

CURRENT DATE:
 PATIENT NAME:
 PATIENT ADDRESS:

PATIENT NUMBER:
 PATIENT PHONE:
 MESSAGE PHONE:
 PATIENT DOB:
 PATIENT AGE:

Vertebroplasty Screening

Patient Information

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Fracture Information:

Fracture site: _____cervical _____Thoracic _____Lumbar

Pain Information:

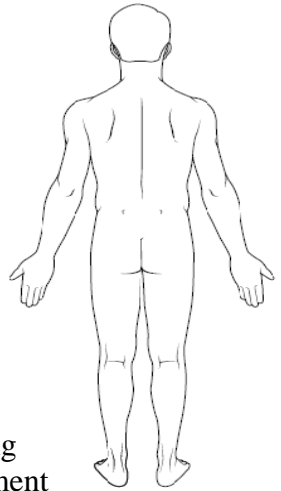
Date of onset of pain _____

Location of pain _____Upper back _____Mid back _____lower back _____central

_____radiates to _____

Duration of pain _____constant _____intermittent

Character of pain _____sharp _____dull _____stabbing _____throbbing



Severity of pain scale (circle please)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (most pain ever)

When do you feel the pain the most? _____day _____evening _____night

Aggravating factors _____standing _____sitting _____laying _____walking

Relieving factors _____standing _____sitting _____laying _____movement

_____Tylenol _____Advil _____Percocet _____oxycontin

_____Other (please describe) _____

Additional comments about your pain or treatments (including loss of bowel or bladder control, weakness etc)

Activities of Daily Living:

Do you live: _____alone _____w/spouse _____w/family _____in nursing home

Do you: _____cook for yourself _____clean house _____bath yourself % of time bedridden each day _____

Overall quality of life: _____

Treatments: (please indicate any treatments you have had, dates and name of facility)

_____Chiropractics _____

_____Acupuncture _____

_____Injections (type and date) _____

_____Vertebroplasty _____

Previous Imaging:

_____ Plain Films (date) _____ _____ CT Scan (date) _____ _____ MRI (date) _____

_____ Bone Scan (date) _____