RISSER ORTHOPAEDIC GROUP

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NEW PMR & INTERVENTIONAL PAIN MANAGEMENT INTAKE QUESTIONNAIRE

Name: ____ Age: _______ Weight: _______ Height: _______

What is the reason for visit? ____

How did it begin (suddenly, gradually, accident)? ____

How long has this been going on? ____

Is it constant or occasional? ____

Is it getting worse, better or the same? ____

Does the pain/discomfort go into the arms or legs? Which one? ________________________________

If pain/discomfort goes into arms or legs, is there numbness, tingling or weakness? _________________

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What makes it worse (examples – lifting, bending, sitting, walking)? ______________________________

What makes it better (examples – resting, sitting, standing, nothing)? _____________________________

Have you: (please circle yes/no)

YES NO Lost control of bladder because of this? Explain ____________________________

YES NO Had prior x-rays, CT, MRI, bone scans for this? Explain _______________________

YES NO Had previous spinal surgery for this problem (what type)? Explain ______________

YES NO Had any spinal injections for this? Explain _________________________________

When? ____________________ Did they help? ____________________

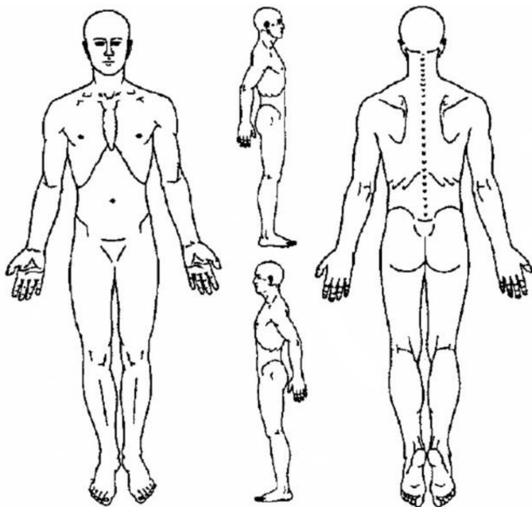
What other conservative treatments have you tried?

- ☐ Physical Therapy/Exercise
- ☐ TENS unit
- ☐ Narcotic Medications
- ☐ Cast/Boot
- ☐ Massage/Ultrasound
- ☐ Traction
- ☐ Anti-Inflammatories
- ☐ Orthotics
- ☐ Manipulation
- ☐ Cane
- ☐ Walker

Please circle your current pain level 0 1 2 3 4 5 6 7 8 9 10

Please circle your highest pain level over the past week 0 1 2 3 4 5 6 7 8 9 10

Please circle you lowest pain level over the past week 0 1 2 3 4 5 6 7 8 9 10



Would you **describe the pain** as: please circle all that apply:

BURNING SHARP ACHING THROBBING SHOOTING

OTHER: (describe) __________________________________

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Please mark the figure with the location of your symptoms as a result of this injury or accident:

Pain = X **Numbness/Tingling = #**