NORTHERN ROCKIES PAIN CENTER

Last Name _____ First Name _____ Middle _____ Social Security # _____ Date _____

Referring Doctor: _____

Dominant Hand: R _____ L _____ Age: _____ Sex: _____ Telephone: _____

ONSET

When did this most recent episode of pain begin? _____

How did the **current** episode of pain occur? Check all that apply.

_____ Gradual onset	_____ Reaching	_____ Lifting	_____ Don't know
_____ Fall	_____ Twisting	_____ Pushing	_____ Other
_____ Direct Blow	_____ Bending	_____ Pulling	

Was your injury the result of one of the following:

_____ Vehicle Accident	_____ Recreational Accident	_____ No Known Cause
_____ On-The-Job Injury	_____ Non-work Related Incident	

Please briefly describe the onset of your pain and the events which preceded onset:

_____

_____

_____

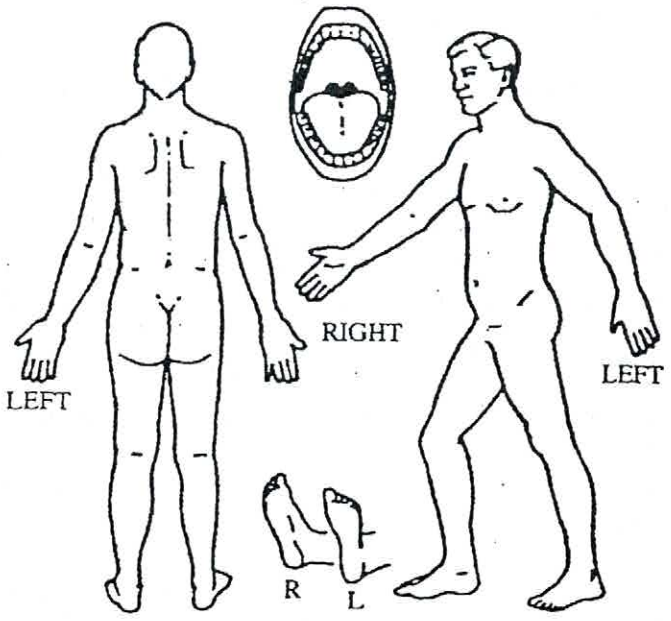
_____

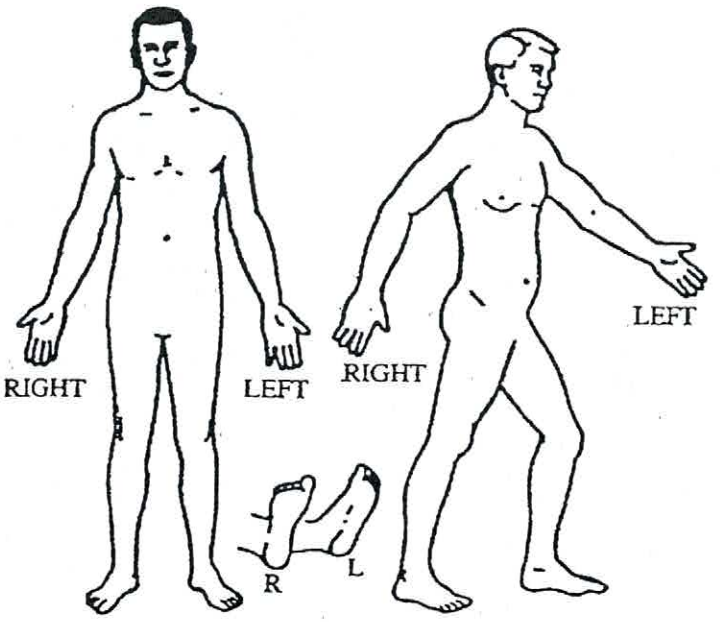
Do you feel this injury was your employer's or another person's fault? _____ Yes _____ No

CURRENT STATUS

Mark the area on your body where you now feel your typical pain. Include all affected areas. Use the appropriate symbols indicated below.

ACHE >>>>> NUMBNESS ═══ PINS & NEEDLES OOOOOOO STABBING //////////
>>>>> ═══ OOOOOOO //////////





OCCUPATIONAL HISTORY

Employer: _____ Date of Hire: _____

Usual Occupation: _____ Briefly describe your job: _____

_____

_____

Work Status Today:

_____ Regular duties

_____ Limited/light duty Date Began:_____

_____ Receiving disability Date Began:_____

_____ Not in work force

How physically demanding is your job?

