Please complete this paperwork and send back to our clinic in order to schedule your initial consult

Paperwork can be returned in person, faxed, or mailed back in prepaid enclosed envelope to:

St. Patrick Hospital
500 West Broadway, Third Floor
Missoula, MT 59802
Phone: 406-327-1670 - Fax: 406-329-5697

Welcome to the Montana Spine and Pain Center. At MSPC we use a holistic, team-based approach to manage persistent and chronic pain. Through this collaborative, integrated, and multi-disciplinary approach, it is likely that your first appointment may be scheduled with our Health Psychologist, one of our many treating providers who may be involved in your care.

If you have any questions, or need assistance completing this New Patient Paperwork, please feel free to call our clinic Monday- Friday 8:00am-4:30pm.

Patient Information Please fill out in BLUE OR BLACK INK

Patient Name: _____ Date of Birth: _____

Preferred Phone:_____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone:_____ ❑ Home ❑ Mobile ❑ Work

Email Address for MyChart/Virtual Visits: _____

Referral Information

Referring Physician: _____ Primary Care Physician: _____

Phone: _____City:_____ Phone:_____ City:_____

Date of last visit with referring provider:_____

Insurance Information

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Thank you for providing us with this information. It is very useful in allowing us to make a thorough evaluation of your pain problem. ***After completing the following intake packet, please return it to the clinic so we may move forward with your care. You can mail, fax, or drop off at the clinic to the address above.***

We highly recommend watching our Patient Orientation Videos which describe our treatment approach at the Montana Spine and Pain Center. Your signature below demonstrates your acknowledgment of the Patient Orientation Video content. ***If you have any questions on how to access the videos, please call 406-327-1670.***

Patient Signature _____ **Date**_____

Thank you for taking the time to complete our new patient paperwork. As you complete it, please feel free to use this page to tell us any additional information you would like us to know.

Providence
Medical Group

Expectations and Goals

What condition do you hope to address at Montana Spine and Pain Center?

What caused this condition, and how long have you had it?

What activity goals, sleeping goals, work goals, etc. do you wish to achieve?

What are your major concerns about your health?

Please provide any additional information you wish to make our providers aware of, including spiritual concerns:

