



13. If you have both back and leg pain: My back is \_\_\_\_\_ % of my pain My leg is \_\_\_\_\_ % of my pain  
 13a. If you have both neck and arm pain: My neck is \_\_\_\_\_ % of my pain My arm is \_\_\_\_\_ % of my pain

14. My symptoms have been: improving unchanged worsening

15. What increases or decreases your pain?

Increase		Decrease
	Bending forward	
	Bending backwards	
	Sitting	
	Standing	
	Walking	
	Exercise	

Increase		Decrease
	Coughing or Straining	
	Bowel movements	
	Lying down	
	Medications (give names):	
	Relaxation	
	Pushing shopping cart	

16. How many blocks can you walk before having to stop because of pain: \_\_\_\_\_ blocks

17. Functional limitations during the past month, what activities you avoided because of pain:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Going to work               | <input type="checkbox"/> Socializing with friends    | <input type="checkbox"/> Physically exercising |
| <input type="checkbox"/> Performing household chores | <input type="checkbox"/> Participating in recreation | <input type="checkbox"/> Driving               |
| <input type="checkbox"/> Doing yard work or shopping | <input type="checkbox"/> Having sexual relations     | <input type="checkbox"/> Caring for self       |

18. Do you have other pain problems? What are they?

1.	3.
2.	4.

19. Previous pain treatments

Treatment	How many, when and by whom	Excellent Relief	Moderate Relief	No Relief
<input type="checkbox"/> Epidural steroid injection		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sacroiliac joint injection		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Trigger point injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nerve block		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical therapy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Exercise		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acupuncture		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> TENS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypnosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Biofeedback		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psychotherapy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Previous diagnostic studies (dates and results)

MRI
CT
X-Rays
EMG
Discography

21. Please check the medications that you are currently on. Indicate the dosage and number of pills you are taking per day. Cross out medications that you have tried in the past, indicate the reason for stopping.

NARCOTICS	ANTIINFLAMMATORIES (NSAIDS)	ANTIDEPRESSANTS
<input type="checkbox"/> Codeine	<input type="checkbox"/> Aleve (Naproxen)	<input type="checkbox"/> Celexa
<input type="checkbox"/> Darvocet (Propoxyphene)	<input type="checkbox"/> Celebrex	<input type="checkbox"/> Cymbalta
<input type="checkbox"/> Demerol (Meperidine)	<input type="checkbox"/> Feldene (Piroxicam)	<input type="checkbox"/> Elavil (Amitriptyline)
<input type="checkbox"/> Dilaudid (Hydromorphone)	<input type="checkbox"/> Ibuprofen (Motrin, Advil)	<input type="checkbox"/> Effexor (Venlafaxine)
<input type="checkbox"/> Fentanyl (Duragesic patch)	<input type="checkbox"/> Indomethacin (Indocin)	<input type="checkbox"/> Desyrel (Trazodone)
<input type="checkbox"/> Levorphanol	<input type="checkbox"/> Lodine (Etodolac)	<input type="checkbox"/> Lexapro
<input type="checkbox"/> Lortab	<input type="checkbox"/> Naprosyn (Naproxen)	<input type="checkbox"/> Norpramin (Desipramine)
<input type="checkbox"/> Methadone	<input type="checkbox"/> Relafen (Nabumetone)	<input type="checkbox"/> Pamelor (Nortriptyline)
<input type="checkbox"/> Morphine	<input type="checkbox"/> Toradol (Ketorolac)	<input type="checkbox"/> Paxil (Paroxetine)
<input type="checkbox"/> MS Contin		<input type="checkbox"/> Prozac (Fluoxetine)
<input type="checkbox"/> Oxycodone		<input type="checkbox"/> Serzone (Nefazodone)
<input type="checkbox"/> Oxycontin	<input type="checkbox"/> Ambien (Zolpidem)	<input type="checkbox"/> Sinequan (Doxepin)
<input type="checkbox"/> Percocet	<input type="checkbox"/> Lunesta	<input type="checkbox"/> Wellbutrin (Bupropion)
<input type="checkbox"/> Tylenol with codeine	<b>BLOOD THINNERS</b>	<input type="checkbox"/> Zoloft (Sertraline)
<input type="checkbox"/> Vicodin (Hydrocodone)	<input type="checkbox"/> Aspirin	<b>OTHERS</b>
<input type="checkbox"/> Norco	<input type="checkbox"/> Coumadin	<input type="checkbox"/> Lidoderm
	<input type="checkbox"/> Plavix	<input type="checkbox"/> Depakote (Valproic Acid)
	<b>ANTIANSXIETY</b>	<input type="checkbox"/> Dilantin (Phenytoin)
<b>ANTISPASMODICS</b>	<input type="checkbox"/> Ativan (Lorezapam)	<input type="checkbox"/> Lamictal (Lamotrigine)
<input type="checkbox"/> Baclofen (Lioresal)	<input type="checkbox"/> Buspar (Buspirone)	<input type="checkbox"/> Lyrica
<input type="checkbox"/> Flexeril (Cyclobenzaprine)	<input type="checkbox"/> Halcion (Triazolam)	<input type="checkbox"/> Neurontin (Gabapentin)
<input type="checkbox"/> Norflex (Orphenadrine)	<input type="checkbox"/> Klonopin (Clonazepam)	<input type="checkbox"/> Phenobarbital
<input type="checkbox"/> Robaxin (Methocarbamol)	<input type="checkbox"/> Serax (Oxazepam)	<input type="checkbox"/> Tegretol (Carbamazepine)
<input type="checkbox"/> Soma (Carisoprodol)	<input type="checkbox"/> Valium (Diazepam)	<input type="checkbox"/> Topomax (Topiramate)
<input type="checkbox"/> Zanaflex (Tizanidine)	<input type="checkbox"/> Xanax (Alprazolam)	<input type="checkbox"/> Ultram (Tramadol) Ultracet

