cancer, If so, what type?	• HIV
• Congestive heart failure	• Ulcers/ GERD
• Heart Disease, Cardiologist:	• History of blood transfusions
• Hypertension (high blood pressure)	• Rheumatoid arthritis
• Heart attack	• Seizures/epilepsy
• Heart murmur	• COPD
• Diabetes: • Insulin • Oral Meds • Diet Controlled	• Asthma, If yes, last hospitalization: _____
• Hypothyroidism	• Sleep apnea, if you, do you use a CPAP? _____
• Depression/Anxiety	• Stroke
• Blood clots (DVT/Pulmonary embolus)	• MRSA

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• Kidney disease	Other:
• Hepatitis A • B • C •	

ALLERGIES

Please list all allergies, including medications, iodine and contrast. None know ☐ Or Yes, ☐ Please list them:

_____

_____

FAMILY HISTORY Please list family history. If yes, list relative, if they are living, and age at death if deceased.

Problem List			Relative	Living?		
	Yes	No		Yes	No	Age at death
Blood Clotting disorders	☐	☐		☐	☐	
Cancer, what type?	☐	☐		☐	☐	
Diabetes	☐	☐		☐	☐	
Heart disease/heart attack	☐	☐		☐	☐	
Hypertension	☐	☐		☐	☐	
Stroke	☐	☐		☐	☐	
Other:						

SOCIAL HISTORY

History of substance abuse?	☐ YES ☐ NO	If yes, describe:
Do you drink alcohol?	☐ YES ☐ NO	If yes, ☐ Occasional ☐ Moderate ☐ Heavy
Smoke currently?	☐ YES ☐ NO	If yes, packs/day for years
Quit Smoking?	☐ YES ☐ NO	If yes, how long ago did you quit?
Are you married?	☐ YES ☐ NO	If yes, what is your spouse's name?
Employed:	☐ YES ☐ NO	☐ Full-time ☐ Part-Time ☐Disabled ☐ Retired
		Occupation:
Do you have children?	☐ YES ☐ NO	If yes, number of children:
Student?	☐ YES ☐ NO	

MEDICATIONS

List ALL medications, including over the counter products, minerals, vitamins, herbals and dietary supplements.
For pain medications, please include the date started and if it provided relief.

Drug Name	Dose/How often	Drug Name	Dose/How often

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HAVE YOU EVER BEEN ON THESE MEDICATIONS:

Medication:	***Date tried or current use:***	***Effects:***
Cymbalta / duloxetine		
Savella / milnacipran		
Elavil /amitriptyline		
Pamelor / nortriptyline		
Neurontin / gabapentin		
Lyrica / pregabalin		
Buprinorphine		

PAST SURGICAL HISTORY Please list all surgeries you have had, including the date. Circle Right of Left.

PRIOR JOINT SURGERIES			Date	Other Surgeries		Date
Hip	☐No ☐Yes	R L		Heart surgery/stents	☐No ☐Yes	
Knee	☐No ☐Yes	R L		Appendectomy	☐No ☐Yes	
Shoulder	☐No ☐Yes	R L		Tonsillectomy	☐No ☐Yes	
Neck	☐No ☐Yes	R L		Gallbladder	☐No ☐Yes	
Back	☐No ☐Yes	R L		Hysterectomy	☐No ☐Yes	
Other Surgeries:	Type & Date					

DIAGNOSTIC STUDIES Which of the following diagnostic tests have been done on your back/neck?

	NO	YES		Date
Regular Spine X-Ray	☐	☐		
CT Scan	☐	☐		
Myelogram	☐	☐		
MRI Scan	☐	☐		
Discogram	☐	☐		
Bone Scan	☐	☐		
EMG	☐	☐		
Nerve Blocks	☐	☐		
Facet Block	☐	☐		

Are you claustrophobic? Yes ☐ No ☐ Do you have any metal in your body? Yes ☐ No ☐

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CONSERVATIVE CARE What types of conservative care have you tried? (Physical therapy, Chiropractic, massage therapy)

What Type?	Where?	How Long? (Date range, # of visits	Did you get relief?