PATIENT	DOB	MRN	DATE

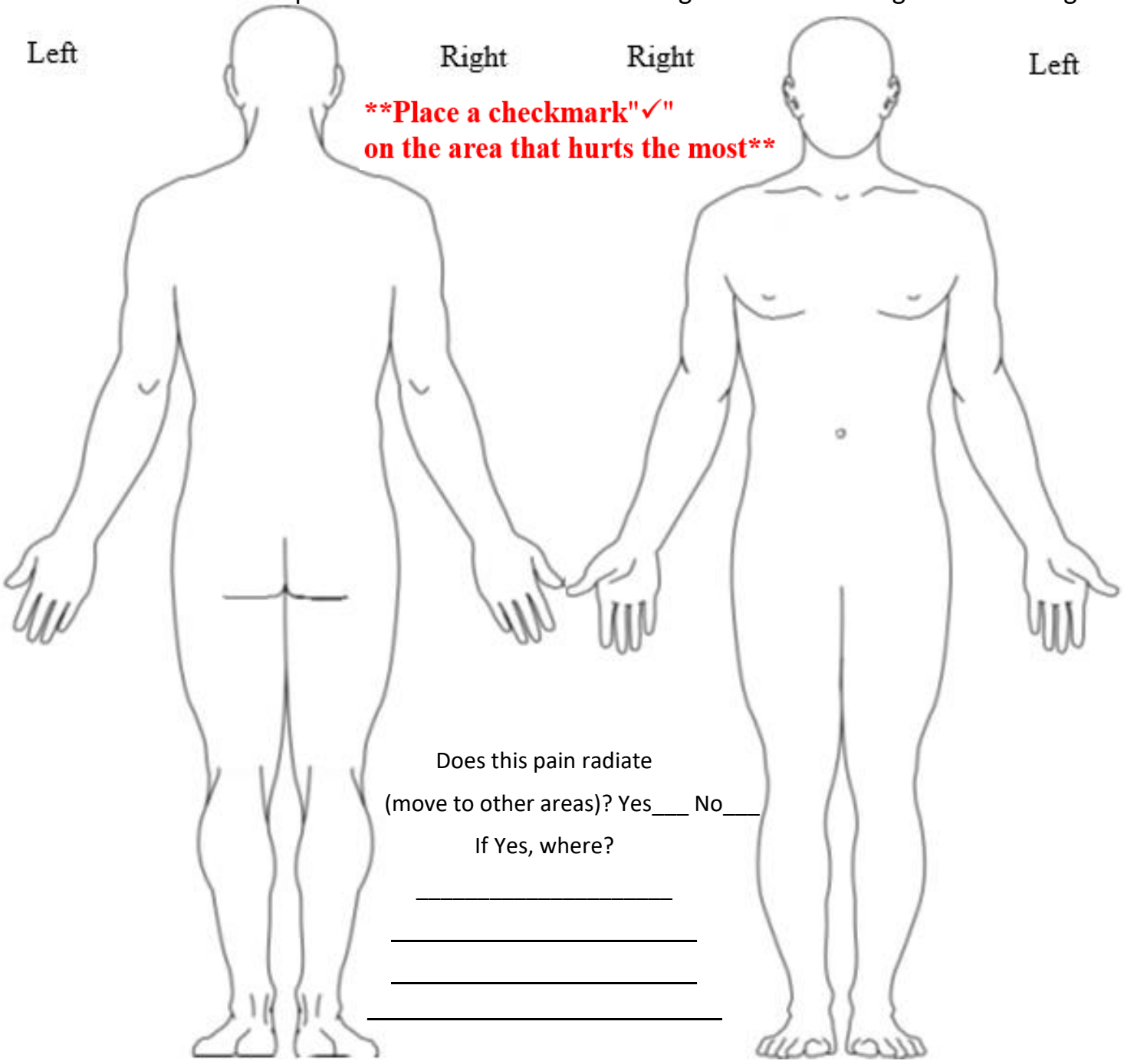
Pain Location

On this scale of 0-10, 10 being the worst, mark your present level of pain.

0 1 2 3 4 5 6 7 8 9 10

Mark the below drawing with the following letters that best describe your symptoms:

"N" = numbness **"P"** = pins and needles **"S" =** stabbing **"B"** = burning **"A"** = aching



Does this pain radiate

(move to other areas)? Yes___ No___

If Yes, where?

_____

_____

_____

_____

Diagnostic Tests and Imaging

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

❑ MRI of the _____ Date: _____ ❑ St. Pat's ❑ Other Facility_____

❑ X-ray of the _____ Date: _____ ❑ St. Pat's ❑ Other Facility_____

❑ CT scan of _____ Date: _____ ❑ St. Pat's ❑ Other Facility_____

❑ EMG/NCV of _____ Date: _____ ❑ St. Pat's ❑ Other Facility_____

❑ Other:_____ Date: _____ ❑ St. Pat's ❑ Other Facility_____

❑ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

IF YOU HAVE HAD ANY IMAGING OR PROCEDURES (INJECTIONS/SURGERIES) OUTSIDE OF ST. PATRICK'S HOSPITAL, PLEASE COMPLETE THE RELEASE OF INFORMATION FOUND ON THE BACK OF THIS PAGE.

Past Surgical History

What surgical procedures have you had in the past?