_____ Very heavy (frequently lifting> 100 pounds)

_____ Heavy (frequently lifting> 60 pounds)

_____ Moderate (frequently lifting> 30 pounds)

_____ Light (frequently lifting>30 pounds)

_____ Sedentary (essentially no lifting)

Work status at the **TIME OF ONSET** of this episode.

_____ Regular: Full Duty

_____ Regular: Part Time

_____ Permanent Light Duty

_____ Temporary Light Duty

_____ On disability

_____ Retired

_____ Not Currently Working

_____ On Public Assistance

How satisfied are you with your job:

_____ Very satisfied _____ Satisfied

_____ Dissatisfied _____ It is the worst job I have had

If your pain gets completely better during the next few weeks, do you think your employer would let you return to the job you had before this episode of pain.?

_____ Yes _____ Probably _____ Doubt it

_____ Definitely not _____ N/A

Has your employer treated you fairly? _____ Yes _____ No _____ N/A

If no, please explain: _____

Do you feel this injury was your employer's fault? _____ Yes _____ No

Has anyone in your family been on disability? _____ Yes _____ No

If yes, what is their relationship to you? _____

SLEEP HISTORY

Use this scale for the following questions: 1=Rarely 2=Occasionally 3=Frequently

Do you feel you have a problem:

1. Getting to sleep at night? .....1 2 3 How long does it take? _____
2. Waking up during the night? .....1 2 3 How often? _____
3. Waking up too early in the morning?.....1 2 3
4. With snoring? 1 2 3
5. Feeling sleepy during the day?.....1 2 3
6. With excessive arm and leg movement at night?.....1 2 3
7. How many hours per night do you sleep? _____
8. Did your sleep problems exist prior to this current problem? _____ Yes _____No
9. If Yes for how long? _____

ENVIRONMENTAL HISTORY

Have you ever smoked? _____ Yes _____ No Age Began:_____
(check all appropriate one/s) _____ Cigarettes _____ Cigar _____ Pipe Other:_____
During time smoking, average number smoked daily:
_____ 1/2 pack per day _____ 1 pack per day _____ 1-2 packs per day _____ more than 2 packs per day
If you have quit smoking, at what age? _____

Have you used alcohol to control your pain? _____ Yes _____ No
Were either of your parents alcoholics? _____ Yes _____ No

Have you ever:
_____ Yes _____ No Felt you should cut down on your drinking?
_____ Yes _____ No Felt annoyed by others criticizing your drinking?
_____ Yes _____ No Felt bad or guilty about your drinking?
_____ Yes _____ No Had a drink first thing in the morning to steady your nerves or get rid of a hangover?

What is your approximate weekly use of alcoholic beverages?
_____ Less than 1-2 drinks a week
_____ 3-6 drinks a week
_____ Drink some alcohol on a daily basis
_____ I don't drink alcohol
What is your preferred alcoholic drink? _____

What is your marital status? _____ Married/partner _____ Divorced/separated _____ Single _____Widowed
How many times have you been divorced? _____

Have you had a stress or change in a significant relationship within the past 12 months? _____ Yes _____ No
Please explain: _____

What are the ages of your children? _____

EDUCATION
_____ I received a high school diploma
_____ I received a GED
_____ I did not complete high school or receive a GED

What is your highest level of education or training? _____

What is your native language?_____

Do you feel you might be depressed or overly anxious? _____ Yes _____ No

Circle the appropriate number to indicate the extent of the problem you are having with each of the following:

	NONE										SEVERE
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10

Have you ever considered yourself a victim of physical, emotional or sexual abuse? _____ Yes _____ No

Does an attorney assist you with your injury claim? _____ Yes _____ No _____ N/A
If yes, please explain briefly: _____

FAMILY HISTORY:

	Living?	Ages or age at death	Present health or cause of death
Father	_____ Yes _____ No	_____	_____
Mother	_____ Yes _____ No	_____	_____
Spouse	_____ Yes _____ No	_____	_____
Brothers	#Living _____	_____	_____
	#Deceased _____	_____	_____
Sisters	#Living _____	_____	_____
	#Deceased _____	_____	_____
Children	#Living _____	_____	_____
	#Deceased _____	_____	_____

