PAIN PREVENTION AND REHABILITATION CENTER

PATIENT INFORMATION

SPINE HISTORY

MANISH SUTHAR, MD
PM & R

Permission for Treatment

During the course of my treatment at the Pain Prevention and Rehabilitation Center, I understand that I will be seen, evaluated, and treated by a qualified healthcare professional.

_____ _____
Patient Name (Please Print) Signature of Patient

If the patient is a minor or under legal guardianship by my signature as a guardian, I authorize evaluation and medically necessary tests and treatment.

_____ _____
Signature of Parent or other legally responsible person (Parent/Guardian) Date/Time

Reason For Visit

Due to patient time slots, multiple problems may require more than one visit for evaluation.

AGE:_____ **DATE OF INJURY/PROBLEM:**_____

Primary reason for this visit is:
(Please choose those that apply):

Pain location: ☐ RIGHT ☐ LEFT ☐ BILATERAL

- ☐ Low Back
- ☐ Hip/Buttock/Groin
- ☐ Thigh/upper leg
- ☐ Knee /lower leg
- ☐ Ankle/Foot/Toes
- ☐ Middle Back
- ☐ Other (list) _____
- ☐ Neck
- ☐ Shoulder
- ☐ Upper Back
- ☐ Arm/Elbow/Forearm
- ☐ Hand/Wrist/Fingers
- ☐ Face/Head
- ☐ Joint pain (list)
  - ○ _____
- ☐ Muscle pain (list)
  - ○ _____
- ☐ Total Body pain

Before you continue…

We know that filling out all of these forms can be annoying – but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem. From this information, we can provide you the best medical care possible. All information will be kept strictly confidential. Thank you for your cooperation.

Who may we thank for your referral?:_____

What do you want to happen as a result of this visit?

_____

_____

Is there something you want to stress that is important? ☐ Yes ☐ No

_____

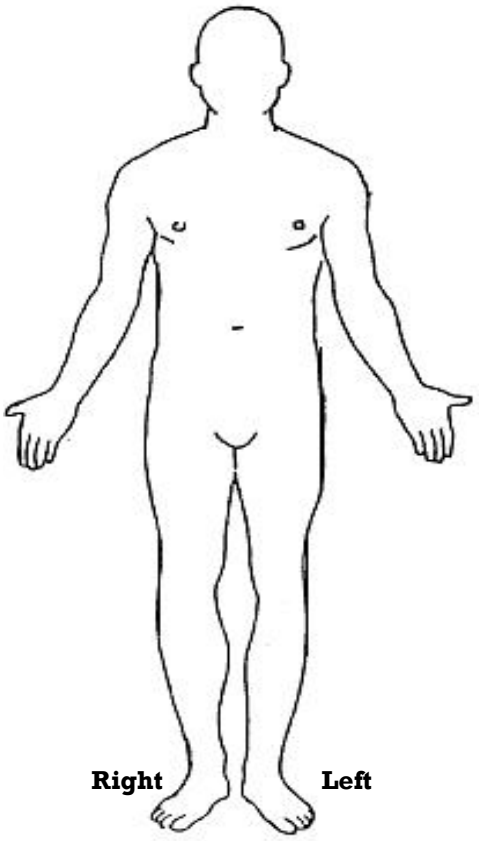
_____

_____

Patient Pain

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.