Procedure	Year
Neck:	
Back:	
Other:	

Prior Treatment

Mark all of the following treatments you have had prior to today's visit for your current pain complaints:

- ❑ Anti-Inflammatory Medications
- ❑ Muscle Relaxants
- ❑ Antidepressants
- ❑ Anti-seizure Medications
- ❑ Trigger Point Injections
- ❑ Surgery
- ❑ Other:_____
- ❑ Chiropractic
- ❑ Narcotic Pain Medications
- ❑ Acupuncture
- ❑ TENS Unit
- ❑ Spinal Injections
- ❑ Pain Program
- ❑ Massage
- ❑ Yoga
- ❑ Meditation/Relaxation
- ❑ Pain Pump
- ❑ Spinal Stimulator
- ❑ Physical Therapy

❑ I HAVE NOT HAD ANY PRIOR TREATMENT FOR MY CURRENT PAIN

What goals do you hope to accomplish in Montana Spine & Pain Center?

Please describe your pain to us:

Check all of the following that describe of your pain:

❑ Aching ❑ Band-like ❑ Burning / Hot
❑ Cramping ❑ Dull ❑ Numb
❑ Pressure ❑ Shooting ❑ Stabbing / Sharp
❑ Shock-like ❑ Spasms ❑ Throbbing
❑ Tiring / Exhausting ❑ Tingling / Pins & Needles

What makes this pain worse? ❑ Sitting ❑ Standing ❑ Walking ❑ Lying down ❑ Work
❑Other_____

What makes this pain better?_____

Check all of the following activities that your pain interferes with:

❑ **Nothing** ❑ Driving ❑ Leisure Activities
❑ Personal Grooming ❑ Relationships ❑ Sleep
❑ Walking ❑ Work duties ❑ Other: _____

Does your pain:

❑ Prevent/interrupt sleep ❑ Worsened when you cough or sneeze ❑ Causes imbalance walking
❑ Cause clumsy hands ❑ Problems controlling bladder/bowels ❑ Cause weakness
❑ Cause numbness in your groin/crotch

Past and Current Medical Care (formal diagnosis by a provider)

Mark the following conditions/diseases that you are being/have been treated for:

❑ ADD/ADHD ❑ Anemia ❑ Arthritis ❑ Asthma
❑ Bipolar disorder (Manic Depression) ❑ Cancer ❑ Depression ❑ Diabetes
❑ Epilepsy ❑ GERD (reflux disease) ❑ Glaucoma
❑ Gout ❑ Head Injury ❑ Heart Disease ❑ Hepatitis
❑ High Blood Pressure ❑ Kidney Disease ❑ Liver Disease ❑ Lung Disease
❑ OCD (Obsessive Compulsive Disorder) ❑ Organ Transplant ❑ Panic/Anxiety Attacks
❑ PTSD (Posttraumatic Stress Disorder) ❑ Psychiatric Hospitalization
❑ Recent Infection ❑ Seizures ❑ Sleep Apnea
❑ Suicide Attempt(s) ❑ Stroke ❑ Thyroid Disease ❑ Ulcer (Gastrointestinal)

Have you ever experienced: ❑ Childhood/Adolescent Abuse (Physical, Emotional, Sexual) – please circle
❑ Adult Abuse (Physical, Emotional, Sexual) – please circle

Do you feel safe at home? Yes/No

Please mark any past or present care from:

❑ Psychiatrist ❑ Past ❑ Present
❑ Clinical Psychologist ❑ Past ❑ Present
❑ Clinical Social Worker ❑ Past ❑ Present
❑ Clinical Counselor ❑ Past ❑ Present
❑ Other Mental Health Professional ❑ Past ❑ Present

PATIENT	DOB	MRN	DATE

Preferred Pharmacy

Pharmacy Name:_____ Phone Number:_____

Street Address:_____ City/State/Zip:_____

Medication History

Please **bring to your appointment a list of *ALL* medications you are currently taking** and attach them **OR write them below**. (Include supplements or over the counter medications).

