Dr. Thiyaga's Spine & Pain Care (page 1 of 2)

Name:.....Date: .....

Reason for visit: (Circle all that apply.)

Back pain Neck pain Mid-back pain
Rt arm pain Rt leg pain Lt arm pain Lt leg pain
Whole body Cancer pain Pelvic Pain Head pain

Rate your pain:
(none)0 1 2 3 4 5 6 7 8 9 10(severe)

Date of Injury: _____
If no injury, how long have you had your pain?
(Enter #)_____ (Circle one) Days, Weeks, Months, Years

The pain is: (Circle one) Continuous Occasional

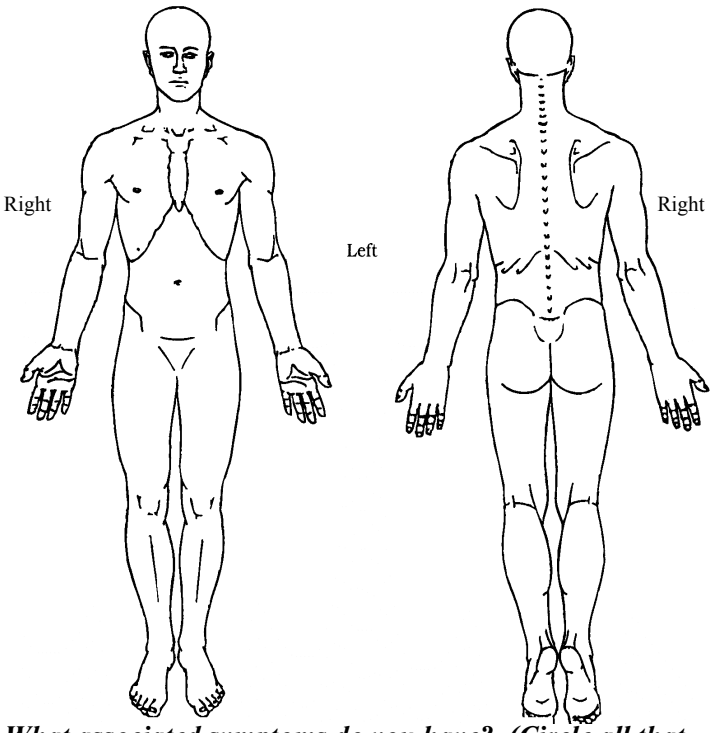
When is your pain worse? (Circle all that apply)
Morning Daytime Evening Nighttime

Describe your pain: (Circle all that apply.)
Dull Sharp Aching Knifelike Stabbing
Throbbing Shooting Burning Like pins and needles

What makes your pain worse? (Circle all that apply.)
Lifting Bending Laying Sitting Standing Driving
Changes in weather Walking Coughing Sneezing

What makes your pain better? (Circle all that apply.)
Medications Bending Laying Sitting Standing
Walking Changing positions Nothing

Mark the location of your pain:



What associated symptoms do you have? (Circle all that apply.)

Numbness Yes / No
Weakness Yes / No
Catching Yes / No
Giving out Yes / No

Do you have any recent changes in controlling your bowel or bladder? (Circle one.) Yes No

Do you have any unexplained fevers > 101.5°F? (Circle one.) Yes No

Do you have any unintended weight loss greater than 15 pounds? (Circle one.) Yes No

What treatments have you had for this problem? (Circle all that apply.)
Medications Physical therapy Chiropractic care Epidural steroid injections Facet injections Trigger point injections Joint injections Surgery Acupuncture Nothing

What diagnostic studies have you had for this problem? (Circle all that apply.) X-ray MRI CT scan Myelogram Discogram Bone scan Bone density scan EMG Nothing

If your symptoms were due to an injury, what type of injury did you have? (Circle all that apply.)
Work related Traffic accident Lifting injury Fall injury Object fell on you Repetitive use injury

Review of Systems: **Do you currently have any of the following medical symptoms? (Mark all that apply.)**

Symptom	Yes	No
Weight Gain		
Unexplained Weight Loss		
Fever		
Rash		
Ear Pain		
Visual Disturbances		
Cough		
Shortness of Breath		
Chest Pain		
Cold Hands/Feet		
Fainting		
Swelling in Legs		
Constipation		
Incontinence of Bowel		
Nausea		
Stomach Pain		
Vomiting		
Incontinence of Bladder		
Muscle Weakness		
Balance Problems		
Memory Problems		
Numbness of Hands / Feet		
Anxiety		
Seizures		
Sleep Disturbance		
Depression		
Symptoms of Thyroid Disease		
Sypmtoms of Diabetes		
Appetite Changes		
Abnormal Bleeding		

Allergies:

(Please list all medication allergies, and the type of reaction to the medication. Please include allergies to iodine, X-ray contrast, and shellfish.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medical History / Family History:

(Check all that apply.)

Illness	**You**	**Any Family Member**
Seasonal Allergies		
Asthma		
Cancer		
Stroke/TIA		
Glaucoma/Cataracts		
Thyroid Disease		
High Blood Pressure		
Heart Disease		
Vein Troubles/Blood Clots		
Abnormalities of Female Organs		
Abnormalities of Prostate		
Lung Disease		
Abnormal Chest X-ray		
Liver disease/Hepatitis		
Kidney/Bladder Disease		
Diabetes		
High Blood Fats/Cholesterol		
Abnormal Bleeding		
Blood Problems (High/low counts)		
Joint Disease		
Anxiety/Depression/Psych Illness		
Skin Disease		

Surgical History: **(Circle all that apply.)**

Cosmetic	Bowel	Vascular
Cancer	Lung	Kidney/Bladder
Head/Brain	Appendix	Liver/Gall Bladder
Cataract	Hernia	Prostate/Female Organs
Tonsils	Bone/Joint	Sinus/Nose
Heart	Spine	Other: _____

Spine.....date:.....Surgeon:.....

Name:
Date: **Time:**
Referring. Phys
Family Phys.

Social History: **Who lives with you? (Circle all that apply.)** Self Spouse Family Children Child Parent(s) Roommate Significant other Partner Friend Caregiver Group home Pet(s):_____ Other

Tobacco Use: (Circle one.) NO /YES.....PACKS for.....(years)

Alcohol Use: (Circle one.) Yes No

Illegal Drug Use: (Circle one.) Yes No

Occupational History:

What is your occupation?.....

How many hours standing:.....Sitting:.....Lifting:.....(wt)

Are you on diasbility? No / Yes: reason:.....Since.....(year)

Are you currently working? Yes/No

Are you on medical leave?.....for how long:.....

Medications: **(Please list ALL of your current medications including over-the-counter medications. Please list dosages, and how often you take the medication.)**

NAME DOSE FREQUENCY

_____
_____
_____
_____
_____
_____
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_____
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_____
_____

LIST YOUR BLOOD THINNER HERE (you need to stop before procedure with permission from doctor)

_____
_____

Pregnancy History: (For women only.)

Are you currently pregnant? Yes No Unknown

Please provide any other concerns or comments:

_____
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Thank you for completing this form in a timely manner