NATIONAL Spine & Pain CENTERS

Patient Name _____ **Patient ID** _____

DOB _____ **Date**_____

NSPC is dedicated to providing comprehensive care to patients and following the federal guidelines regarding important public health issues. *Please circle your answer to the following questions.*

SECTION 1: DEPRESSION

Over the last 2 weeks, how often have you been bothered by the following problems?

Are you currently being treated for a diagnosis of depression?	YES	NO

If you answered Yes to the above question please DO NOT COMPLETE the remainder for Section 1

	Not At All	Several days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

SECTION 2: ADVANCED DIRECTIVE

Are you age 65 or older?	YES	NO

In the event that you are incapacitated, who would you like to have make your medical decisions? *Provide name, phone number, and relationship. If none assigned, leave blank.*

_____

SECTION 3: FALL RISK

Please circle "Not Applicable" if you Use Wheelchair for Mobility or are Unable to Walk

Do you feel unsteady when walking? YES NO NOT APPLICABLE (N/A)

Do you worry about falling? YES NO NOT APPLICABLE (N/A)

Have you fallen in the past 1 year? YES NO

If yes, how many falls? 1 2 3 or more falls

Were you injured during any of the falls? YES NO

SECTION 4: TOBACCO USE

Are you currently smoking cigarettes or using other tobacco products? YES NO

SECTION 5: BLOOD PRESSURE

Have you ever been diagnosed with high blood pressure (Hypertension)? YES NO

Patient Signature: _____ Date_____

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SECTION 5: HYPERTENSION (continued from page 1)

BP: Systolic _____ / Diastolic _____

SECTION 6: BODY MASS INDEX

What is your height? _____feet _____inches What is your weight? _____lbs.

Official Use Only **BMI =**

SECTION 7: Medication Documentation

Official Use Only *See Medication List is Patient Chart.*

SECTION 8: Pain Assessment

Official Use Only *See pain scale in office note*

Completed by staff member: _____