



Established Patients: Post Medial Branch Block Injections Questionnaire

IMPORTANT: Please complete all sections of this form. Do not leave any unanswered items. If the question does not apply, you may put "N/A".

Personal Information

Full Name

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First Name

Middle Name

Last Name

Date of Birth

Today's Date

Date of Injection

Injection performed in:

- Cervical (neck)
- Thoracic (mid-back)
- Lumbar (lower back)

Was this

- 1st Medial Branch Block Injections
- 2nd Medial Branch Block Injections

The injection gave the following percentage of relief:

- 80% or more relief only in the first few hours
- 80% or more relief only within the first 2 days
- 80% or more relief and still lasting
- Less than 80%
- Other:

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RICHMOND SPINE Interventions & Pain Center

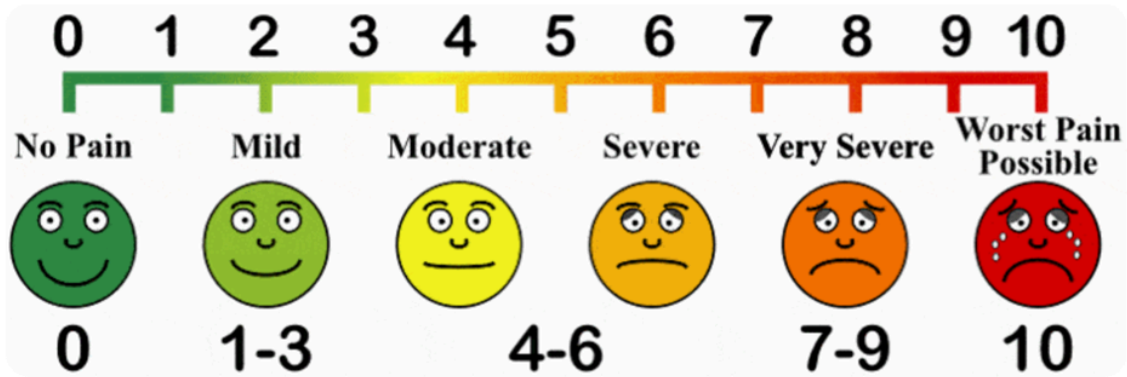
The injection helped in performing the following activities:

- | | | |
|--|---|---|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Cooking | <input type="checkbox"/> School |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Lawn Care | <input type="checkbox"/> Home duties |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Laundry | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Sitting at Work | <input type="checkbox"/> Dining outside |
| <input type="checkbox"/> Getting dressed | <input type="checkbox"/> Walking at Work | <input type="checkbox"/> Sports |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Standing at Work | <input type="checkbox"/> None |

Other treatment modalities used at present and since the procedure:

- | | | |
|--|---|--|
| <input type="checkbox"/> Home exercises | <input type="checkbox"/> Cognitive-behavioral therapy | <input type="checkbox"/> Massage therapy |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Chiropractic care | <input type="checkbox"/> Nothing |
| <input type="checkbox"/> Pain medications | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Muscle relaxant pills | <input type="checkbox"/> Aquatic therapy | |
| <input type="checkbox"/> Heat/Ice | <input type="checkbox"/> Dry Needling | |

On a scale of 0-10, **0 being no pain** and **10 being the worst pain** you can imagine.



Worst Pain (0 as no pain and 10 as the worst pain imaginable):

- | | | |
|----------------------------|----------------------------|-----------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 4 | <input type="checkbox"/> 8 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 | <input type="checkbox"/> 9 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 6 | <input type="checkbox"/> 10 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 7 | |

Pain Level Today (0 as no pain and 10 as worst pain imaginable):

- | | | |
|----------------------------|----------------------------|-----------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 4 | <input type="checkbox"/> 8 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 | <input type="checkbox"/> 9 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 6 | <input type="checkbox"/> 10 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 7 | |



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Interventions & Pain Center

Have you visited the emergency room since your last visit?

- Yes
- No

Date and name of the facility:

Have you had MRI Scan for this pain?

- Yes
- No

Date and name of the facility where MRI was performed:

Have you had CT scan for this pain?

- Yes
- No

Date and name of the facility where CT scan was performed:

Have you had X-ray for this pain?

- Yes
- No

Date and name of the facility where X-ray was performed:

Have you had any operations or procedures since your last visit?

- Yes
- No

Please describe briefly:

Have you been diagnosed with any new medical problems since your last visit?

- Yes
- No

Please describe briefly: