

PAIN PREVENTION AND REHABILITATION CENTER

PATIENT INFORMATION

Medicine Consent Form

**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?: _____

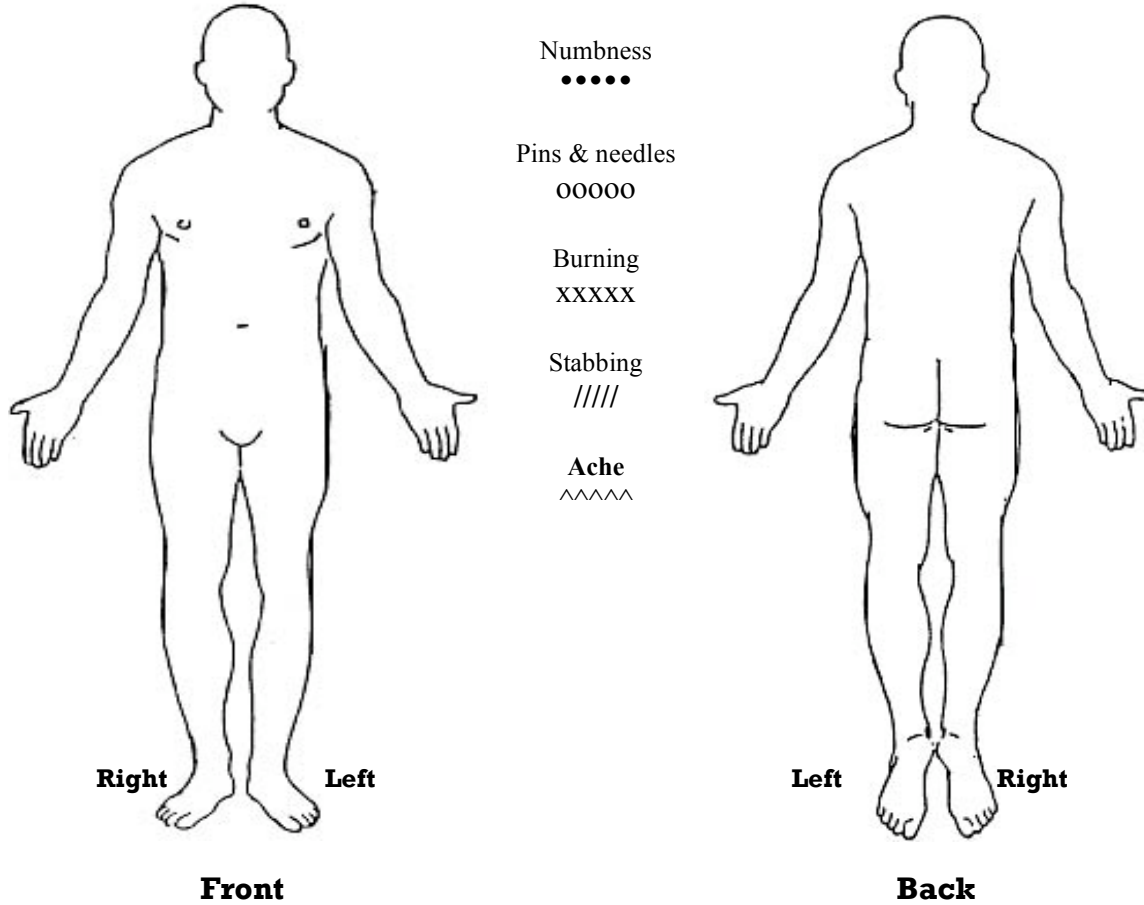
What do you want to happen as a result of this visit?

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

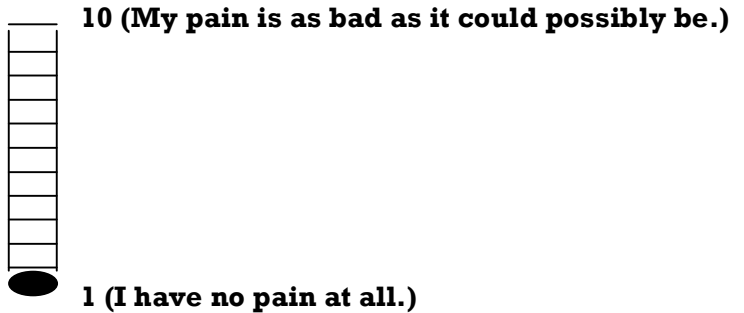
Patient Pain

Where is your pain now?

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



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



Chief/Primary Complaint

Explain how your pain or problem began:

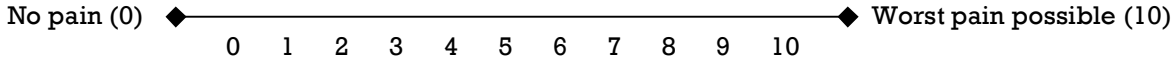
- "I don't know how it began"
- It is recurrent – it comes and goes
- Recent injury/trauma
- On-the-job injury
- Off work due to this recent problem? Yes No How long? _____
- Old injury ("I've had it a long time")
- Approximate date: _____
- Previous occurrence(s): No 1-4 previous occurrences more than 4 times

Chief/Primary Complaint (Cont.)

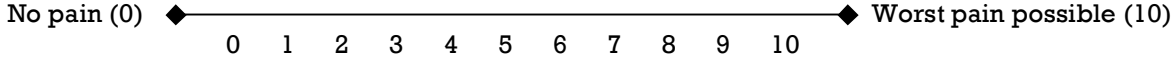
I have pain in my (check all that apply): Low back Leg Mid back Neck Arm

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

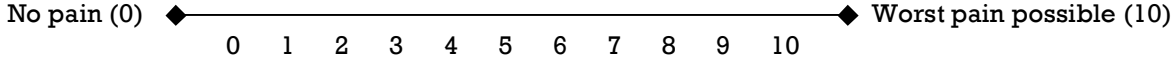
Low Back



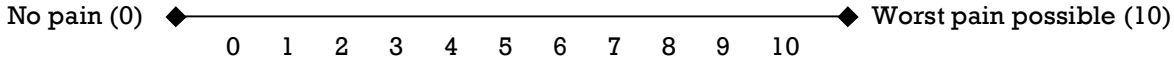
Leg/Foot



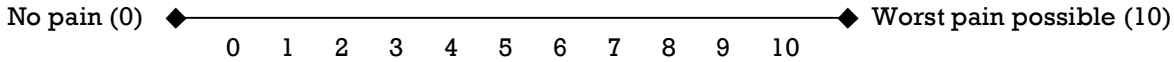
Middle Back



Neck / Upper Back



Arm / Hand



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

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

Previous Treatments For This Condition

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

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

Previous treating doctors: _____

Specialty(ies) i.e. Surgeon: _____

Medications – Please list **all other** current medications (other than for neck/back problems):
 (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		
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
<input type="checkbox"/> NONE: (Go to next section below)		<input type="checkbox"/> Heart Trouble	
<input type="checkbox"/> Stroke		<input type="checkbox"/> Back Problems	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Lung Disease		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Don't Know	

Social History

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!