PAIN PREVENTION & REHABILITATION CENTER

PATIENT INFORMATION

ORTHO HISTORY

MANISH SUTHAR,MD
PM & R

Permission for Treatment

During the course of my treatment at the Pain Prevention & 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 ailments 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
- ☐ Mid 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

_____

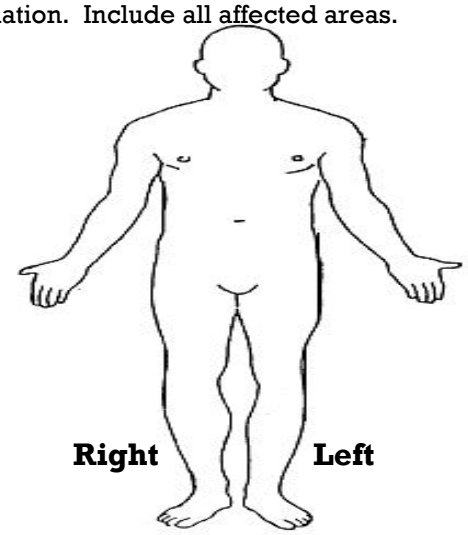
_____

_____

Patient Pain Drawing

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.



Front

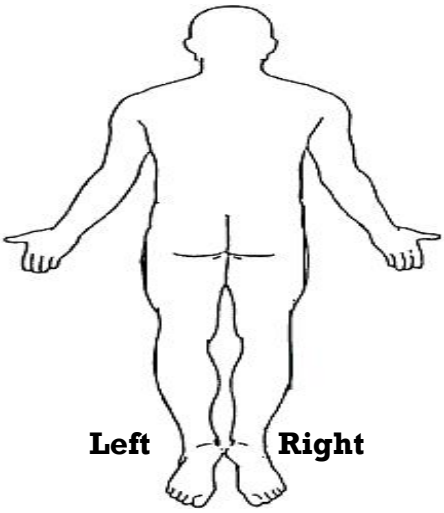
Numbness
•••••

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" ☐ It is recurrent – it comes and goes ☐ Recent injury/trauma

☐ On-the-job injury ☐ Off work due to this recent problem? ☐ Yes ☐ No How long?

_____

☐ Old injury ("I've had it a long time") ☐ Approximate date: _____

☐ Previous occurrence(s): ☐ None ☐ 1-4 previous occurrences ☐ more than 4 times

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:
☐ Tingling (falling asleep) in:
☐ 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)

Chief/Primary Complaint (Cont.)

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

Nothing makes me feel better: ☐ True ☐ False

What decreases your symptoms?

_____

_____

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			

Previous Treatments For This Condition

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

GENERAL MEDICAL HISTORY

Major Illnesses

Now	Ever	(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 Diseases: ☐ Rheumatic Fever ☐ CP ☐ Polio	

Major Surgeries

Surgery	When	Surgery	When
☐ **NONE:**(Go to next section)			
Tonsillectomy		Biopsy	
Appendectomy		Fracture Repair	
Gall Bladder		Hernia	
Heart		Digestive	
Hysterectomy		Spine	
Joint Repair		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 Systems: *(Please list any additional complaints)*

_____

_____

_____

_____

Family Medical History

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

Father: ☐ Alive Age _____ ☐ Good Health ☐ Suffers with _____
☐ 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

Living status (i.e. alone, family, caregiver): _____

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 !

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