Spine Pain Diagnostics Associates / Niagara Health Center
INITIAL LEARNING ASSESSMENT

For Clinical Use Only

Name: Date: _____

DOB:

MR#: Physician: ☐ Singh ☐ Liao

During your visit with our organization you will be presented with information that may be new to you. To aid us in providing this information to you in a manner that allows for optimal understanding, please answer the following questions.

1. How do you like to learn new things? Please check all that apply.
   ☐ Verbal ☐ Written ☐ Visual
2. Do you speak English in your home? ☐ Yes ☐ No
   If no, what language do you speak? _____
   Name of Interpreter: _____
3. Can you read English? ☐ Yes ☐ No
4. Can you write English? ☐ Yes ☐ No
5. Can you hear well? ☐ Yes ☐ No
   If no, do you use a hearing device? ☐ Yes ☐ No
6. Do you need to receive information through sign language? ☐ Yes ☐ No
7. Do you see well? ☐ Yes ☐ No
   If no, do you wear glasses or contacts? ☐ Yes ☐ No
8. Do you forget things easily? ☐ Yes ☐ No
9. Do you feel your level of pain interferes with learning? ☐ Yes ☐ No
   If yes, do you feel the need to have a family member or someone present during education? ☐ Yes ☐ No
10. Do you have any cultural or religious practices/beliefs that may affect our care or treatment?
    ☐ Yes ☐ No
    If yes, please explain: _____

Patient Signature: _____ Date: _____

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STAFF ASSESSMENT

1. **Barriers to Patient Teaching/Learning:**

   ☐ None Identified
   ☐ Reading Barrier
   ☐ Hearing Impairment
   ☐ Visual Impairment
   ☐ Cognitive Impairment
   ☐ Pain Level
   ☐ Cultural
   ☐ Lack of Motivation _____
   ☐ Emotional _____
   ☐ Other: _____

2. Patient / Family readiness to Learn:

   Accurately explains reason for visit and relates medical history? ☐ Yes ☐ No
   Verbalizes readiness and willingness to learn about plan of care? ☐ Yes ☐ No

3. Preferred Method of Learning:

   ☐ Verbal ☐ Written ☐ Demonstration

4. Patient / Family verbalized understanding of information provided? ☐ Yes ☐ No

   If no, please explain: _____

Comments: _____

_____

_____

_____

Staff Signature: _____ Date: _____

Physician Signature: _____ Date: _____