



ISAAC SPINE, JOINT & PAIN INSTITUTE, PLLC

Victor W. Isaac, MD, FAAPMR

*Diplomate of the American Board of Physical Medicine & Rehabilitation
Diplomate of the American Board of Pain Medicine*

2001 Charlotte Ave, Suite 205
Nashville, TN 37203

Phone: (615) 294-8453

Fax: (615) 369-3062

HEALTH QUESTIONNAIRE

PERSONAL DATA

Date: ____ - ____ - ____

Name: (first, middle, last) _____ DOB: ____ - ____ - ____ Age: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Othopedic Surgeon: _____ Phone: _____

Spine/ Neurosurgeon: _____ Phone: _____

Pharmacy: _____ Phone: _____

Primary Insurance: _____ Policy Number: _____

Policy Holder: _____ Group Number: _____

For Worker's Compensation

If you are seeing us due to a work related accident, please answer the following questions:

Date of Injury: _____ Case Number: _____

Assigned Caseworker: _____ Phone: _____

For Auto Accident

If you are seeing us due to an auto accident, please answer the following questions:

Date of accident: _____

Auto Insurance: _____ Policy Number: _____ Phone Number: _____

Name of your Attorney: _____ Phone: _____

How did you here of this practice: Your doctor other patients Yellow Pages Internet Other: _____

CHIEF COMPLAINT

What is the reason for your office visit today? Neck pain Arm pain Back pain Leg pain Shoulder pain

Hip pain Knee pain Ankle pain Headaches other reason(s): _____

HISTORY OF PRESENT INJURY

When did this problem start? (Estimate if no specific date) _____

Was there an inciting event to your symptoms? Work injury Auto accident other: _____

Did you have these symptoms in the past? Yes No If yes, when? _____

Are you seeing other doctor(s) for this problem? _____ Diagnosis? _____

Are you in any legal actions regarding this injury? Yes No

What testing have you had for this problem? (Please give date and results if available)

X-rays: _____ MRI: _____ Bone scan: _____

CAT scan: _____ EMG: _____ Other: _____

What treatment have you had? Physical Therapy Chiropractic care Injections: _____

Surgeries: _____ Other: _____



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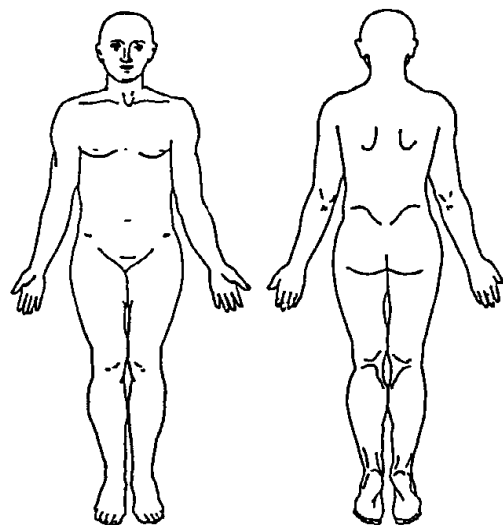
List the **pain** medications that you have taken, including over-the-counter medications: _____

Did you take time off work because of this problem? Yes No If yes, dates off work: _____

Mark on the picture diagram where the pain is using the following:

/ – sharp/stabbing x – burning o – numbness
= – dull s – cramping • – pins & needles

The pain is: constant or comes and goes
Worse during: morning noon evening bedtime
What activities make it worse: _____
What activities make it better: _____
Circle the level of your pain? 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10



REVIEW OF SYSTEM

- Gen Weight loss Weight gain Fever Fatigue Loss of appetite Nausea Vomiting
- Skin Skin problem Rash Psoriasis Slow healing Easy bruising Itching
- Neuro Light headed/dizziness Fainting Weakness Stroke Tremor Seizure Memory loss
- Eyes Vision problem Glaucoma Blurred vision Double vision
- ENT Ear pain Hearing loss Ear noises Nose bleed Sore throat Hoarseness Dental problems
- Cardiovascular Chest pain Chest pressure Shortness of breath Irregular heart beat Murmurs
- Respiratory Coughing Difficulty breathing Asthma/Wheezing Coughing up blood
- Gastrointestinal Constipation Diarrhea Heartburn Bloody stool Pain in stomach Ulcers Hepatitis
- Genitourinary Painful urination Frequent urination Bloody urine Kidney stone Incontinence Loss of libido Sexual difficulty Infection
- Endocrine Hypothyroidism Hyperthyroidism Diabetes Parathyroid problems
- Hematology Anemia Bleeding disorder Easy bleeding Lymphoma/Leukemia Sickle cell disease
- Immunologic Catch cold easily HIV/AIDS Fever Hay fever Frequent sinus problems Allergies
- Musculoskeletal Arthritis Rheumatoid arthritis Osteoarthritis Compression fracture Head injury Neck injury Lower back injury Spinal trauma Birth trauma Birth defect Lupus Spina bifida Gout Osteoporosis Muscular dystrophy Muscle pain Scoliosis
- Women only Irregular periods Premenstrual depression Hot flashes Menstrual cramps Vaginal discharge Hysterectomy Breast surgery Nipple discharge Breast lumps Last mammogram _____
- Men only Burning on urination Dripping after urination Prostate problems Difficulty starting urination
- Psychiatric Depression Anxiety Panic attacks OCD Manic Bipolar Suicidal attempts Suicidal ideation Homicidal Hallucination Psychosis Other _____