REVIEW OF SYSTEMS:

Please put an "X" next to any of the symptoms you have had during the **past year**:

_____ Unexplained fevers
_____ Night sweats
_____ Chills
_____ Weight loss of 10 lbs or more
_____ Loss of appetite
_____ Excessive fatigue
_____ Problem with depression
_____ Unusual stress at work life
_____ Unusual stress in the home
_____ Easy bruising
_____ Excessive bleeding
_____ Any lumps in neck, armpits or groin

_____ Chest pain or tightness
_____ Persistent or unusual cough
_____ Trouble breathing with exercise
_____ Trouble breathing lying flat
_____ Coughing up blood
_____ Swollen ankles
_____ Stomach pain
_____ Nausea
_____ Vomiting
_____ Change in bowel habits
_____ Excessive constipation
_____ Persistent diarrhea

_____ Dark black stools
_____ Blood in stools
_____ Pain or burning when urinating
_____ Need to urinate more at night
_____ Generalized morning stiffness
_____ Persistent eye redness
_____ Muscle tenderness
_____ Dry eyes or mouth
_____ Skin rashes
_____ Joint pain or swelling
_____ Persistent diarrhea
_____ List joints: _____
_____

Please explain above: _____
_____
_____
_____

When was your last physical exam? _____ By whom? _____

WOMEN ONLY: (please put an "X" next to any of the following that apply)

_____ Pain increases with menstrual period
_____ Pregnant or possibly pregnant
_____ Take over 1000 mgs. Calcium daily

_____ _____
PATIENT'S SIGNATURE **DATE**

_____ _____
PHYSICIAN'S SIGNATURE **DATE**

TREATMENT

Please list the physicians, chiropractors, osteopaths, physical therapists or any health care professionals you have seen in the **LAST YEAR** for your back pain along with the approximate dates.

TYPE OF DOCTOR	DOCTOR'S NAME	LOCATION	APPROXIMATE DATES

Put an "X" next to each type of treatment you have had for your back in the **past year**. Then put an "X" in the column that best describes the effect of the treatment. If you have had treatments not given on the list, write them in at the bottom and indicate how they affected you.

TREATMENT	EFFECT OF TREATMENT		
	Helped	**Made things worse**	**Didn't do much either way**
_____ Hot packs / ice / ultrasound			
_____ Massage			
_____ Electrical stimulation			
_____ TENS Unit for home use			
_____ Body mechanics training			
_____ Strengthening exercises			
_____ Aerobics (e.g., exercise bike)			
_____ Gravity inversion / traction			
_____ Bed rest			
_____ Chiropractic treatment			
_____ Osteopractic manipulation			
_____ Biofeedback			
_____ Local (trigger point) injections			
_____ Epidural injections			
_____ Soft back brace			
_____ Rigid back brace			
_____ Acupuncture			
_____ Other _____			

Are you currently receiving any treatments listed above? _____ Yes _____ No

If yes, which ones? _____

If you are not under active treatment as listed above, approximately how long has it been since you have been under treatment for your back? _____

Do you have a home exercise program for your back that you do on a regular basis? _____ Yes _____ No

Have you received care from a mental health professional? _____ Yes _____ No

If yes, briefly explain: _____

If you have had surgery on your back (including chymopapain), please fill in the following for each operation:

DATE	TYPE OF SURGERY AND SURGEON	PAIN AFTER SURGERY Worse	Same	Better	*(M.D. USE ONLY)*

Which of the following diagnostic tests have been done on your back? Please indicate date for "yes" answers.

WORKUP	NO	YES	APPROXIMATE DATE	*RESULTS (M.D. USE ONLY)*
Reg. Spine X-rays				
Myelogram				
CT Scan				
MRI Scan				
Discogram				
Bone Scan				
EMG/SSEP				
Facet Blocks				
Other				

PREVIOUS BACK HISTORY

Have you had **any** previous back symptoms severe enough to seek professional help other than the current problem?
_____ Yes _____ No
If yes, how long ago and briefly explain: _____

Were any of these previous episodes the result of an industrial injury or motor vehicle accident? _____ Yes _____ No
If yes, please explain: _____

Please list approximate dates off work, that exceed **two weeks**, for these **previous** injuries: _____

Were you compensated for any of these injuries via disability coverage or a legal settlement? _____ Yes _____ No
If yes, please explain: _____

Including this current episode, about how many episodes of back pain have you had in the last **TWO YEARS**, severe enough to see a physician? _____

GENEARL HEALTH HISTORY

Who is your primary care physician?

