RICHMOND SPINE Interventions & Pain Center

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

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:

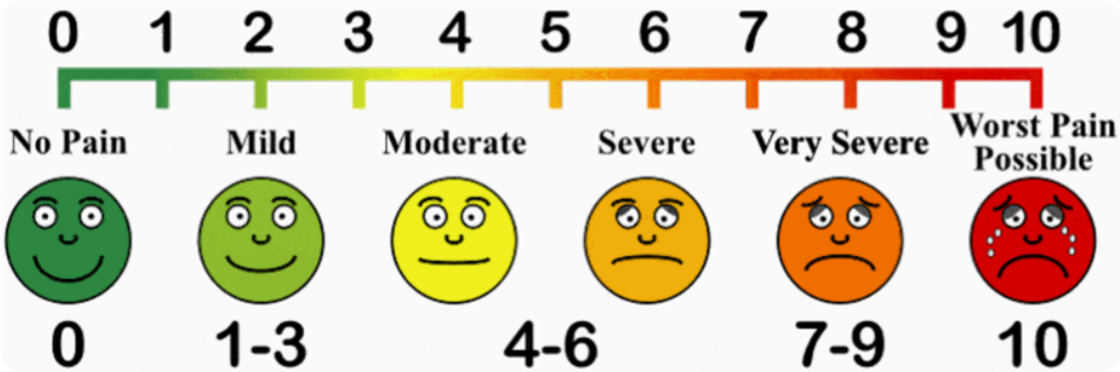
The injection helped in performing the following activities:

- ☐ Walking
- ☐ Standing
- ☐ Sitting
- ☐ Bathing
- ☐ Getting dressed
- ☐ Cleaning
- ☐ Cooking
- ☐ Lawn Care
- ☐ Laundry
- ☐ Sitting at Work
- ☐ Walking at Work
- ☐ Standing at Work
- ☐ School
- ☐ Home duties
- ☐ Child Care
- ☐ Dining outside
- ☐ Sports
- ☐ None

Other treatment modalities used at present and since the procedure:

- ☐ Home exercises
- ☐ Physical therapy
- ☐ Pain medications
- ☐ Muscle relaxant pills
- ☐ Heat/Ice
- ☐ Cognitive-behavioral therapy
- ☐ Chiropractic care
- ☐ Acupuncture
- ☐ Aquatic therapy
- ☐ Dry Needling
- ☐ Massage therapy
- ☐ Nothing
- ☐ Other: _____

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):

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

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

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

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: