John G Stark, M.D.,P.A.

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TELL US ABOUT YOU:

Patient Name	Date Seen	Reviewed/Initials	Reviewed/Initials

Sex	Age	Date of Birth	Marital Status	Years of Education Completed
			S M W D	6 7 8 9 10 11 12 13 14 15 16 17 18 19+

TELL US ABOUT YOUR HEALTH: *(Please check √ if you have problems with any of the following)*

		Treating Physician:
	EYES (BLURRED VISION, REDNESS, EYE PAIN)	
	EARS, NOSE, MOUTH, THROAT (DEAFNESS, RINGING, SNEEZING, HOARSENESS, DIZZINESS)	
	SKIN (SKIN DISEASE, ITCHING OR RASHES)	
	PSYCHIATRIC (CONFUSION, DISORIENTATION OR HALLUCINATIONS)	
	MUSCULO-SKELETAL (ARTHRITIS, SWELLING, WEAKNESS OR NUMBNESS OF ARMS OR LEGS)	
	GASTROINTESTINAL (LOSS OF APPETITE, NAUSEA, VOMITING, CONSTIPATION, DIARRHEA, ULCERS)	
	ENDOCRINE (***HORMONAL,*** EXCESSIVE THIRST, HEAT OR COLD INTOLERANCE, DIABETES)	
	RESPIRATORY (***LUNGS*** , ASTHMA, SHORTNESS OF BREATH, COUGHING)	
	CARDIOVASCULAR (***HEART*** DISEASE, PALPITATIONS, CHEST PAIN, SWELLING ANKLES, HIGH BLOOD PRESSURE)	
	GENITO URINARY (PROBLEMS URINATING, WEIGHT CHANGE, DISCHARGE OR BLEEDING)	
	NEUROLOGICAL (***NERVES,*** NUMBNESS, TINGLING, PARALYSIS)	
	HEMATO / LYMPH (***BL0OD*** CLOTS, SWOLLEN GLANDS, ANEMIA, BLEEDING TENDENCIES)	
	CONSTITUTIONAL (FEVER, WEIGHT LOSS)	
	ALLERGIC / IMMUNOLOGIC (ANAPHYLACTIC REACTION, HIVES)	

GENERAL HOSPITALIZATIONS (WITHIN THE LAST 7 YEARS):

Date	Reason	Date	Reason

ALLERGIES TO MEDICATIONS / METALS:

CURRENT MEDICATIONS:

For Office Use Only

Date		Date
Weight		Weight
HR		HR
BP		BP

TELL US ABOUT YOUR HABITS:

Currently Smoke?	☐ YES	☐ NO	PACKS DAILY	____	HOW LONG	____
Did you used to smoke?	☐ YES	☐ NO	PACKS DAILY	____	HOW LONG	____
Coffee/ Tea/ Cola?	☐ YES	☐ NO	CUPS DAILY	____		
Alcohol?	☐ YES	☐ NO	TYPE ____	1-2 oz/day ____	more?	____
Recreational Drugs?	☐ YES	☐ NO	TYPE/ AMOUNT	____		

TELL US ABOUT YOUR FAMILY:

	Father	Mother	Sibling		Father	Mother	Sibling		Father	Mother	Sibling
Heart Disease				Neuromuscular Disease				Diabetes			
Kidney Disease				High Blood Pressure				Stroke			
Thyroid Disease				Epilepsy/ Convulsions				Cancer			
Mental Illness				Bleeding Disorders				Other			

THINGS WE NEED TO KNOW TO PROTECT YOU:

PROBLEMS WITH ANESTHESIA?	☐ YES	☐ NO	HEPATITIS?	☐ YES	☐ NO	OTHER?
LATEX ALLERGIES?	☐ YES	☐ NO	HIV / AIDS?	☐ YES	☐ NO	

PATIENT'S SIGNATURE	DATE

Patient: **DOB:** **Date:**

John G. Stark, M.D., P.A. *IME Form*

1. Please describe in specific details **what** happened and **how** you felt when you were injured.

2. Is your problem due to an injury? ____________ Date of Injury: ____________

Type of injury ☐ Work ☐ Auto ☐ Slip & fall ☐ Other: ____________

4. Have there been other injuries? ☐YES ☐NO If yes, please list:

Date	*How did it happen? Please be specific.*	*How did your leg or back symptoms change following this injury?*
____________	________________________	________________________
	________________________	________________________
____________	________________________	________________________
	________________________	________________________
____________	________________________	________________________
	________________________	________________________

CONSERVATIVE METHODs

6. Which of the following conservative methods have you tried?

Methods	***List/Describe***	***How long?***	***Did it help?***	*Please explain:*
Physical Therapy	____________	____________	☐Yes ☐No	____________
Medications	____________	____________	☐Yes ☐ No	____________
Chiropractic	____________	____________	☐Yes ☐No	____________
Massage therapy	____________	____________	☐ Yes ☐ No	____________

