Piedmont HealthCare
Govil Spine & Pain Care

Harsh Govil, MD, MPH, DABPM, DABIPP
Fellowship Trained & Board Certified in Pain Medicine
Interventional Spine & Pain Management
Electrodiagnostic Medicine

Our philosophy: Multidisciplinary Approach to Pain Management

We believe that the 1st step in successful pain management is to i**dentify the cause of pain**; then utilize appropriate therapies to treat it. Research shows there is no "one size fits all" for pain management, therefore we tailor our treatment program based on your specific pathology and pain problem. We have identified the following core methods that have proven to be effective in treating pain.

1. Patient Education

2. Home Exercise Program

3. Physical Therapy

4. Medications (anti-inflammatories, muscle relaxants and medications for nerve pain)

5. Interventional/Injection Therapies that target the cause of pain

6. Advanced Therapies like Radiofrequency Ablation and Spinal Cord Stimulation

7. Opioid Pain Medications to be used along with other treatment modalities if necessary.

Our Goal is to use proven, evidence based techniques to target and treat various pain disorders so that you can lead a pain free and productive lifestyle.

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New Patient Visit

Date: ____________________ Patient Name: ____ DOB: ________________________

Best contact: ____________________________ (☐Home ☐Cell) Alternate number: ______________________________ (☐Home ☐Cell ☐Work)

Patient is responsible for providing a valid phone number & return attempted calls, as they are subject to be called in for a random pill count.

1. **Pain Location & Radiation:** Where do you hurt? Check **(✓).**

☐Low back	☐Both sides, equally ☐Both sides, worse on Right side ☐Both sides, worse on Left side ☐Only the Right side ☐Only the Left side	**and radiates to**	☐No radiation ☐Buttock (R L Both) ☐Both legs ☐Only the right leg ☐Only the Left leg	**how far down the leg**	☐Thigh ☐Knee ☐Calf ☐Ankle ☐Foot ☐Toes	which side of the leg	☐Back of the leg ☐Outer side of the leg ☐Front of the leg ☐Inner side of the leg ☐Along the whole leg
☐Neck	☐Both sides, equally ☐Both sides, worse on Right side ☐Both sides, worse on Left side ☐Only the Right side ☐Only the Left side	**and radiates to**	☐No radiation ☐Shoulder blade (R L Both) ☐Both arms ☐Only the right arm ☐Only the Left arm	**how far down the arm**	☐Shoulder ☐Upper arm ☐Elbow ☐Forearm ☐Hand ☐Fingers	which side of the arm	☐Back of the arm ☐Outer side of the arm ☐Front of the arm ☐Inner side of the arm ☐Along the whole arm
☐Other area							

2. **Pain Severity:** Please circle a number that best describes your pain.

	0 = No pain										**10 = Worse possible pain**
Least pain score on a typical day	0	1	2	3	4	5	6	7	8	9	10
Worst pain score on a typical day	0	1	2	3	4	5	6	7	8	9	10
Pain score **Today**	0	1	2	3	4	5	6	7	8	9	10

3. **Pain Quality:** Describe your pain: ☐Sharp ☐Shooting ☐Dull ☐Aching ☐Throbbing ☐Stabbing ☐Stinging ☐Burning

4. **Pain Frequency or Timing**: ☐Constant ☐Intermittent

5. **What makes your pain WORSE (aggravating Factors):**____

6. **What makes your pain BETTER (relieving factors):** ☐OTC meds ☐Prescription meds ☐Sitting ☐Lying in bed ☐Rest ☐Massage ☐Exercise ☐Heat/Hot bath ☐Ice ☐Other: ____

7. **Associated Symptoms:** Do you have any of the following symptoms?

Numbness in legs	☐ No ☐Yes	Where **=>**	☐ Constant	☐ Intermittent
Tingling in legs	☐ No ☐Yes	Where **=>**	☐ Constant	☐ Intermittent
Weakness in legs	☐ No ☐Yes	☐Because of pain but no strength problems ☐If strength problems, describe **=>**		
Tingling in arms	☐ No ☐Yes	Where **=>**	☐ Constant	☐ Intermittent
Tingling in arms	☐ No ☐Yes	Where **=>**	☐ Constant	☐ Intermittent
Weakness in arms	☐ No ☐Yes	☐Because of pain but no strength problems ☐If strength problems, describe **=>**		