Medication Name	Strength	Number of pills	Schedule	Name of prescriber	Why do you take it?
Example: glyburide	*10 mg*	*2*	*twice daily*	*Dr. Strong*	*diabetes*

Please list any medications tried in the past that have not worked:

_____

_____

_____

Allergies to Medications (please list medication and type of reaction)

Medication	Reaction

Personal Background

Education: ❑ High School Diploma/GED ❑ Some College ❑ College/Associates Degree ❑ Graduate Degree

Learning Style: ❑ Visual ❑Written ❑ Demonstration ❑ Audio ❑ Explanation ❑Other

Receiving disability benefits: ❑ Social Security ❑ VA ❑ Other_____ ❑ None

Working: ❑ Yes ❑ No Occupation: _____ Retired? ❑ Yes ❑ No

Hours spent in work/school related activities: _____ Hours/Week

Missed work due to current pain? ❑ Yes ❑ No If yes, how much? _____ Years ____ Months ____ Weeks

Last Date of Work (if applicable): _____

Legal Action related to current pain? ❑ Yes ❑ No If yes, please provide attorney information below:

Attorney Name:_____ Location: _____

Social Habits

Please mark current use and frequency:

Alcohol ❑ Never ❑ Current ❑ Former – Quit Date _____

_____ Glasses of wine/Week _____ Beers/Week _____ Shots of Liquor/Week

Cigarettes/Tobacco ❑ Never ❑ Current ____ Packs/Day ❑ Former – Quit Date _____

E-Cigarettes ❑ Never ❑ Current ❑ Former – Quit Date _____

Snuff/Chew ❑ Never ❑ Current ❑ Former – Quit Date _____

Pipe/Cigars ❑ Never ❑ Current ❑ Former – Quit Date _____

THC ❑ Never ❑ Current ❑ Former – Quit Date _____

IV Drug Use ❑ Never ❑ Current ❑ Former – Quit Date _____

Personal History of Substance Abuse: ❑ Alcohol ❑ Illegal drugs ❑ Prescription Drugs ❑ N/A

Family History of Substance Abuse: ❑ Alcohol ❑ Illegal drugs ❑ Prescription Drugs ❑ N/A

Drug/Alcohol Treatment Program: ❑ Yes ❑ No If yes, location and dates _____

Review of Systems

Please check the boxes next to any symptoms you have ***RECENTLY*** been experiencing on a ***FREQUENT*** basis:

Constitution
- ☐ Activity Change
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected Weight Change

Head, Ears, Nose, Throat
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Trouble Swallowing

Eyes
- ☐ Eye pain
- ☐ Light sensitive
- ☐ Blurry Vision

Respiratory
- ☐ Stop breathing during sleep (apnea)
- ☐ Difficulty breathing when flat
- ☐ Chest tightness
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Leg Swelling
- ☐ Irregular Heartbeat

GI
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive Hunger

Urinary System
- ☐ Difficulty urinating
- ☐ Urinary Frequency
- ☐ Urinary Urgency

Musculoskeletal
- ☐ Joint Pain
- ☐ Gait problem
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Neck stiffness

Skin
- ☐ Color change
- ☐ Rash
- ☐ Open Wound

Allerg/Immuno
- ☐ Environmental allergies
- ☐ Food allergies

Neurological
- ☐ Dizziness
- ☐ Facial asymmetry
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech difficulty
- ☐ Fainting
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Bruises/bleeds easily

Psychiatric
- ☐ Confusion
- ☐ Decreased concentration
- ☐ Depressed
- ☐ Hallucinations
- ☐ Nervous/anxious
- ☐ Self-injury
- ☐ Sleep disturbances
- ☐ Suicidal ideas

The Keele STarT Back Screening Tool

Thinking about the **last 2 weeks** check your response to the following questions		**Disagree**	**Agree**
1	My back pain has spread down my leg(s) at some point in the last 2 weeks	❑	❑
2	I have had pain in the shoulder or neck at some time in the last 2 weeks	❑	❑
3	I have only walked short distances because of my back pain	❑	❑
4	In the last 2 weeks, I have dressed more slowly than usual because of my back pain	❑	❑
5	It's not really safe for a person with a condition like mine to be physically active	❑	❑
6	Worrying thoughts have been going through my mind a lot of the time	❑	❑
7	I feel that my back pain is terrible and it's never going to get any better	❑	❑
8	In general I have not enjoyed all the things I used to enjoy	❑	❑

9 Overall, how bothersome has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very Much	Extremely
☐	☐	☐	☐	☐

PATIENT	DOB	MRN	DATE

Pain Disability Questionnaire

Instructions: This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by circling ONE number in each section for the statement which best applies to you *today*.