Patient: **DOB:** **Date:**

7. Have you had any of the following tests?

Test		***Where?***	***Ordering Physician***
MRI	☐Yes ☐ No	___________	___________________
CT	☐Yes ☐ No	___________	___________________
Myelogram	☐Yes ☐ No	___________	___________________
Discogram	☐Yes ☐ No	___________	___________________
Nerve Root Injection	☐Yes ☐ No	___________	___________________
Facet Injection	☐Yes ☐ No	___________	___________________
Sacroiliac Injection	☐Yes ☐ No	___________	___________________
Trigger Point Injection	☐Yes ☐ No	___________	___________________
Epidural Injection	☐Yes ☐ No	___________	___________________
EMG	☐Yes ☐ No	___________	___________________
Psychiatric Evaluation	☐Yes ☐ No	___________	___________________

WORK HISTORY

8. Into which category does your ***current*** occupation fall? Occupation: ______________________

☐ Heavy—lifting more than 75 lbs. ☐ Medium—lifting between 25 and 75 lbs.
☐ Light—lifting less than 25 lbs. ☐ Sedentary—no lifting

9. Into which category did your occupation fall into at the time of injury? Occupation: __________________

☐ Heavy—lifting more than 75 lbs. ☐ Medium lifting between 25 & 75 lbs.
☐ Light—lifting less than 25 lbs. ☐ Sedentary—no lifting

10. What is your current work status?

☐ Unemployed ☐ Part-time since ___________ ☐ Full-time ☐ Off work since ___________
☐ Retired ☐ Student ☐ Homemaker ☐ Other: __________________

11. Estimate the "total time" **in months** you have missed/been off of work due to this injury: __________

PERSONAL

13. Has your marriage been strained because of your injury (optional)? ☐YES ☐NO
If yes, please feel free to explain how…

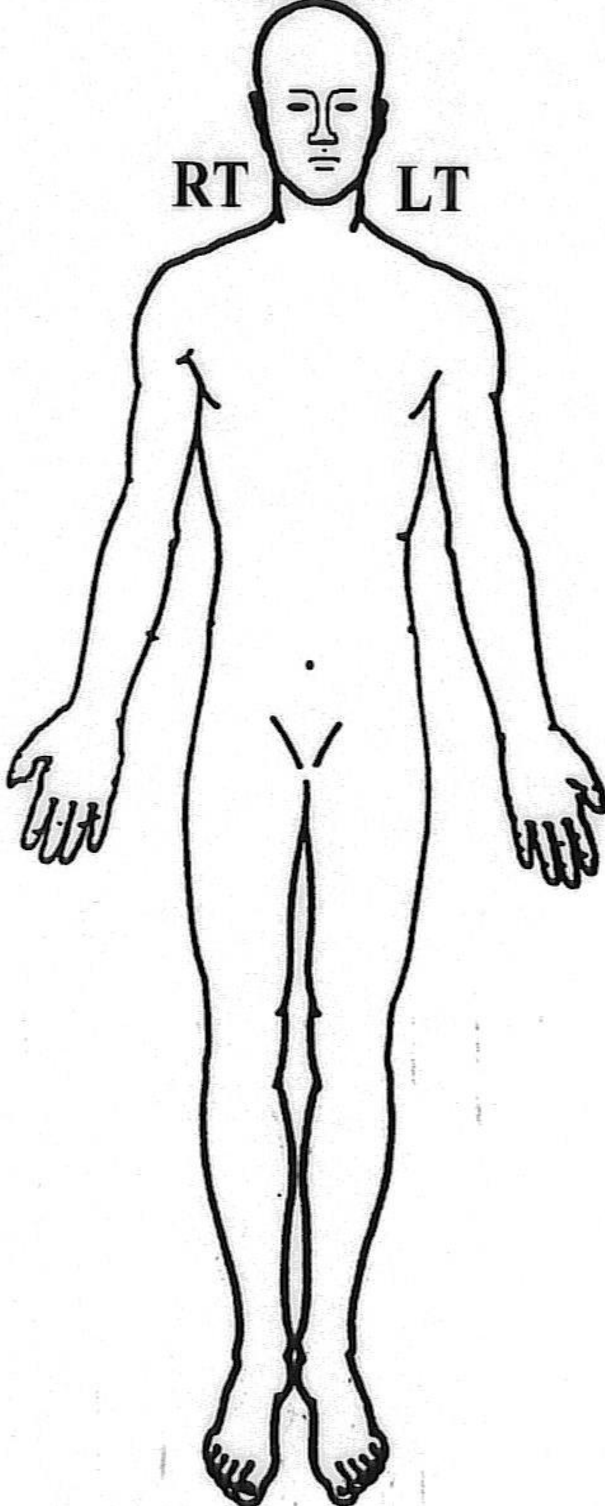
14. Are your finances a problem because of your injury (optional)? ☐YES ☐NO
If yes, please feel free to explain how…