Muscle Spasms	☐ No ☐Yes	☐Low back ☐Legs ☐Neck ☐Mid back
Sleep disturbance because of pain	☐ No ☐Yes	☐Difficulty falling asleep ☐Pain wakes me up
Loss of Bladder control	☐ No ☐Yes	☐Describe **=>**
Loss of Bowel control	☐ No ☐Yes	☐Describe **=>**
Do you have constipation	☐ No ☐Yes	If yes, ☐Do not take anything for it ☐Taking, list medication **=>**

8. Medications: What medications are you taking **<u>for this problem</u>** and for how long?

Narcotic Pain Medications	For how long	How many pills per day	When was your last dose	Is it helping	Any side effects
				☐Yes ☐No	☐No ☐Yes, list **=>**
				☐Yes ☐No	☐No ☐Yes, list **=>**
Other Medications and/or OTC	For how long	Is it helping	Any side effects		
		☐Yes ☐No	☐No ☐Yes, list **=>**		
		☐Yes ☐No	☐No ☐Yes, list **=>**		
		☐Yes ☐No	☐No ☐Yes, list **=>**		

9. Past Treatment: Which of the following treatments have you tried for pain relief in the past?

Treatment	No	Yes	**Circle all that apply**
Activity Modification			
Home Exercise Program			
Heat			
Ice			
TENS unit			☐helps ☐does not help
Massage Therapy			
Acupuncture			
Chiropractic			
Brace			☐Low back brace ☐Neck brace ☐Knee brace **=>** ☐OTC ☐medial grade; ☐helps ☐does not help
Physical Therapy			If yes, when: where:
OTC Medications			Aleve Advil Ibuprofen Tylenol Goody powder
Prednisone dose pack			
NSAID'S (Anti-inflammatory meds)			Naproxen Diclofenac Ibuprofen Celebrex Meloxicam Relafen Piroxicam Etodolac Arthrotec Indocin Daypro Ketoprofen Vimovo Duexis
Topical Agents (OTC & Prescription)			OTC pain patches Icy hot Biofreeze Bengay Asperecreme Lidoderm patch Volteran gel Flector patch Compounding cream
Muscle relaxants			Flexeril Zanaflex Robaxin Skelaxin Norflex Baclofen Parafon-Forte Soma
Anticonvulsants			Gabapentin Lyrica Topamax Gralise Keppra Horizont Tegretol Lamictal Trileptal Trokendi
Antidepressants			Amitriptyline Nortriptyline Cymbalta Effexor Savella
Opioid/Narcotic pain medications			Tramadol Codeine Vicodin Lortab Hydrocodone Oxycodone Percocet Morphine Opana Nucynta OxyContin Fentanyl patch Dilaudid Embeda Exalgo Butrans patch Hysingla ZoHydro Belbuca Oxaydo Xtempza
Previous Pain Clinics & Injections			If yes, which clinic/doctor(s) & when: what did they do for you (e.g. meds/injections):
Have you seen a surgeon for this problem			If yes, who:
Pertinent surgeries (low back surgery, neck surgery etc.)			☐low back surgery, by which surgeon & when: ☐neck surgery, by which surgeon & when:
Have you ever been discharged from a pain clinic for abusing pain meds, failing urine drug test, violating "pain contract"			If yes, which clinic & what was the issue:

10. Diagnostic Studies: What imaging studies/tests have you had **for this problem**. Please check **(✓).**

☐X-ray	When:	Where:
☐MRI	When:	Where:
☐CT scan	When:	Where:
☐Nerve Conduction Study/EMG	When:	Where:

11. Blood Thinners: Do you take any blood thinners? ☐No ☐Yes. If yes, check **(✓)** which one:

☐ASA 81 mg ☐ASA 325 mg ☐Coumadin ☐Plavix ☐Eliquis ☐Xeralto ☐Pradaxa ☐Brilinta ☐Savaysa ☐Effient ☐Aggrenox ☐Pletal ☐Ticlid ☐Trental ☐Arixtra ☐Lovenox ☐Blood Thinner is prescribed by Dr. **=>**

12. Allergies (Pertinent to procedures): Are you allergic to any of the following?

Betadine or Iodine	☐No	☐Yes, Reaction **=>**
X-ray dye or IV contrast dye	☐No	☐Yes, Reaction **=>**
Latex	☐No	☐Yes, Reaction **=>**
Novocaine or Lidocaine	☐No	☐Yes, Reaction **=>**
Shellfish	☐No	☐Yes, Reaction **=>**
Steroids	☐No	☐Yes, Reaction **=>**

13. ALLERGIES (Medications): Are you allergic to any medications you know of?

☐No Known Drug Allergies	☐Yes, list medication **=>**

14. Psychiatric History & Meds: please check **(✓)** psychiatric problems you currently have or had in the past.

☐None (no psyche history)