Front

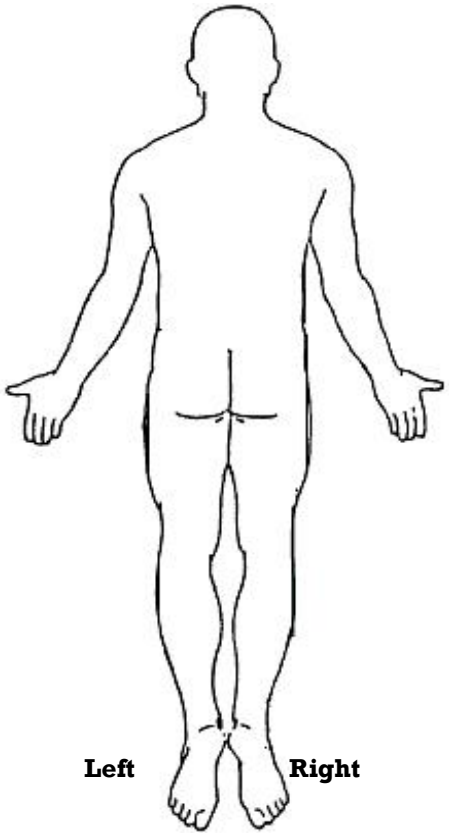
Numbness
●●●●●

Pins & needles
ooooo

Burning
xxxxx

Stabbing
/////

Ache
^^^^^



Back

Please put one mark on the thermometer to show how bad your usual pain is these days.

10 (My pain is as bad as it could possibly be.)

1 (I have no pain at all.)

Chief/Primary Complaint

Explain how your pain or problem began:

_____

_____

_____

☐ "I don't know how it began"
☐ On-the-job injury
☐ It is recurrent – it comes and goes
☐ Off work due to this recent problem?
☐ Recent injury/trauma
☐ Yes ☐ No How long?

_____

☐ Old injury ("I've had it a long time")
☐ Approximate date: _____
☐ Previous occurrence(s): ☐ No ☐ 1-4 previous occurrences ☐ more than 4 times

Chief/Primary Complaint (Cont.)

I have pain in my (check all that apply): ☐ Low back ☐ Leg ☐ Mid back ☐ Neck ☐ Arm

Rate the severity of your pain at this time by marking an '**X**' on the (---------**X**---------) line:

Low Back

No pain (0) ◆——————————————————◆ Worst pain possible (10)

0 1 2 3 4 5 6 7 8 9 10

Leg/Foot

No pain (0) ◆——————————————————◆ Worst pain possible (10)

0 1 2 3 4 5 6 7 8 9 10

Middle Back

No pain (0) ◆——————————————————◆ Worst pain possible (10)

0 1 2 3 4 5 6 7 8 9 10

Neck / Upper Back

No pain (0) ◆——————————————————◆ Worst pain possible (10)

0 1 2 3 4 5 6 7 8 9 10

Arm / Hand

No pain (0) ◆——————————————————◆ Worst pain possible (10)

0 1 2 3 4 5 6 7 8 9 10

What improves your pain? _____

What increases your symptoms? _____

What makes your pain better, worse, or has no effect? Please check (✓) the appropriate answer in the table below:

	Better	Worse	No Effect
Heat			
Cold			
Bath/Shower			
Walking			
Sitting			
Lying Down/Sleeping			
Stress/Worry			
Exercise/Activity			
Sexual Activity			

Nothing makes me feel better. ☐ True ☐ False

I also have the following problems:

☐ Weakness of muscles in arms or hands
☐ Weakness of muscles in legs, ankles or feet
☐ Numbness (loss of feeling) in:
___ arms/hands
___ legs/feet
☐ Tingling (falling asleep) in:
___ arms/hands
___ legs/feet
☐ My legs/feet fatigue when I walk too far.
I can walk:
___ Less than a block
___ 1-3 blocks
___ More than 3 blocks
___ This is relieved by resting my legs
☐ My pain is worse at night.
☐ My pain awakens me from sleep
☐ Trouble with my bladder (urine) control:
___ Can't empty bladder
___ Loss of urine (accidents)
☐ Trouble with bowels:
___ Constipation
___ Loss of control (accidents)

Previous Tests For This Condition

☐ **NONE** (Go to next section below)	**How Many**	**When** (Month/Year)	**What Facility** (Clinic/Hospital)	**Results** (As given to you)
☐ Regular x-rays				
☐ CT Scan				
☐ MRI Scan				
☐ Discogram				
☐ Injections ☐ Epidural ☐ SI Joint ☐ Facet ☐ Other _____				
☐ CT Myelogram				
☐ Nerve Tests (EMG/NCV)				
☐ Other: _____				