Name: _____ Phone: _____

Address: _____

When was your last complete check-up? _____

Please list **ALL** medical problems you have:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Please list any surgeries you have had and the approximate date of each one:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Please list any **ALLERGIES** to medications.

MEDICATION	**REACTION**

I-90 EAST

- Take the 27TH STREET exit towards CITY CENTER
- Turn LEFT onto S 27TH ST/MT-3 N
- Go 2.45 miles
- Turn LEFT onto 12TH AVE N

I-90 WEST

- Take the 27TH STREET exit towards CITY CENTER
- Turn RIGHT onto S 27TH ST/MT-3 N
- Go 2.45 miles
- Turn LEFT onto 12TH AVE N

MONTANA AVE/I-90 Business Route

- Take MONTANA AVE/I-90 Business Route E.
- Go 1.85 miles
- Turn LEFT onto N 27TH ST go 1.13 miles
- Turn LEFT onto 12TH AVE N

AIRPORT

- Go WEST on TERMINAL CIR toward OVERLOOK DR
- TERMINAL CIR becomes N 27TH ST/MT-3 SOUTH
- Go 1.2 miles
- Turn RIGHT onto 12TH AVE N

HIGHWAY 3

- Turn SLIGHT RIGHT onto N 27th ST/MT-3S
- Go 1.3 miles
- Turn RIGHT onto 12TH AVE N

US-87

- Turn SLIGHT RIGHT onto US-312 WEST/US-87 SOUTH
- Go 2.8 miles
- Turn RIGHT onto E AIRPORT RD and go 2.9 miles
- Turn LEFT onto N 27TH STREET
- Go 1.2 miles
- Turn RIGHT onto 12TH AVE N

Magnetic Resonance Imaging

Accession Number	Exam	Exam Date/Time	Ordering Physician
MR-11-000058	MR L Spine w/o Contrast	01/04/11 7:12:48 AM	Emery, Dale W MD

Patient Name: **BRODIE, GREG K**

Disc bulges resulting in foraminal impingement most prominent at the L5-S1 level.
Final Report
Dictated by: Lindenbaum, Jeffry MD
Signed by: Lindenbaum, Jeffry MD
Signed Date and Time: 01/04/11 08:41:15
Technologist: Dietz , Stacey
Transcriptionist: PS
Transcribed Date and Time: 01/04/11 08:42:33
****

Message

BRODIE, GREG K - BCH0355467

From: Emery , Dale W
Sent: 01/04/11 13:09:43
To: Montez ,Amber;
Patient's Name: BRODIE, GREG K
Caller Name:
Phone:
Subject: Results - Message Center

From: Emery, Dale W MD
To: Montez , Amber;
Sent: 01/04/2011 13:09:42 MST Show up: 01/04/11 13:09:00
Subject: Results - Message Center
Actions: Reminder: Mail results to patient

There is some disc bulging, mainly around the L5-S1 area. Try the physical therapy and Spine Clinic to see if they help.

Results:

Date	Result Type	Result Name
01/04/2011 8:42	Radiology	MR L Spine w/o Contrast

Printed By : MONTEA
Printed On : 01/04/11 13:18:34

Magnetic Resonance Imaging

Accession Number	Exam	Exam Date/Time	Ordering Physician
MR-11-000058	MR L Spine w/o Contrast	01/04/11 7:12:48 AM	Emery, Dale W MD

Patient Name: **BRODIE, GREG K**

Reason for Exam
LBP

Report
Sagittal T1 FLAIR, fast T2, STIR, and axial fast T2 imaging lumbar spine obtained noncontrast. History is bilateral leg pain and weakness with numbness. Run over by SUV.

Findings:

Lumbar vertebral bodies appear normal in contour and signal characteristics. No fracture or focal marrow lesion. The conus medullaris appears normal located posteriorly at L1-L2. Axial images demonstrate no paraspinal mass or focal atrophy.