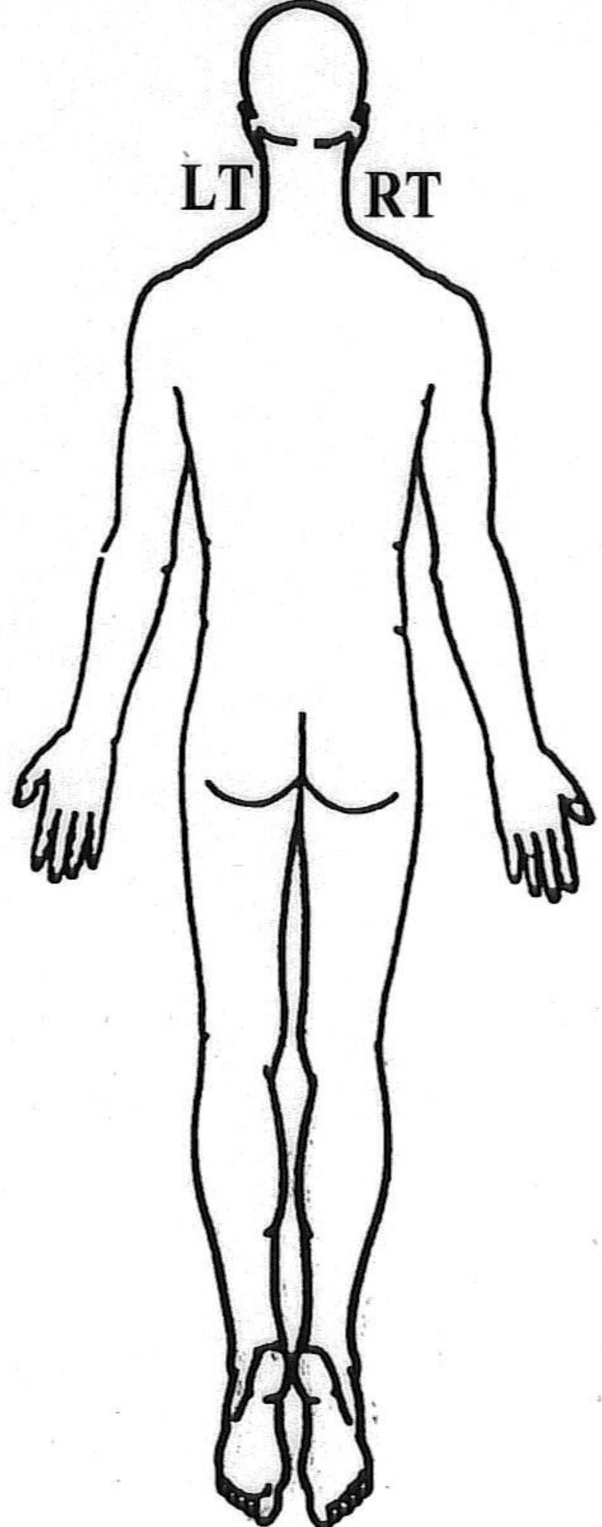
Patient: **DOB:** **Date:**

Use the **symbols below** to describe where you feel the **listed sensations** on your body. Include all the affected areas.

Numbness = ▌▌▌▌ **Burning =** ∿∿ **Pins and Needles =** ○○○○○

Aching = ▀▄▀▄ **Stabbing = V V V V V** **Tightness =** XXXXX





Millon Pain Questionnaire

Make an "X" on the line to show how far from normal the worst possible situation your pain problem has taken.

Patient: **DOB:** **Date:**

1. How bad is your pain?

No pain — Worst Possible

2. How bad is the pain at night?

No pain — Worst Possible

3. Does the pain interfere with your lifestyle?

No pain — Total Change in Lifestyle

4. How good are pain killers for your pain?

Complete Relief — No Relief

5. How stiff is your back/leg (please circle one or both)?

No Stiffness — Worst Possible Stiffness

6. Does your pain interfere with walking?

No problem — Cannot Walk

7. Do you hurt when you walk?

No pain — Worst Possible Pain

8. Does your pain keep you from standing still?

Can Stand as Long as I Want — Cannot Stand at All

9. Does your pain keep you from twisting?

No Problem — Cannot Twist

10. Does your pain allow you to sit in a hard chair?

Can Sit as Long as I Want — Cannot sit in Hard Chair

11. Does your pain allow you to sit in a soft chair?

No Problem — Cannot Sit in Soft Chair

12. Do you have back/leg (please circle one or both) pain when lying in bed?

No pain — Worst Possible

13. How much does your pain limit your lifestyle?

No Limit — Cannot do Anything

14. Does your pain interfere with your work?

No Problem — Totally cannot work

15. How much have you had to change your workplace because of your back/leg (please circle one or both) pain?

No Change — So Much, Cannot Keep a Job

Total Score ____________________

Patient: **DOB:** **Date:**

McGill Pain Questionnaire

Indicate pain location ________________________________

What does your pain feel like? Circle only the words that best describes your **pain**. Leave out any category not suitable. Use only **one** word per category.

