St Luke's
Spine & Pain Associates

Welcome to St. Luke's Spine & Pain Associates,

On behalf of our staff and providers, we would like to welcome you. We understand that pain is a daily part of life for many people, and is often undertreated or ignored. We want to assure you that we will take your pain and the impact that it has on your life seriously.

For your benefit, we would like to familiarize you to our service. For each patient, a diagnosis is made and individualized treatment plans are offered. We believe in utilizing a multidisciplinary approach to pain with an emphasis on restoring the patient to the full extent possible.

In order to accomplish this, we utilize many diagnostic and treatment modalities, including, but not limited to; interventional therapy, individualized therapy programs, electro diagnostics and appropriate medications. Surgery will be advised when non-operative care cannot achieve necessary results. We do all of this with the hope of maximizing your pain relief, physical function and quality of life.

We also have office policies in place to protect you and your well-being. At St. Luke's Spine & Pain Associates, we feel that the patient-provider relationship needs to be built on a foundation of mutual trust in order to permit high quality, effective and safe care to our patients.

Here are some common policies that all patients need to be aware of, upon their initial consultation at St. Luke's Spine & Pain Associates.

1. The first visit is a consultation only; no procedures/injections are performed on the first visit, as this time is utilized to thoroughly evaluate your individual needs and coordinate your treatment plan.
2. Medication prescriptions are not given on the first office visit.
3. You will be rescheduled if you are more than 15 minutes late for your appointment as a courtesy to other patients who are on time.

Most importantly you can expect us to listen and validate your specific concerns. We will offer our expert advice and develop customized clinical pathways with a goal of reducing your pain and improving your quality of life. Everything we do is designed with your health and safety in mind. We strive to treat you with the respect, kindness and compassion that you deserve.

We look forward to your visit with us.

St. Luke's Spine & Pain Associates providers and staff

Allentown
501 Cetronia Road
Suite 125
Allentown, PA 18104

Anderson Campus
1700 St. Luke's Blvd
Suite 200
Easton, PA 18045

Bethlehem
830 Ostrum Street
Bethlehem, PA 18015

East Stroudsburg
3 Parkinsons Road
East Stroudsburg, PA 18301

Easton Hospital
250 S 21st Street
Easton, PA 18042

Kutztown
15065 Kutztown Road
Suite 200
Kutztown, PA 19530

Lehighton
575 S 9th Street
Lehighton, PA 18235

Miners
120 Pine Street
Tamaqua, PA 18252

Orwigsburg
1165 Centre Turnpike
Orwigsburg, PA 17961

Palmerton
217 Franklin Avenue
Suite 103
Palmerton, PA 18071

Phillipsburg, NJ
Hillcrest Plaza
755 Memorial Parkway
Suite 201
Phillipsburg, NJ 08865

Quakertown
1534 Park Avenue
Suite 310
Quakertown, PA 18951

Whitehall
2363 MacArthur Road
Whitehall, PA 18052

Wind Gap
487 East Moorestown Road
Suite 110
Wind Gap, PA 18091

484-526-7246 (Phone)

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INITIAL PAIN QUESTIONNAIRE

Patient Name: _____ Age: _____ Date of Birth: _____

Referring Physician: _____ Primary Care Physician: _____

Specific Complaint: _____

Length of current pain problem: _____ Years _____ Months Are you: ☐ Right Handed ☐ Left Handed

Occupation: _____

How did your current pain start?
☐ Injury at work: **Date of accident:** _____
☐ Injury – not at work: **Date of accident:** _____
☐ Motor vehicle accident: **Date of accident:** _____

Over the past month, the intensity of pain has been:
☐ Mild
☐ Moderate
☐ Severe
☐ Other (describe): _____

Pain Scale: (Rate 0 – 10)
Current pain (10 most severe): _____
Interference with daily activities: _____

How often do you have pain? (Check one)
☐ Constantly (100% of the time)
☐ Nearly constantly (60 – 95% of the time)
☐ Intermittently (30 – 60% of the time)
☐ Occasionally (less than 30% of the time)

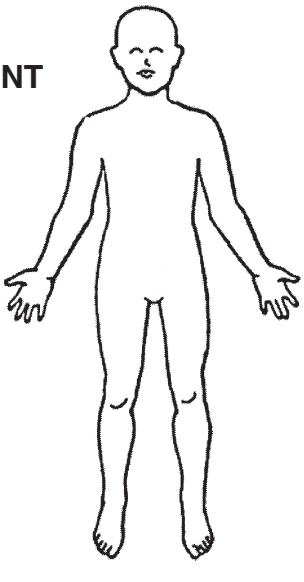
Please describe your pain: (Check all that apply)
☐ Burning ☐ Cutting
☐ Cramping ☐ Pins and Needles
☐ Shooting ☐ Pressure-like
☐ Numbness ☐ Throbbing
☐ Sharp ☐ Dull/Aching
☐ Other (describe): _____

