

# ARIZONA SPINE CARE, PLC

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## **Acknowledgment of Receipt of Privacy Notice**

Original to be maintained in patient's permanent medical record

I acknowledge that the office's Notice of Privacy Practices has been made available to me.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient or legally authorized individual signature

Date

\_\_\_\_\_

Printed Name if signed on behalf of the patient  
Relationship



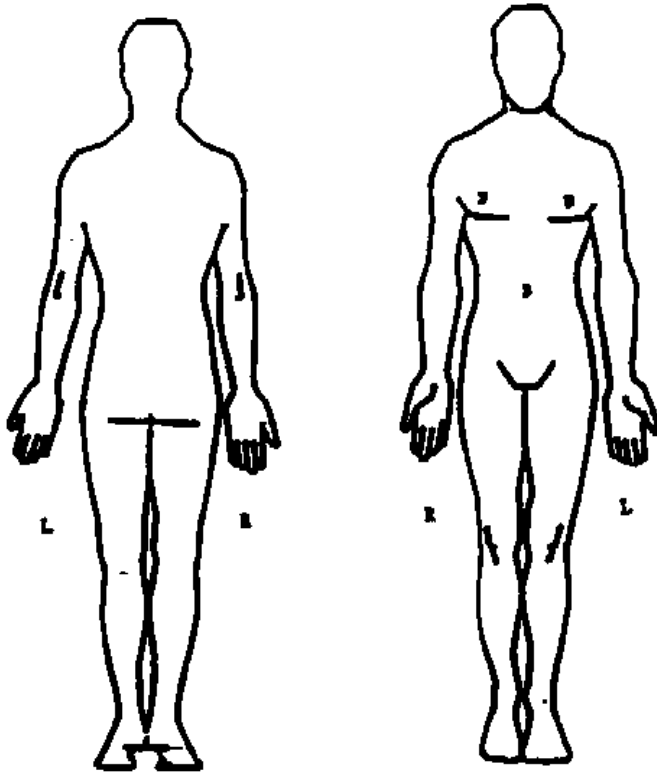
Follow Up Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_
AZSpineCare #: \_\_\_\_\_ Date of Surgery/Injection: \_\_\_\_\_
(If applicable)

Pain Drawing

1. Mark these drawings using the symbol that best describes your pain

Numbness ===== Ache ^^^^^^ Pins and Needles O O O O O
Stabbing ////////// Burning X X X X X Cramping ++++++



2. Which hurts you more, your legs or back? (Check only ONE statement)

- 1. Legs hurt much more than back
2. Legs hurt somewhat more than back
3. Legs and back hurt about the same
4. Back hurts somewhat more than legs
5. Back hurts much more than legs

% back pain (total of back and leg percentage should equal 100%)
% leg pain

3. Which hurts you more, your neck or arms? (check only ONE statement)

- 1. Arms hurt somewhat more
2. Arms hurt much more
3. Neck hurts much more than arms
4. Neck hurts somewhat more than arms
5. Neck and arms hurt about the same

% neck pain (total of neck and arm percentage should equal 100%)
% arm pain

4. Please circle the ONE number which best describes your current pain level.

0 represents no pain 10 is the worst pain you can imagine

0 1 2 3 4 5 6 7 8 9 10

**Post surgery or injection patients only**

5. Approximately how long has it been since your surgery, injection, or last visit?
- |   |   |
|---|---|
| <input type="checkbox"/> 1. Less than 1 month | <input type="checkbox"/> 4. 6 months            |
| <input type="checkbox"/> 2. 1 month           | <input type="checkbox"/> 5. 1 year              |
| <input type="checkbox"/> 3. 3 months          | <input type="checkbox"/> 6. Greater than 1 year |
6. If you had back or neck pain, how has your pain been affected by the procedure?  
(Check only ONE statement)
1. The pain is totally gone
2. The pain is much better than before treatment
3. The pain is somewhat better than before treatment
4. The pain is about the same as before treatment
5. The pain is somewhat worse than before treatment
6. The pain is much worse than before treatment
7. If you had leg or arm pain, how has your pain been affected by the procedure?  
(Check only ONE statement)
1. The pain is totally gone
2. The pain is much better than before treatment
3. The pain is somewhat better than before treatment
4. The pain is about the same as before treatment
5. The pain is somewhat worse than before treatment
6. The pain is much worse than before treatment
8. During the last week, how often have you taken narcotic medication such as Codeine, Percodan, or Vicodin for your neck and/or arm pain?
1. 3 or more times a day
2. Once or twice a day
3. Once every couple of days
4. Once a week
5. Not at all
9. During the last week, how often have you taken non-narcotic medication such as aspirin, Motrin, or Tylenol for your back and/or leg pain?
1. 3 or more times a day
2. Once or twice a day
3. Once every couple of days
4. Once a week
5. Not at all