Language:			
Ethnicity	☐ Hispanic/Latino	☐ Not Hispanic/Latino	☐ Refuse to report
Race: ☐White ☐American Indian/Alaska Native	☐ Asian ☐ Pacific Islander	☐ Black/African American ☐ Refuse to report	

Weight: _____ Height: _____ Dominate Hand: ☐ Right ☐ Left

What type of activites do you want to be able to do that you have trouble doing currently?-

_____

_____

_____

Nearest friend/relative to contact in case of an emergency, NOT living with you:

Name: (Last)_____(First)_____(MI)_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home_____ Relationship: _____

Patient/Guardian's Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY AND INSURANCE AUTHORIZATION

Patient Name: _____SSN#_____

Guarantor Name: _____SSN#_____

Guarantor Date of Birth: _____ Telephone Number_____

Guarantor Address: _____

Primary Health Insurance: _____ Policy #_____

Group #_____

Secondary Health Insurance (if applicable: _____

Is your insurance company an HMO or Medicare Replacement/Advantage Plan? Yes_____ No_____

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***Please bring all insurance cards at the time of your visit.**
***All co-payments are due at the time of your visit.**
*** If you have no health insurance to bill, returning visits you will be required to pay $125.00 at time of service.**

Northwest Spine and Pain Medicine (NWSPM) relies on the insurance and billing information provided to us by you or your referring provider. After services are provided, we will submit our claim to your insurance carrier if applicable. In the event that payment is denied, the patient is responsible for full payment. It is the patient's responsibility to contact the financial services department if this obligation cannot be met.

ASSIGNMENT: I HAVE READ, COMPLETED, AND FULLY UNDERSTAND THE INFORMATION ABOVE. I HEREBY AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN AND RELEASE OF ANY INFORMATION REQUIRED.

INSURANCE

To accommodate the needs and requests of our patients, Northwest Spine and Pain Medicine is contracted with most major insurance companies. We are pleased to be able to provide this service to you, yet it is very difficult for us to keep track of all the individual requirements of each plan as they change from time to time. It is ultimately your responsibility to check with your insurance to understand the contract and coverage.

Each plan has different restrictions regarding how often services may be rendered or more importantly, where you should obtain these services.

If your insurance company requires an insurance referral (i.e Tricare, Group Health, Premera Med Advantage, AARP,Humana) we require that prior to scheduling your appointment. Each authorization will specify the number of visits and expiration date. The patient is responsible for knowing when this authorization expires. Please contact your Primary Care Physician to find out the status of your referral before your scheduled appointment.

Providing the highest quality of care for our patients is our primary concern. We are more than willing to provide care within your insurance plan guidelines whenever possible. As a specialist office, we will contact your insurance for any pre-authorizations for procedures. We may request and collect a deposit prior to services rendered based on the amount of expected patient responsibility.

If you do not inform us of special requirements required by your plan and we perform a service that is not covered by your plan, we will bill you directly for those charges. By working together, we can assist you in receiving the benefits you are entitled to. If you have any questions, please contact our billing department at 509-464-6208 Ext 752.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Signature: _____ Date: _____

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CONSENT FOR TREATMENT

By signing below, I (or my authorized representative) authorize Northwest Spine and Pain Medicine (NWSPM) to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my treating healthcare providers to explain to me the reasons for any diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION FOR FINANCIAL PURPOSES

I hereby assign the benefits of any applicable insurance coverage to Northwest Spine and Pain Medicine to be applied towards the payment of the services rendered for which I acknowledge financial responsibility. I hereby authorize NWSPM to release information to settle my insurance claims for treatment (to include drug, alcohol, and mental diagnosis).

NO SHOW POLICY

I understand that I may be charged a fee for "no-showing" for a scheduled appointment if I do not give the clinic 24 hours' notice. The fee for Clinic visits is $25.00. Procedures/Physical Therapy and Psychology visits is $50.00.

COMMUNICATION

I hereby authorize NWSPM to contact me by SMS text message and email. I understand that message/data rates may apply to messages sent to me under my cellular service plan.

PHOTOGRAPHING AND VIDEOGRAPHING

I hereby consent to the photographing and/or videotaping for the purpose of identification and/or documentation of my care. I understand photographs, video, and/ or audio monitoring/recording may be taken for patient care, security, or for the purpose of healthcare operations. (e.g., quality improvement or risk management activities).

STUDENTS/RESIDENTS

I hereby consent to the observation and participation of health care students and certified emergency medical technicians in the medical care provided to me while I am a patient at NWSPM.

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS & RESPONSIBILITIES

I hereby acknowledge that I have received and understand the NWSPM "Notice of Privacy Practices for Health Information" and "Patient Rights and Responsibilities". I understand that unless I object, NWSPM may disclose protected health information to a member of my family, relative, close friend, or other person who is involved in my healthcare or payment of my healthcare.

Patient Name_____Signed_____

Relationship to Patient_____ Date_____

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Notice: Upon your request a clinical summary of your visit will be available for you to pick up at our front desk within 7 business day.