Fill out ***EITHER*** Back ***OR*** Neck section. If you are experience ***BOTH*** back and neck pain, complete both sections.

Back Pain – (including lower back, hips or legs)

Section 1- Pain Intensity
0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment
3. The pain is fairly severe at the moment
4. The pain is very severe at the moment
5. The pain is the worst imaginable at the moment

Section 2- Personal Care (washing, dressing etc.)
0. I can look after myself normally without causing increased pain
1. I can look after myself normally but it increases my pain
2. It is painful to look after myself and I am slow and careful
3. I need some help but manage most of my personal care
4. I need help every day in most aspects of self-care
5. I do not get dressed; I wash with difficulty and stay in bed.

Section 3- Lifting
0. I can lift heavy weights without increased pain
1. I can lift heavy weights but it causes increased pain
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned
3. Pain prevents me from lifting heavy weight, but I can manage light to medium weights if they are conveniently positioned
4. I can lift very light weights
5. I cannot lift or carry anything at all

Section 4 – Walking
0. Pain does not prevent me walking any distance
1. Pain prevents me from walking more than 1 mile
2. Pain prevents me from walking more than ¼ mile
3. Pain prevents me from walking more than 100 yards
4. I can only walk with crutches or a cane
5. I am in bed most of the time and have to crawl to the toilet

Section 5- Sitting
0. I can sit in any chair as long as I like
1. I can only sit in my favorite chair as long as I like
2. Pain prevents me sitting more than one hour
3. Pain prevents me from sitting more than ½ hour
4. Pain prevents me from sitting more than 10 minutes
5. Pain prevents me from sitting at all

Section 6 – Standing
0. I can stand as long as I want without increased pain
1. I can stand as long as I want but it increases my pain
2. Pain prevents me from standing for more than 1 hour
3. Pain prevents me from standing for more than ½ hour
4. Pain prevents me from standing for more than 10 mins
5. Pain prevents me from standing at all

Section 7 – Sleeping
0. My sleep is never disturbed by pain
1. My sleep is occasionally disturbed by pain
2. Because of pain I get less than 6 hours sleep
3. Because of pain I get less than 4 hours sleep
4. Because of pain I get less than 2 hours sleep
5. Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)
0. My sex life is normal and causes no increase in pain
1. My sex life is normal but causes some increase in pain
2. My sex life is nearly normal but is very painful
3. My sex life is severely restricted by pain
4. My sex life is nearly absent because of pain
5. Pain prevents any sex life at all

Section 9 – Social life
0. My social life is normal and does not increase my pain
1. My social life is normal but increases my level of pain
2. Pain prevents me from participating in more energetic activities (ex. sports, dancing etc.)
3. Pain prevents me from going out very often
4. Pain has restricted my social life to my home
5. I have hardly any social life because of my pain

Section 10 – Travelling
0. I can travel anywhere without increased pain
1. I can travel anywhere but it increases my pain
2. My pain restricts travel over 2 hours
3. My pain restricts my travel over 1 hour
4. My pain restricts my travel to short necessary journeys under ½ hour
5. My pain prevents all travel except for visits to the doctor/therapist or hospital

Pain Disability Questionnaire

Instructions: This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by circling ONE number in each section for the statement which best applies to you *today*.

Fill out ***EITHER*** Back ***OR*** Neck section. If you are experience ***BOTH*** back and neck pain, complete both sections.

Neck Pain – (including neck, shoulder or arms)

Section 1 -Pain Intensity
0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Section 2- Personal Care (washing, dressing etc.)
0. I can look after myself normally without causing extra pain.
1. I can look after myself normally, but it causes extra pain.
2. It is painful to look after myself, and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of my self-care.
5. I do not get dressed; I wash with difficulty and stay in bed.

