COASTAL VIRGINIA
SPINE & PAIN
CENTER

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Thank you for choosing Coastal Virginia Spine and Pain Center to provide you with health care services. We appreciate your trust in us, and we pledge to do all that we can to accommodate your needs and expectations.

On the day of your appointment please arrive approximately thirty (30) minutes early, so that we can ensure all necessary paperwork is in order.

Your initial visit will require that you be in our office for approximately ninety (90) minutes. Occasionally, due to unforeseen circumstances, this length of time may be longer.

We also would like to familiarize you with some record-keeping items that will facilitate your visit with us. Enclosed, you will find the following forms. **Please complete each of these forms prior to your scheduled appointment.**

- ☐ In-Office Visit during Covid-19 Pandemic - Patient Authorization and Consent Form
- ☐ Physical Therapy Questionnaire
- ☐ Short Musculoskeletal Assessment Form

The following documents are available for your review in our office or on our website www.CovaSpineandPain.com.

- Our Notice of Privacy Practices (HIPAA)
- Notice of Patient Rights and Responsibilities

On the day of your appointment, please bring your insurance card, a state-issued ID (driver's license, Virginia ID card) and your specialist co-pay in order to be seen.

The doctors and staff of Coastal Virginia Spine and Pain Center are dedicated to excellence in patient care, service and satisfaction. If you have any questions please do not hesitate to ask any staff member in our practice.

Sincerely,

Coastal Virginia Spine and Pain Center

PHYSICAL THERAPY MEDICAL HISTORY QUESTIONNAIRE

DATE: _____

Name: _____ Age: _____ ☐ Right-Handed ☐ Left Handed

Referring Physician: _____ Primary Care Physician (PCP): _____

What is your PRIMARY Reason/Diagnosis for coming to physical therapy? ☐ Left ☐ Right

☐ Headache ☐ Face/Jaw Pain ☐ Neck Pain ☐ Shoulder Pain ☐ Arm Pain ☐ Thoracic Pain ☐ Rib/Chest Pain

☐ Abdominal Pain ☐ Low Back Pain ☐ Hip Pain ☐ Leg Pain ☐ Foot/Ankle Pain ☐ Other: _____

Please describe the event and any initial treatment. DATE OF INJURY/ONSET OF PAIN: _____

☐ Accident/Injury ☐ Work Related ☐ Motor Vehicle Accident ☐ Surgery ☐ After Illness ☐ Came on gradually ☐ Unknown

PAIN CHARACTERISTICS:

Describe your pain: ☐ Aching ☐ Deep Ache ☐ Burning ☐ Stabbing ☐ Sharp ☐ Shooting ☐ Numbness ☐ Pulsating ☐ Tingling ☐ Weakness ☐ Other _____

Does the pain shoot or refer to another part of the body? ☐ Yes ☐ No If yes, where? _____

Your pain is: ☐ Constant ☐ Intermittent ☐ Occasional Describe: _____

Your pain is ☐ Getting Better ☐ Getting Worse ☐ Staying the Same ☐ Progresses as the day progresses _____

How many hours per day do you have pain? _____ Hours/day _____

How long have you been in pain? _____

Do you occasionally need to stop all activities because of pain? ☐ Yes ☐ No

- If yes, number of times? ☐ Daily _____ ☐ Weekly _____ ☐ Monthly _____ ☐ Yearly _____

Have you ever previously experienced this type of pain? ☐ Yes ☐ No If yes, what was done for you? _____

Do you have any of the following with your pain?

-Tingling/numbness in the hands/feet? ☐ Yes ☐ No

-Weakness in the hands/feet? ☐ Yes ☐ No

-Dragging of the foot while walking? ☐ Yes ☐ No ☐ Left ☐ Right

-Pain radiating to the arm/forearm/hands? ☐ Yes ☐ No

-Pain radiating to the thigh/buttocks/legs/feet ☐ Yes ☐ No

-Difficulty holding bladder or bowel movement ☐ Yes ☐ No

Which of the following affects your pain? *PLEASE Mark "B" for Better and "W" for Worse*

B W Massage/Rubbing	B W Coughing	B W Strong emotions	B W Standing	B W Alcohol
B W Sudden Movements	B W Anxiety	B W Getting Out of Bed	B W Running	B W Coffee/Tea/Caffeine
B W Noise	B W Heat	B W Sitting	B W Bright Light	B W Eating
B W Cold Weather	B W Lying Down	B W Walking	B W Bending	B W Sleep/Rest
B W Vibration	B W Ice	B W Physical Therapy	B W Straining	B W Distraction (TV/Reading)
B W Wet Climate	B W Fatigue	B W Reaching	B W Lifting	B W Work/Hobbies