L1-L2: Normal.

L2-L3: Normal.

L3-L4: Mild hypertrophic facet changes but no canal or foraminal stenosis.

L4-L5: Hypertrophic facet changes with broad-based disc bulge resulting in mild degree of bilateral foraminal stenosis but no significant canal stenosis.

L5-S1: Hypertrophic facet changes. No focal disc extrusion. Mild bulge resulting in moderate left greater than right foraminal stenosis. The visualized sacroiliac joints appear intact.

Impression:

MONTANA
ORTHOPEDICS
& SPORTS MEDICINE P.C.

Yellowstone Medical Building • 2900 12th Ave. No., Suite100, East Building • Billings, MT 59101
406 238-6700/Medical • 406 238-6724/Business • 406 238-6734/Fax • 1-800-299-6708
www.montanabones.com

NAME: BRODIE, GREG AGE: 28 12/26/1977

11/16/2006 LEFT ARM

Greg was seen last in August of 2006. At that time, I evaluated him for persistent dysesthetic pain in his left upper extremity following a work related injury. I have not seen him since that last visit. He apparently continues in litigation with his workers' compensation insurance carrier and is currently scheduled for a legal mediation in January of 2007. He presents complaining of increasing pain in relation to the colder weather. Pain again is along the volar ulnar aspect of his forearm and radiates to the ulnar aspect of his palm and occasionally into his ulnar digits.

PHYSICAL EXAMINATION: His clinical exam findings again reveal tenderness particularly over the proximal wound site with a positive Tinel's at this level along the ulnar nerve distribution. There is no hyperhidrosis or allodynia. Distally, he has no obvious changes in his gross motor or sensory function. His digits are well profused.

IMPRESSION: Dysesthetic pain, left upper extremity. Again, I think it is plausible he sustained an injury to the ulnar nerve in addition to the soft tissue in the left forearm and likely has some residual symptoms related to the trauma. I certainly cannot rule out the possibility of a conduction problem in the ulnar nerve based solely on his clinical exam findings.

My recommendation would be to again authorize a neurodiagnostic test so we can evaluate conduction of the ulnar nerve through the distal forearm and hand. In the interim, I am going to provide him with a prescription for Lyrica medication that he can use for discomfort. If the nerve test is authorized, I would be happy to see him back and review the results and discuss any and all additional appropriate treatment options. No change in work restrictions at this time.

Ralph M. Costanzo, MD/jrd 719.43
DD: 11/16/2006 DT: 11/17/2006

cc: Work Comp

Valerie C. West/MR
1-19-07 FAXED OFFICE NOTES ATTN: DR. ECHEVERRI CKS

MONTANA ORTHOPEDICS & SPORTS MEDICINE P.C.

John R. Dorr, M.D. Richard P. Lewallen, M.D. David W. Shenton, M.D. Steven J. Rizzolo, M.D.
Dean C. Sukin, M.D. Michael R. Yorgason, M.D. Steven J. Klepps, M.D. Ralph M. Costanzo, M.D.

PATIENT: Brodie, Greg **AGE:** 29 years old **12/02/1977**
EXAM DATE: 02/05/07

PAST HISTORY:

Illnesses:	.No Serious Illnesses Reported
Operations:	Abdominal: hernia repair x2
	Wrist: left forearm- I &D laceration 4/2006
Social History:	Caffeine
	Employment: Unemployed
	Marital Status: Single
Family History:	.Family History Reviewed
Outside TX Physician:	No data for Outside Tx Physicians
Medications:	No data for Medication
Allergies:	.No Known Drug Allergies

HPI: The patient was seen last in the office on November 16, 2006. Since his last visit, he reports very little change in the symptoms in the right upper extremity. He continues to have occasional dysesthetic pain along the right forearm along with numbness in the only digits. Symptoms are worsened with cold exposure. The patient has not completed the legal mediation process. He continues in a self-employed occupation.

Review of the neurodiagnostic test results from Dr. Eccheverri revealed normal conduction parameters for both the median any ulnar nerve proximally and distally. The electromyographic was normal.