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, but I can manage if they are conveniently positioned for example on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift only very light weights.
5. I cannot lift or carry anything.

Section 4- Reading
0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want to with slight pain in my neck.
2. I can read as much as I want to with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I can hardly read at all because of severe pain in my neck.
5. I cannot read at all.

Section 5- Headaches
0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all the time.

Section 6- Concentration
0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7- Work
0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Section 8- Driving
0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive at all because of severe pain in my neck.
5. I cannot drive my car at all.

Section 9- Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

Section 10- Recreation
0. I am able to engage in all of my recreational activities with no neck pain at all.
1. I am able to engage in all of my recreational activities with some pain in my neck.
2. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
3. I am able to engage in a few of my usual recreational activities because of pain in my neck.
4. I can hardly do any recreational activities because of pain in my neck.
5. I cannot do any recreational activities at all.

PATIENT REQUEST TO ACCESS/DISCLOSE A DESIGNATED RECORD SET

EXPLANATION:

This authorization is being requested of you to comply with state and federal regulations.

Patient's Name	Date of Birth:	
Prior Name(s) Used:	Phone #:	
Patient's Address:		
City:	State:	Zip Code:
Email Address: @		

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize PSJH to release my medical records to: ☐ Myself ☒ Recipient listed below:

Recipient's Name: Montana Spine & Pain Center	Attention: Referral Coordinator	
Recipient's Address: 500 W Broadway St, 3rd Floor		
City: Missoula	State: MT	Zip Code: 59802
Phone: 406-327-1670	Fax: 406-329-5697	
Delivery Option: ☐ MyChart ☐ Paper (Mailed) ☐ CD (Mailed) ☐ FAX ☐ Email: _____ @ _____		

INFORMATION TO BE RELEASED:

I am requesting information from the following Hospital(s):

List Hospital(s) or Clinics	Specify the Dates of Treatment

INFORMATION TO BE RELEASED (Only check one box in this section):

☐ Pertinent information **(This is what most patients and physicians need)**. Discharge Summary, Emergency Department Report, History and Physical, Consultations, Operative Reports, Labs, Radiology Reports, EEG, EMG, EKG, Pathology Reports. (A fee may be charged)

☐ All/Entire Medical Record **(Includes pertinent information plus all other documentation in the medical record)** (A fee may be charged)

☐ Other (specify): _____

☐ Last two years only **(Specify print package):**
☐ Pertinent Information ☐ All/Entire Medical Record

ADDITIONAL AUTHORIZATION REQUIRED FOR THE FOLLOWING DUE TO STATE/FEDERAL STATUTES:

I specifically authorize release of the following information **(check and initial as appropriate)**:

☐ Mental Health treatment information	Initial and Date:
☐ HIV test results	Initial and Date:
☐ Alcohol/drug treatment information	Initial and Date:

PURPOSE:

Purpose of requested use or disclosure: ☐ Patient Request ☐ Continuing Care ☐ Legal ☐ Insurance
☐ Other: _____

EXPIRATION:

This Authorization expires (Date): _____
If no Date is given, this authorization will expire in six months from the signature date.

MY RIGHTS:

I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

Providence St. Joseph Health
Health Information Release of Information/Revoke Authorization
P.O. Box 4950
Portland, OR 97208

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE:

Patient Signature:	Date:
Legal Representative Signature: (Patient representative/spouse)	Date:

If signed by someone other than the patient, state your legal relationship to the patient and please provide, i.e, copy of DPOA, Death Certificate, Guardianship:

Relationship to Patient:	Date:

Dependent on State Regulations, authorization from the physician who attended the patient during their stay may be required.

HOSPTIAL USE ONLY

PHYSICIAN RELEASE OF MEDICAL RECORD

☐ APPROVED by Physician Name: _____Date:_____HIM-ROI CG Initials:_____

☐ DENIED – REASON FOR DENIAL: _____

MD Signature:_____Date:_____ Time:_____