Previous Treatments For This Condition

☐ **NONE** (Go to next section below) **MEDICATIONS:**	**Name if Known**	**No Help**	**Some Relief**	**Good Relief**
☐ Anti-inflammatory				
☐ Muscle Relaxants				
☐ Pain Medications				
☐ Other: _____				
THERAPIES:				
☐ Chiropractic Care/Manipulation				
☐ Physical Therapy/Rehabilitation				
☐ Psychological Consult				
☐ Other: _____				

☐ Spinal Surgery (List Type, Level, Approximate date and surgeon):

_____

_____

_____

Previous treating doctors: _____

Specialty(ies) i.e. Surgeon: _____

GENERAL MEDICAL HISTORY

Major Illnesses

Now	Prior	(Please check all that apply)	Other
		☐ **NONE:** (Go to next section below)	
		Heart Trouble: ☐ Angina ☐ Heart Attack ☐ Heart Murmur ☐ Valve Disease	
		Vascular: ☐ High Blood Pressure ☐ Stroke ☐ Blood clots	
		Ulcers/digestive: ☐ Stomach ☐ Duodenal ☐ Colon	
		Diabetes: (high blood sugar) ☐ Insulin dependent	
		Liver Disease: ☐ Hepatitis – Type A____, Type B____ ☐ Cirrhosis	
		Kidney Disease: ☐ Stones ☐ Infections	
		Lung Disease: ☐ Emphysema ☐ TB ☐ Chronic bronchitis ☐ Cancer ☐ Frequent pneumonia ☐ Asthma	
		Blood Disorders: ☐ Anemia ☐ Leukemia ☐ Bleeding tendency	
		Eye Disease: ☐ Glaucoma	
		Arthritis: ☐ Degenerative ☐ Rheumatoid ☐ Gout	
		Cancer: ☐ Type _____	
		Psychological Difficulties: ☐ Depression ☐ Psychosis ☐ Anxiety	
		Ladies: ☐ Menstrual Problems ☐ Osteoporosis ☐ Problems with sexual function	
		Men: ☐ Prostate BPH ☐ Problems with sexual function	
		Childhood: ☐ Rheumatic Fever ☐ CP ☐ Polio	

Major Surgeries (Other than on spine)

Surgery	When	Surgery	When
☐ **NONE:** (Go to next section)			
Tonsillectomy		Biopsy	
Appendectomy		Fracture Repair	
Gall Bladder		Joint Repair	
Heart		Digestive	
Hysterectomy		Hernia	
Vasectomy		Other: _____	

Major Injuries

Type of Injury	What (Describe)	When	What was injured?
☐ **NONE:** (Go to next section)			
Auto or cycle accidents, etc.			
Prior sports or misc. injuries			

Medications – Please list **ALL** current medications:
(Include aspirin, Coumadin, Herbal medication, diet pills, cold tablets, etc.)

Medicine	Strength	How many?	How often?

Allergies

	List Medicine i.e. Penicillin	Reaction(s) i.e. Rash
Medicine		
	List Other Allergy i.e. Mold, Detergents…	**Reaction(s)** i.e. Sneezing, runny nose…
To Other Things		

Review of Symptoms (Please check all conditions which apply currently):

Constitutional Symptoms
- ☐ Fever
- ☐ Weight loss/gain
- ☐ Fatigue

HEENT
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Glasses
- ☐ Light Sensitivity
- ☐ Hearing Difficulty/Aid
- ☐ Ear pain
- ☐ Congestion
- ☐ Bleeding
- ☐ Sinus Infection
- ☐ Dentures
- ☐ Jaw/Tooth Pain
- ☐ Mouth Sores
- ☐ Sore Throat
- ☐ Hoarseness

Cardiovascular
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Abnormal Heart Rhythm
- ☐ Swelling of Ankles
- ☐ Pacemaker
- ☐ Blood Clot
- ☐ Use of Blood Thinners

Respiratory
- ☐ Painful Breathing
- ☐ Productive Cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Shortness of Breath