B W Medication ☐ Other: _____

EFFECTIVE: 1/2/2019
REVISED: 1/17/2024

SLEEP PATTERNS:

Do you have trouble falling asleep? ☐ Never ☐ 1-2 times/week ☐ 3-5 times/week ☐ 6-7 times/week

How long does it take for you to fall asleep? _____

Do you wake up in the middle of the night because of pain? ☐ Never ☐ 1-2 times/week ☐ 3-5 times/week ☐ 6-7 times/week

How long does it take for you to return to sleep?_____

Need for medication to sleep? ☐ Never ☐ 1-2 times/week ☐ 3-5 times/week ☐ 6-7 times/week

What sleep medication do you take? (Include over-the-counter medications):_____

How many hours of sleep do you average per night? _____ Hours. Do you feel rested when you wake? ☐ Yes ☐ No

How many hours of sleep do you need to feel rested? ____ Do you take or need to take daytime naps? ☐ Yes ☐ No

Primary sleeping position: ☐ Back ☐ Left Side ☐ Right Side ☐ Stomach Number of pillows used: _____

Do you have any pets that sleep with you at night? ☐ Yes ☐ No _____

What assistive do you have to or need to use for walking or for support?

☐ None ☐ Cane/walking stick ☐ Crutches ☐ Walker ☐ Brace ☐ Wheelchair ☐ Motorized scooter

Do you have stairs at home? ☐ Yes ☐ No How many in to the house: ____ In the house: ____

Do you have trouble navigating stairs? ☐ Yes ☐ No If Yes, describe:_____

Have you fallen in the recent past? ☐ Yes ☐ No If Yes, how many times. ____ When was your last fall? _____

How did you fall?_____

Have you attended a Balance Clinic? ☐ Yes ☐ No If Yes, When _____ Where _____

GENERAL HEALTH: **CURRENT:** ☐ Excellent ☐ Good ☐ Fair ☐ Poor **PREVIOUS**: ☐ Excellent ☐ Good ☐ Fair ☐ **Poor**

PREVIOUS TREATMENT

☐ Physical Therapy
☐ Chiropractic
☐ Dental
☐ TENS/Electrical Stimulation Unit (Home Use)
☐ Psychological support ☐ Yes ☐ No Name: _____
☐ Work Hardening
☐ Acupuncture
☐ Injections: _____
☐ Radiofrequency Ablations
☐ Other: _____

Pain ☐ Yes ☐ No If yes, Where: _____ When? _____

How did you fall. _____

PROBLEMS AND GOALS

How does your pain limit your daily function? _____

_____

_____

What specific activities are you limited in or not able to do that you hope to improve? _____

_____

_____

_____

What are your goals/expectations for physical therapy for your primary problem?

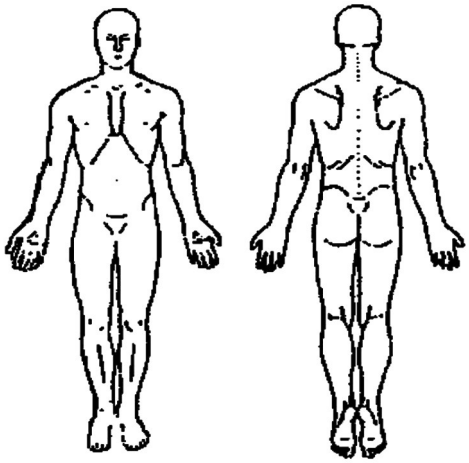
☐ Decrease pain ☐ Increase Function ☐ Learn Management Skills ☐ Ability to Return to Full Pre-Injury/Pain Status

☐ Other: _____

_____

SHORT MUSCULOSKELETAL FUNCTION ASSESSMENT

NAME: _____ **DOB:** _____ **DATE:**_____



Please rate your pain over this past week. **Only circle one answer per question. . Please shade in the primary areas of pain your are being seen for today.**

Worst pain this past week:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (Lots of Pain)
Least pain this past week:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (Lots of Pain)
Average pain this past week:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (Lots of Pain)
Current pain:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (Lots of Pain)

These questions are about **how much difficulty you may be having this week** with your daily activities because of your injury, condition or pain.