1	2	3	4	5	6	7
Flickering	Jumping	Pricking	Sharp	Pinching	Tugging	Hot
Quivering	Flashing	Boring	Cutting	Pressing	Pulling	Burning
Pulsing	Shooting	Drilling	Lacerating	Gnawing	Wrenching	Scalding
Throbbing		Stabbing		Cramping		Searing
Beating		Lancinating		Crushing		
Pounding						

8	9	10	11	12	13	14
Tingling	Dull	Tender	Tiring	Sickening	Fearful	Punishing
Itchy	Sore	Taut	Exhausting	Suffocating	Frightful	Grueling
Smarting	Hurting	Rasping			Terrifying	Cruel
Stinging	Aching	Splitting				Vicious
	Heavy					Killing

15	16	17	18	19	20
Wretched	Annoying	Spreading	Tight	Cool	Nagging
Binding	Troublesome	Radiating	Numb	Cold	Nauseating
	Miserable	Penetrating	Drawing	Freezing	Agonizing
	Intense		Squeezing		Dreadful
	Unbearable		Tearing		Torturing

Indicate pain location ________________________________ **if you are having pain elsewhere.** Circle only the words that best describes the **pain**. Leave out any category not suitable. Use only **one** word per category.

1	2	3	4	5	6	7
Flickering	Jumping	Pricking	Sharp	Pinching	Tugging	Hot
Quivering	Flashing	Boring	Cutting	Pressing	Pulling	Burning
Pulsing	Shooting	Drilling	Lacerating	Gnawing	Wrenching	Scalding
Throbbing		Stabbing		Cramping		Searing
Beating		Lancinating		Crushing		
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	Intense		Squeezing		Dreadful
	Unbearable		Tearing		Torturing

Patient: **DOB:** **Date:**

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1: Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable.

Section 2: Personal Care (*eg. washing, dressing)*

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ I can look after myself normally but it causes me extra pain It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care.
- ☐ I need help almost every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives me extra pain.
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if its conveniently placed on a table.
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything.

Section 4: Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking ¼ mile.
- ☐ I can walk using a stick or crutches.
- ☐ I am in bed most of the time.

Section 5: Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than an hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6: Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from stand for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I have less than 6 hours of sleep.
- ☐ Because of pain I have less than 4 hours of sleep.
- ☐ Because of pain I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests i.e. sports.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10: Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

otal: _________/_____________

Oswestry Pain Questionnaire

John G. Stark, M.D., P.A.

612-332-2324
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PATIENT INFORMATION

PATIENT NAME		DATE OF BIRTH	AGE	SEX ☐ MALE ☐ FEMALE
STREET ADDRESS		APARTMENT NUMBER	CELL PHONE NUMBER	
TOWN/ STATE	ZIP CODE	E-MAIL ADDRESS	HOME PHONE NUMBER	
EMPLOYER		WORK NUMBER	SOCIAL SECURITY NUMBER	
EMERGENCY CONTACT		PHONE NUMBER	RELATIONSHIP	
DO YOU HAVE A FAMILY DOCTOR? ☐YES ☐ NO NAME:		DID YOUR DOCTOR REQUEST THIS VISIT? ☐ YES ☐ NO	REQUESTING PHYSICIANS NAME:	

PATIENT OR RESPONSIBLE PARTY MUST SIGN

AUTHORIZATION TO RELEASE MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS AND CONSENT FOR MEDICAL TREATME NT:

√ ______ Initials

I hereby authorize the release of any information by John G. Stark, M.D.,P.A. to any health care provider, insurance company, QRC, employer, and /or attorney. This will hold true for services provided during the next year. I also hereby authorize payment of medical benefits directly to John G. Stark, M.D.,P.A.. for services rendered to myself and/ or dependents. I understand that I am responsible for any and all charges that are not covered by my insurance company and/ or expired policy or denied claim. With my signature I am also authorizing medical treatment to be performed by John G. Stark, M.D.,P.A.. and his staff.

√ ______ Initials

John G. Stark, MD, PA participates in research studies involving the spine and sacroiliac joints. By signing this form I authorize the use of any and all of my medical records, personal image, and/or medical imaging. Every effort will be made to de-identify information and images if used.

Patient/ Responsible Party Signature ______________________ **Date** ____________