Psychiatric Problem(s)	Taking any meds for this problem	If, yes please **circle** pertinent meds or **list** the name of the medication.
☐Depression	☐No ☐Yes	Cymbalta Effexor Lexapro Prozac Paxil Pristiq Zoloft Celexa Wellbutrin Amitriptyline Nortriptyline Luvox Remeron ☐List Medication **=>**
☐Anxiety	☐No ☐Yes	Xanax Ativan Valium Klonopin Halcion Dalmane Tranxene Librium Serax Buspar Wellbutrin ☐List Medication =>
☐ADD	☐No ☐Yes	Adderall Vyvanse Dexedrin Ritalin Focalin Provigil Nuvigil Adipex(Phentermine) Meridia ☐List Medication **=>**
☐Bipolar Disorder	☐No ☐Yes	☐List Medication **=>**
☐Schizophrenia	☐No ☐Yes	☐List Medication **=>**
☐PTSD		☐List Medication **=>**
☐OCD		☐List Medication **=>**

Do you take any meds to help you sleep (sedatives)	☐No ☐Yes	Ambien Lunesta Trazodone Restoril (Temazepam) ☐List Medication **=>**

15. Past Medical History: Please check **(✓)** conditions you currently have or had in the past.

- Hematological: ☐Blood clots in legs (DVT) ☐Blood clots in lungs (PE) ☐Bleeding disorder **=>** ☐Thrombocytopenia ☐Hemophilia ☐Other
- Endocrine: ☐Diabetes ☐Thyroid disease
- GI: ☐Acid Reflux (GERD) ☐GI ulcers ☐GI ulcers ☐IBS ☐Hiatal Hernia ☐Gastric-Bypass surgery ☐Lap-Band surgery
- Cardiac: ☐Coronary artery disease ☐Heart attack (MI) ☐Heart stents (cardiac stents) ☐Open heart surgery (CABG) ☐Congestive heart failure ☐Atrial Fibrillation ☐Pacemaker implant ☐Defibrillator implant ☐High Blood pressure ☐High Cholesterol
- Kidney: ☐Decreased Kidney Function ☐On Dialysis (ESRD)
- Liver: ☐Decreased liver function ☐Hepatitis A ☐Hepatitis B ☐Hepatitis C
- Rheumatological: ☐Fibromyalgia ☐Rheumatoid Arthritis ☐Lupus (SLE) ☐Osteoarthritis ☐Psoriatic Arthritis ☐Gout ☐Osteoporosis
- Respiratory: ☐Asthma ☐COPD ☐Obstructive Sleep Apnea

- Neurological: ☐Peripheral Neuropathy ☐Stroke ☐TIA (Transient Ischemic Attack) ☐Seizures (epilepsy) ☐Migraine Headaches
- Genitourinary (bladder): ☐Leakage with coughing, sneezing or straining (stress incontinence)
  ☐Overactive bladder and can't make it to the bathroom in time (urge incontinence)
  ☐leakage after surgery: ☐hysterectomy ☐bladder prolapse surgery ☐prostate surgery

16. Past Surgical History: Please check **(✓)** surgeries you have had in the past. (Do not need exact dates; month/year is ok)

- Low back surgery: ☐No ☐Yes, by which surgeon & when ______________________________________
- Neck surgery: ☐No ☐Yes, by which surgeon & when ____
- ☐Open heart surgery (CABG) ☐Gastric-bypass/Bariatric surgery
- ☐Knee replacement (Circle: R L Both) ☐Hip replacement (Circle: R L Both) ☐Shoulder surgery (Circle: R L Both)
- ☐Knee surgery (Circle: R L Both) ☐Carpal tunnel release (Circle: R L Both), when ___________________

17. Social History:

- **Occupation:** ☐Employed: _________________________________ ☐Unemployed ☐Disabled ☐Retired ☐Homemaker ☐Student
- **Current Job Status:** ☐Do not work ☐Regular duty ☐Off work due to this condition ☐On restrictions ☐Long Term Disability
  ☐Short Term Disability ☐On Social Security Disability
- **Smoking**: ☐Do not smoke ☐Never a smoker ☐Former smoker, age quit smoking ______ ☐Current smoker; packs per day? _________
- **Alcohol use**: ☐Do not drink ☐Quit drinking at age ___________ ☐Occasional/Social ☐Regular drinking:
  ☐Everyday; how many drinks per day? __________ ☐Not every day; how many drinks per week? ___________
- **Illegal drugs** (marijuana, ecstasy, meth, cocaine etc.): **Current**: ☐No ☐Yes, list (what substance/last use) __________________________
  In the past: ☐No ☐Yes, list (what substance/last use) ________________________