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Hiatal Hernia
- ☐ Nausea & Vomiting
- ☐ Constipation & Diarrhea
- ☐ Ulcers
- ☐ Liver/ Gallbladder Problems
- ☐ Black, Bloody Stools

Genitourinary
- ☐ Painful Urination
- ☐ Bladder Infection
- ☐ Difficult Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Sexually Transmitted Disease

Musculoskeletal
- ☐ Arthritis
- ☐ Bursitis
- ☐ Pain/Numbness
  - ☐ Shoulder
  - ☐ Arms
  - ☐ Hands
  - ☐ Elbows
  - ☐ Neck
  - ☐ Hip
  - ☐ Legs
  - ☐ Knees
  - ☐ Feet
  - ☐ Tailbone
- ☐ Poor Posture

Integumentary (skin or breast)
- ☐ Rash
- ☐ Itching
- ☐ Bruise easily
- ☐ Shingles
- ☐ Skin Cancer

Neurological
- ☐ Tremors
- ☐ Weakness/Numbness/Tingling
- ☐ Dizziness
- ☐ Loss of Coordination

Psychiatric
- ☐ Memory Loss
- ☐ Alzheimer's
- ☐ Depression
- ☐ Anxiety
- ☐ Alcoholism
- ☐ Thoughts of Suicide
- ☐ Irritability

Allergic/Immunologic
- ☐ Hay Fever
- ☐ Allergies (other than drugs)
- ☐ AIDS/HIV
- ☐ Cancer _____

Women Only
- ☐ Breast Pain
- ☐ Cramps or Backache
- ☐ Heavy Menstruation
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Lumps in Breast
- ☐ Menopause
- ☐ Painful Menstruation
- ☐ Vaginal Discharge
- ☐ Pain on Intercourse

Family Medical History

Mother: ☐ Alive Age _____ ☐ Good Health ☐ Suffers_____
☐ Deceased Age _____ Cause of Death: _____

Father: ☐ Alive Age _____ ☐ Good Health ☐ Suffers _____
☐ Deceased Age _____ Cause of Death: _____

Members of family (brothers, sisters, grandparents, aunts and uncles) suffer with the following:

Medical Problem	Relationship	Medical Problem	Relationship
☐ **NONE:** (Go to next section below)		☐ Heart Trouble	
☐ Stroke		☐ Back Problems	
☐ Diabetes		☐ Arthritis	
☐ Lung Disease		☐ Other: _____	
☐ High Blood Pressure		☐ Don't Know	

Social History

To provide a safe environment for all our patients, we ask this question to all patients. Are you in a relationship with someone who makes you feel afraid, is hurting you, forcing sexual contact or trying to control you life or making you feel unsafe? (Optional)
☐ No ☐ Yes

☐ Married ☐ Separated ☐ Divorced ☐ Widow/widower ☐ Single

Ability to enjoy life: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

My pain has affected my ability to perform my job or acquire a job: ☐ Yes ☐ No

The changes in my lifestyle due to my problem have been difficult for me: ☐ Yes ☐ No

Where do you live? (i.e. two-story home, assisted living home):_____

Number of children: Living at home _____ Away _____ Other dependents: _____

☐ Currently Employed Occupation: _____ Previous occupation:_____

☐ Retired Occupation(s) prior to retirement: _____

Highest educational level attained: ☐ Grammar ☐ High School ☐ College ☐ Post Graduate

Do you have special needs? ☐ Yes ☐ No Explain: _____

Alcohol Use: ☐ None ☐ Beer ☐ Wine ☐ "Hard" Drinks
Frequency: ☐ Rarely ☐ Socially ☐ Daily

Tobacco Use: ☐ None ☐ Cigarettes ☐ Cigar/Pipe ☐ Smokeless/leaf
Frequency: How many per day? _____ How many years? _____

☐ I quit!! When: _____

Thank You!

13710 Olive Blvd • Chesterfield, Missouri 63017 • Office (314) 469- PAIN (7246)
Fax (314) 469-7251 • www. painprevent.com