No data for Vitals

Exam: On examination, he has the two areas on the forearm which showed tattoo marks along the ulnar volar forearm. He has a palpable defect over the flexor carpi ulnaris musculature. There is some tenderness in the same area. He is a positive Tinel sign along the ulnar nerve in the same location.

Distally, he has no signs of intrinsic atrophy. He has a normal sweat pattern of vascularity to his digits. Sensation is intact.

Radiology:

IMPRESSION: Dysesthetic pain right forearm

Diagnosis: 729.5-PAIN IN LIMB
CPT: 99212-OFFIC/OUTPT E&M ESTAB MINOR 10MIN

Plan: I had a lengthy discussion with the patient regarding his residual symptoms in the right upper

extremity. It is unclear that surgical intervention would resolve the symptoms. I did tell him that if he felt his symptoms were disabling one might consider exploring the ulnar nerve with a possible neuroplasty and even a venous conduit wrapping.

The patient is to discuss the situation with his lawyer if he wants to proceed in any fashion in the future and I will be happy to see him back. I had a lengthy discussion with the patient regarding the symptoms in the right upper extremity.

The patient may continue at work without restriction. I would consider him as having achieved maximum medical improvement. He does not appear to require an impairment rating at this time.

Prescription: ~Prescription~

Ralph Costanzo, M.D.

St. Vincent Healthcare
Northern Rockies Regional Pain Center

Dear Greg,

Thank you for choosing the Northern Rockies Regional Pain Center for your medical needs. Your appointment has been scheduled on 10/28/11 at 9:30 AM with Dr. Michael Schabacker.

Please complete the enclosed paperwork prior to your appointment. This must be done thoroughly and accurately as it will be a record of reference for establishing your medical record with us and will assist us in the management of your care.

In order to accommodate as many new referrals as possible, we require first time patients confirm their appointment attendance 48 hours in advance. If you fail to contact us with the established time frame, not only will your appointment be cancelled but you will not be allowed to reschedule.

Required Documents for your Initial Appointment

- New Patient Packet – thoroughly completed
- Insurance identification cards or other billing information. **If your care is to be billed to Workman's Compensation you will need prior authorization for your appointment.***
- Co-payments required by your health insurance carrier. This payment will be collected at the time of your appointment. Your co-payment amount should be stated on your insurance card.

Please feel free to contact our office at 406-237-8808 option #2 if you have any questions/concerns of if your contact information changes. We look forward to serving you!

If you do not have your insurance or billing information available at the time of your visit, we will request you make a personal payment at the time of service.

PLEASE ARRIVE AT 9:00 AM

2900 12th Avenue North • Suite 335W • Billings, MT 59101 • (406) 237-8808

St. Vincent Healthcare

Northern Rockies Regional Pain Center

The Northern Rockies Regional Pain Center requires all new patients in our pain management program to participate in the following:

Baseline BBHI (psychological questionnaire)**

It is a requirement of our pain clinic to administer these tests to allow our physicians to form a plan of care to address pain issues. This tool measures physical, surgical, emotional and psychological issues that are affected by the pain, or affecting the pain.

This test is not saying there are psychological issues; it is measuring other issues that will affect the outcome of the management of the pain. In other words, it helps us track if what we are doing for you is helpful.

Baseline & Random Urine Drug Screens**

Pain Medication Agreement

****Please be aware a fee is associated with the BBHI and the Urine Drug Screens. Your insurance will be billed. However, if the service is not covered by your insurance plan you will be responsible for all charges. If you have questions related to these fees, please contact us prior to receiving these services.**

2900 12th Avenue North • Suite 335W • Billings, MT 59101 • (406) 237-8808

St. Vincent Healthcare
Medical Practices Division

Date List Started:_____
Page: _____ of_____

Medication List

Patient
Name:_____DOB:_____

* A current medication list helps prevent medication errors.

RX Date	Medication Name & Strength to include: over the counter vitamins, herbs, diet supplements, natural remedies, alcohol and recreation drugs	Dosage (mg drops, etc.)	How & When to Use (daily, at bedtime, etc.)	Stop Date

ALWAYS KEEP THIS FORM WITH YOU – Take this form to all healthcare visits.

USE THIS FORM TO DOCUMENT ALL CHANGES MADE TO YOUR MEDICATIONS – Taking an active role in your health care can help prevent medication errors and **KEEP YOU SAFE!**