18. Substance Abuse History: please check **(✓)** conditions you currently have or had in the past.

- Family History of Substance abuse (Parents & Siblings): ☐No ☐Alcohol abuse ☐Illegal drug abuse ☐Prescription drug abuse
- Personal History of Substance abuse: ☐No ☐Alcohol abuse ☐Illegal drug abuse ☐Prescription drug abuse
- Have you ever been treated with Methadone, Suboxone or Subutex for substance abuse/addiction problem:
  ☐No ☐Yes, when ____

19. Family History: please list any known medical problems.

Father: Medical problems: ____ ☐Unknown to me
Mother: Medical problems: ____ ☐Unknown to me

20. Review of systems: Do you have any problems related to the following systems?

- Constitutional: Fever ☐No ☐Yes; Significant weight loss in recent past: ☐No ☐Yes
- Psychiatric: Suicidal Ideation ☐No ☐Yes
- Respiratory: Shortness of Breath ☐No ☐Yes
- Neurological: Confusion ☐No ☐Yes; Slurred speech ☐No ☐Yes
- Gastrointestinal: Constipation ☐No ☐Yes
- Hematological: Bleeding disorder ☐No ☐Yes
- Cardiovascular: Leg swelling ☐No ☐Yes
- Skin: Rash ☐No ☐Yes
- Eyes: Blurry vision ☐No ☐Yes

21. In the **past week**, **what number** (on a scale of 0-10), best describes: [Please CIRCLE a number]

Your **average** pain score	0	1	2	3	4	5	6	7	8	9	10
How pain has interfered with your enjoyment of life	0	1	2	3	4	5	6	7	8	9	10
How pain has interfered with your general activity	0	1	2	3	4	5	6	7	8	9	10

(For office use: **PEG score**)

CANCELLATION/NO-SHOW POLICY: We kindly requests a 24-hour notice to reschedule or cancel an appointment.
Please note that **3 no-show appointments may result in termination from our practice**.

I certify that the above information is correct to the best of my knowledge.

Patient Signature: ____

____

ORT

Patient Signature: ____________________

Please answer the following questions by checking one of the boxes (□Yes □No).
Choose the appropriate column based on your gender.

	Male (choose this column if you are a Male)	**Female** (Choose this column if you are Female)
Family History of Substance Abuse (Parents & Siblings)		
• Alcohol Abuse	□ Yes □ No (3)	□ Yes □ No (1)
• Illegal Drugs	□ Yes □ No (3)	□ Yes □ No (2)
• Prescription Drugs	□ Yes □ No (4)	□ Yes □ No (4)
Personal History of Substance Abuse		
• Alcohol	□ Yes □ No (3)	□ Yes □ No (3)
• Illegal Drugs	□ Yes □ No (4)	□ Yes □ No (4)
• Prescription Drugs	□ Yes □ No (5)	□ Yes □ No (5)
Age (mark Box if between 16-45)	□ Yes □ No (1)	□ Yes □ No (1)
History of Preadolescent Sexual Abuse	□ Yes □ No (0)	□ Yes □ No (3)
Psychological Disease		
• Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia	□ Yes □ No (2)	□ Yes □ No (2)
• Depression	□ Yes □ No (1)	□ Yes □ No (1)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Signature: ____________________

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle appropriate number to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

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

FOR OFFICE USE Add columns ____________ + ____________ + ____________

TOTAL: ______________________________

Please turn over & complete the other side ➡

Generalized Anxiety Disorder Questionnaire (GAD-7)

Patient Signature: ___________________

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle appropriate number to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

8. If you checked off *any problems,* how *difficult* have these 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

FOR OFFICE USE

Add columns __________ + __________ + __________

TOTAL: ______________________________

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Prescription Release – Patient Authorization

Provider(s): Harsh Govil, MD/Kim Walters, PA-C/Patricia Hatfield, NP

I authorize the providers listed above, to release my written/printed prescription(s) to be picked up on my behalf by the following:

______________________________ ______________________
Name Relationship

______________________________ ______________________
Name Relationship

______________________________ ______________________
Name Relationship

I understand that I am responsible for the safe use of my prescription(s) and will report any discrepancies to my physician.

______________________________ ______________________
Patient Signature Date

Office: *633, Brookdale Drive, Suite# 300, Statesville, NC-28677, Phone: (704) 978-4025, Fax: (704) 978-4007*