Please circle only one answer and answer ALL questions.	Not At All Difficult	A Little Difficult	Moderately Difficult	Very Difficult	Unable To Do
01. How difficult is it for you to get in or out of a low chair?	0	1	2	3	4
02. How difficult is it for you to open medicine bottles or jars	0	1	2	3	4
03. How difficult is it for you to shop for groceries or other things?	0	1	2	3	4
04. How difficult is it for you to climb stairs?	0	1	2	3	4
05. How difficult is it for you make a tight fist?	0	1	2	3	4
06. How difficult is it for you get in or out of the bathtub or shower?	0	1	2	3	4
07. How difficult is it for you to get comfortable to sleep?	0	1	2	3	4
08. How difficult is it for you to bend or kneel down?	0	1	2	3	4
09. How difficult is it for you to use buttons, snaps, hooks or zippers?	0	1	2	3	4
10. How difficult is it for you to cut your own fingernails?	0	1	2	3	4
11. How difficult is it for you to dress yourself?	0	1	2	3	4
12. How difficult is it for you to walk?	0	1	2	3	4
13. How difficult is it for you to move after sitting or lying down?	0	1	2	3	4
14. How difficult is it for you to go out by yourself?	0	1	2	3	4
15. How difficult is it for you to drive?	0	1	2	3	4
16. How difficult is it for you to clean yourself after going to the bathroom?	0	1	2	3	4
17. How difficult is it for you to turn knobs or levers (i.e. opening doors, roll down car windows)?	0	1	2	3	4
18. How difficult is it for you to write or type?	0	1	2	3	4
19. How difficult is it for you to pivot?	0	1	2	3	4
20. How hard is it for you to do your usual physical recreational activities (i.e. biking, jogging, walking)?	0	1	2	3	4
21. How hard is it for you to do your usual leisure activities (i.e. crafts, gardening, playing cards, going out with friends)?	0	1	2	3	4
22. How much difficulty are you having with sexual activity?	0	1	2	3	4
23. How difficult is it for you to do light housework or yard work (i.e. dusting, washing dishes, watering plants)?	0	1	2	3	4
24. How difficult is it for you to do heavy housework or yard work (i.e. vacuuming/ washing floors, mowing lawns)?	0	1	2	3	4
25. How difficult is it for you to do your usual work (i.e. paid job, housework, volunteer activities)?	0	1	2	3	4

EFFECTIVE: 1/2/2019
REVISED: 1/17/2024

SHORT MUSCULOSKELETAL FUNCTION ASSESSMENT

NAME: _____ **DOB:** _____ **DATE:**_____

These next questions ask how often you are experiencing problems **this week** because of you injury, condition or pain.

Please circle only one answer, and answer ALL questions.	None of the Time	A Little of the Time	Some of the Time	Most of the Time	All of the Time
26. How often do you walk with a limp?	0	1	2	3	4
27. How often do you avoid using your painful limb(s), neckor back?	0	1	2	3	4
28. How often do you have your leg lock or give way?	0	1	2	3	4
29. How often do you have problems with concentration?	0	1	2	3	4
30. How often do you find too much in one day affects what you do the next day?	0	1	2	3	4
31. How often do you act irritable toward those around you, (i.e. snap at people, give sharp answers or criticize easily)?	0	1	2	3	4
32. How often are you tired?	0	1	2	3	4
33. How often do you do you feel disabled?	0	1	2	3	4
34. How often to you feel angry or frustrated that you have this injury, condition or pain?	0	1	2	3	4

These next questions are about **how much you are bothered** by problems you are having **this week** due your injury, condition or pain. *Please circle only one answer and answer ALL questions*.

How much are you bothered by:	Not Bothered At All	A Little Bothered	Moderately Bothered	Very Bothered	Extremely Bothered
35. Problems using your hands?	0	1	2	3	4
36. Problems using your neck or back?	0	1	2	3	4
37. Problems doing work around your home?	0	1	2	3	4
38. Problems with bathing, dressing, toileting or other personal care?	0	1	2	3	4
39. Problems with sleep and rest?	0	1	2	3	4
40. Problems with leisure or recreational activities?	0	1	2	3	4
41. Problems with your friends, family or other important people in your life?	0	1	2	3	4
42. Problems with thinking, concentrating or remembering?	0	1	2	3	4
434. Problems adjusting or coping with your injury or condition?	0	1	2	3	4
44. Problems doing your usual work?	0	1	2	3	4
45. Problems with feeling dependent on others?	0	1	2	3	4
46. Problems with stiffness and pain?	0	1	2	3	4

For Office Use Only **DYSFUNCTION INEX: _____% BOTHER INDEX: _____% PAIN SCORE: _____/10**

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