Have you had weakness in your:
☐ Upper extremities ☐ Lower extremities
☐ Dropping objects
☐ Other (describe): _____

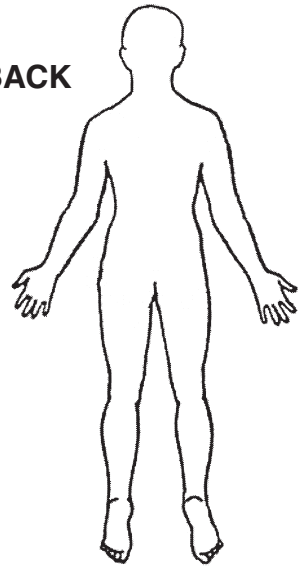
Do you use a:
☐ Cane ☐ Walker
☐ Wheelchair ☐ No assistance device

PAIN LOCATION: ***Please mark the location(s) of your pain on the diagrams with an "X". If entire areas are painful, please shade in these areas.***

FRONT



BACK



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INITIAL PAIN QUESTIONNAIRE

How do the following affect your pain? (Check one for each item)

	DECREASE	NO CHANGE	INCREASE		DECREASE	NO CHANGE	INCREASE
Prayer	☐	☐	☐	Exercise	☐	☐	☐
Lying down	☐	☐	☐	Relaxation	☐	☐	☐
Standing	☐	☐	☐	Coughing	☐	☐	☐
Bending	☐	☐	☐	Sneezing	☐	☐	☐
Sitting	☐	☐	☐	Bowel Mvmt	☐	☐	☐
Walking	☐	☐	☐	Menstruation	☐	☐	☐

PAIN MEDICATIONS: (Check all medication you have used for the treatment of pain and if they provided relief)

Opioids	CURRENT	PAST	PROVIDED RELIEF
Oxycodone, Tramadol, Morphine, etc.	☐	☐	☐

Topicals	CURRENT	PAST	PROVIDED RELIEF
Lidocaine, Voltaren Gel, Pennsaid, etc.	☐	☐	☐

NSAIDS/Tylenol	CURRENT	PAST	PROVIDED RELIEF
Celebrex, Ibuprofen, Meloxicam, Diclofenac, etc.	☐	☐	☐

Muscle Relaxants	CURRENT	PAST	PROVIDED RELIEF
Baclofen, Cyclobenzaprine, Tizanidine, Methocarbamol, etc.	☐	☐	☐

Other

Please list any other medications you have used to treat your pain: _____

_____

_____

_____

_____

_____

PAIN TREATMENTS: (Check your response to all the treatments you have tried)

	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF		NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
Surgery	☐	☐	☐	Heat/Ice	☐	☐	☐
Traction	☐	☐	☐	Psychotherapy	☐	☐	☐
Nerve block	☐	☐	☐	Acupuncture	☐	☐	☐
Nerve Injection	☐	☐	☐	Hypnosis	☐	☐	☐
Physical Therapy	☐	☐	☐	Biofeedback	☐	☐	☐
Exercise	☐	☐	☐	TENS	☐	☐	☐
Osteopathic Manipulation	☐	☐	☐	Chiropractic Manipulation	☐	☐	☐

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Answer the below yes and no questions:

	NO	YES	
Do you smoke **tobacco?**	☐	☐	If yes, packs per day _____, _____ years smoking
Do you smoke **marijuana?**	☐	☐	If yes, how frequently _____
Do you drink **alcohol?**	☐	☐	If yes, how frequently _____
Are you currently on **blood thinning medication?**	☐	☐	
Do you have an **allergy to latex?**	☐	☐	If yes, what is your reaction _____
Do you have an **allergy to contrast dye?**	☐	☐	If yes, what is your reaction _____

REVIEW OF SYSTEMS: (Check all symptoms that you are currently experiencing)

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain

HENT
- ☐ Loss of Hearing
- ☐ Nose Bleeds
- ☐ Sore Throat

EYES
- ☐ Eye Pain
- ☐ Red Eyes
- ☐ Visual Disturbances

RESPIRATORY
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting

ENDOCRINE
- ☐ Frequent Urination
- ☐ Thirsty

URINARY
- ☐ Pain with Urination
- ☐ Blood in Urine

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain

SKIN
- ☐ Rashes
- ☐ Skin Wounds

NEUROLOGICAL
- ☐ Dizziness
- ☐ Headache
- ☐ Numbness

PSYCHIATRIC
- ☐ Difficulty Concentrating
- ☐ Anxiety
- ☐ Suicidal
- ☐ Depression

_____ _____ _____ _____
PATIENT SIGNATURE **PRINTED NAME** **DATE** **TIME**

Please note that we do not determine disability.

Reviewed by: _____