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PAST MEDICAL HISTORY

Do you have any of the following conditions? (Check all that apply)

- | | | | |
|------------------------------------------------------|----------------------------------------|---------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke(s) | <input type="checkbox"/> Anemia (low blood count) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> TB | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> HIV | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Cancer: _____ | | | |

PAST SURGICAL HISTORY

- Spine (Cervical, Thoracic, Lumbar) _____
- Joint replacement: _____
- List other surgeries and dates: _____
- List any prior accidents or work injuries: _____

MEDICATION HISTORY (Please list all current medications)

Medication:	Dosage:	Frequency: (how often)	Prescribing Physician:
1- _____	_____	_____	_____
2- _____	_____	_____	_____
3- _____	_____	_____	_____
4- _____	_____	_____	_____
5- _____	_____	_____	_____
6- _____	_____	_____	_____
7- _____	_____	_____	_____
8- _____	_____	_____	_____
9- _____	_____	_____	_____
10- _____	_____	_____	_____

Do you have any **Allergies**? Yes No If yes, list them? _____

FAMILY HISTORY

Are there any medical conditions that are common in your family? Yes No If yes, list: _____

SOCIAL HISTORY

Tobacco use: Cigarettes Cigars others: _____ How much per day? _____ For how long? _____

Alcohol use: Beer other: _____ How often? _____ For how long? _____

Illicit drug use: Yes no If yes, what type(s): _____ How often? _____ For how long? _____

Do you have a drug or alcohol dependency? Yes No If yes, did you have drug rehabilitation? Yes No

Occupation: _____ Full-time Part-time Marital Status: S M W D

Family Status: Living with _____

Disability: No Yes (Type) _____



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SOAPPSM Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Isaac Spine, Joint & Pain Institute who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

- | | |
|------------------------------------------------------------------------------------------------------------------------|-----------|
| 1. How often do you have mood swings? | 0 1 2 3 4 |
| 2. How often do you smoke a cigarette within an hour after you wake up? | 0 1 2 3 4 |
| 3. How often have any of your family members, including parents and grandparents, had a problem with Alcohol or Drugs? | 0 1 2 3 4 |
| 4. How often have any of your close friends had a problem with alcohol or drugs? | 0 1 2 3 4 |
| 5. How often have others suggested that you have a drug or alcohol problem? | 0 1 2 3 4 |
| 6. How often have you attended an AA or NA meeting? | 0 1 2 3 4 |
| 7. How often have you taken medication other than the way that it was prescribed? | 0 1 2 3 4 |
| 8. How often have you been treated for an alcohol or drug problem? | 0 1 2 3 4 |
| 9. How often have your medications been lost or stolen? | 0 1 2 3 4 |
| 10. How often have others expressed concern over your use of medication? | 0 1 2 3 4 |
| 11. How often have you felt a craving for medication? | 0 1 2 3 4 |
| 12. How often have you been asked to give a urine screen for substance abuse? | 0 1 2 3 4 |
| 13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? | 0 1 2 3 4 |
| 14. How often, in your lifetime, have you had legal problems or been arrested? | 0 1 2 3 4 |

Score:

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

The above information is complete and accurate to the best of my knowledge.

This form is completed by

- Patient X _____ Date _____
 Other X _____ Name / Relation _____



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For Physician Only

HPI: _____

PHYSICAL EXAM:

Vital: HR: _____ BP: _____ RR: _____ Height: _____ Weight: _____

Appearance: _____ **A/O:** _____

Skin: _____

Motor: _____ **Sensation:** _____ **Reflexes:** _____ **Tone:** _____

Gait: _____ **Special Tests:** _____

ROM: _____ **Palpation:** _____

RADIOLOGIC STUDIES: _____

LABORATORY STUDIES (UDS): _____

PMP _____

IMPRESSION:

RECOMMENDATIONS

1. Medicines _____
2. PT _____
3. Labs/X- rays/ MRI _____
4. Procedure _____
5. Consults _____
6. RTC in 2w 4w 8w PRN _____

PHYSICIAN NAME: _____ Victor Isaac, MD, FAAPMR