How long have you had your pain?	• Less than 3 months • 3-6 months • 7-9 months • 10-12 months • 1-2 years • 3-5 years • 6-10 years • 10 of more
Where is your pain located?	• Head • Neck • Shoulder • Chest • Upper back • Middle back • Lower back • Abdomen
Does the pain start in one place and move to another?	• Yes • No
Have you had any weakness in any of your extremities?	• Yes • No
Have you had any numbness or tingling in any of your extremities?	• Yes • No
How would you describe your pain?	• Aching • Burning • Cramping • Numbness • Pressure • Sharp • Shooting • Squeezing • Stabbing • Throbbing • Tingling
What makes your pain better?	
What makes your pain worse?	
How would you rate the severity of your pain?	0- None 1-2 Slight 3-4 Mild 5-6 Mod 7-8 Severe 9-10 Excruciating
Do you have your pain all the time or does it come and go?	All the time Come and Goes
Have you had any difficulties controlling your bladder or bowel since your pain started?	• Yes • No
Did your pain start all of a sudden or come on over time?	All of a sudden Came on over time
What brought on your pain?	• Work accident • Home accident • Auto accident • Surgery • Illness • Unknown
Is your pain worse at rest or with activities?	• At rest • With activities • No difference
What over the counter medications have you tried for your pain?	
What prescribed medication have you tried for your pain?	

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Have you tried Hot/cold packs to treat your pain?	• Yes • No

Have you used a brace support to treat your pain?	• Yes • No
Have you had any physical therapy to treat your pain?	• Yes • No
Have you have any nerve blocks to treat your pain?	• Yes • No
Have you had any nerve stimulation to treat your pain?	• Yes • No
Have you had surgery to treat your pain?	• Yes • No
Have you seen a chiropractor?	• Yes • No
Have you had any massage therapy?	• Yes • No
What other treatments have you tried for your pain?	
How has the intensity of your pain changed since it started?	• Better • Same • Worse
Which of your usual activities are you unable to do because of your pain?	
Does your pain interfere with your ability to work?	• Yes • No
Current work status?	
What was your work status before your pain started?	
Is this episode the first time you have had this pain or have you had it before?	• First time • Had it before
Have you had any joint stiffness or swelling?	• Yes • No
Have you had a fever since your pain started?	• Yes • No
Have you had any radiologic exams?	• Yes • No
Are you currently or could you possibly be pregnant?	• Yes • No

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Have you ever had a problem with alcohol, illegal drugs, prescription drugs or other substance use including attending drug treatment program, or DUI/DWI?	• Yes • No
Do you have a psychiatric or mental disorder?	• Yes • No

Mark each box that applies	*Please circle Yes or No*	
Family history of substance abuse		
Alcohol	Yes	No
Illegal drugs	Yes	No
Rx drugs	Yes	No
Personal history of substance abuse		
Alcohol	Yes	No
Illegal drugs	Yes	No
Rx drugs	Yes	No
History of preadolescent sexual abuse	Yes	No
Psychological disease		
ADD, OCD,bipolar, schizophrenia, PTSD or Anxiety	Yes	No
Depression	Yes	No

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Name: _____ Date: _____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in the home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o

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Name: _____ Date: _____

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
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?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

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Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ***Unbearable pain***

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

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SPINE & PAIN MEDICINE

PHQ-9

Patient Name_____ Date _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every Day
1.Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3.Trouble falling asleep, staying asleep or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself-or that you're a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite- being so fidgety or restless that you have ben moving around a lot more than usual				
9. Thoughts that you would be better of dead or of hurting yourself in some way				

10. If you checked off any problems, how difficult have those 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

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GAD-7

Patient Name_____ Date _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every Day
1.Feeling nervous, anxious or on edge?				
2. Not being able to stop or control worrying?				
3.Worrying too much about different things?				
4. Trouble relaxing?				
5. Being so restless that it is hard to sit still?				
6. Becoming easily annoyed or irritable?				
7. Feeling afraid as if something awful might happen?				

NORTHWEST
SPINE & PAIN MEDICINE

American Chronic Pain Association

Ability Chart

Having pain can make the simplest everyday task difficult. It can be hard to explain to your health care professional how climbing stairs, getting out of a chair, or bathing might be challenging. This tool will help you to identify all the areas where you struggle and how much trouble you have with each item. Simply circle your level of difficulty. 0 means not difficult at all and 10 means it is extremely difficult for you to accomplish.

Pain Level

0 1 2 3 4 5 6 7 8 9 10

No Pain — Extreme Pain

Getting Out of Bed

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Climbing Stairs

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Descending Stairs

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Getting Out of a Chair

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

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Ability Chart

Walking

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Personal Care

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Daily Activity

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Working

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Leisure Activities

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Quality of Life

0 1 2 3 4 5 6 7 8 9 10

Excellent — Poor