21a. Other medications


22. Allergies to medications (including antibiotics, local anesthetics, or materials):

latex			
x-ray contrast dye, iodine			

23. Review of Systems (Circle all that apply).

<b>General</b>	Fever    Unplanned weight loss    Night sweats
<b>Eyes</b>	Glaucoma    Double    blurred    vision    Blind spots
<b>Nose:</b>	Sinusitis    Bleeding    Congestion    Runny nose    S    Hearing loss
<b>Throat:</b>	Sore throat    Difficulty swallowing    Hoarseness    Dentures Full/Partial    Snoring
<b>Heart:</b>	Chest pain    Previous heart attack    Murmur    Dizzy spells    Congestive heart failure last six months
<b>Lungs:</b>	Wheezing    Shortness of breath    Cough    Tuberculosis
<b>GI:</b>	Abdominal pain    Heartburn    Nausea    Vomiting    Diarrhea    Constipation    Incontinence    Dark stools    Rectal bleeding
<b>GU:</b>	Sexual dysfunction    Urinary retention
<b>Musculoskeletal:</b>	Knee pain    Shoulder pain    Restricted movement
<b>Skin</b>	Rash    Lesions    Change in hair or nails
<b>Neurological:</b>	Seizures    Dizziness    Weakness    Drowsiness    Trouble walking    Problems controlling bowel/ bladder
<b>Psychiatric:</b>	Difficulty falling or remaining asleep    Excessive fatigue    Feeling depressed    Memory loss
<b>Endocrine:</b>	Heat / cold intolerance    Diabetes    Thyroid disorder
<b>Hematology:</b>	Easy bruising    Low platelet count    Enlarged lymph nodes

24. Past medical history: Have you ever had any of the following health problems?

<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> Stroke (TIA)	<input type="checkbox"/> Seizure or epilepsy	<input type="checkbox"/> HIV/ AIDS
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Hepatitis A B C
<input type="checkbox"/> Chest pain, heart attack	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other	

Other medical problems:

1	5
2	6
3	7

25. List all surgeries (date and type of operation):

1. Laminectomies	5.
2. Fusion	6.
3.	7.
4.	8.

26. I have a family history of  Back pain  Migraine headaches  Suicide  Psychiatric illnesses  Cancer

27. Have you ever had any problems with anesthesia/sedation? Yes No

Please describe \_\_\_\_\_

28. Is there any chance you might be pregnant?  Yes  No  N/A

29. Have you ever abused alcohol?  Yes  No been in Alcoholics Anonymous?  Yes  No

29a. Have you ever abused drugs?  Yes  No if yes, please name: \_\_\_\_\_

30. I am currently smoking  Yes  No \_\_\_\_\_ packs of cigarettes per day for \_\_\_\_\_ years.

30a. I quit smoking \_\_\_\_\_ years ago. I used to smoke \_\_\_\_\_ packs of cigarettes per day for \_\_\_\_\_ years.

31. Are you on a special diet:  Yes  No Please describe \_\_\_\_\_

31a. Do you exercise on a regular basis:  Yes  No \_\_\_\_\_ average min/day, \_\_\_\_\_ times/week

32. PSYCHOSOCIAL HISTORY

32a. Education (highest level achieved):

- |  |  |
|--|--|
| <input type="checkbox"/> postgraduate or professional training (obtained degree) | <input type="checkbox"/> GED or trade-technical school graduate                |
| <input type="checkbox"/> college graduate (obtained degree)                      | <input type="checkbox"/> partial high school (10th grade through partial 12th) |
| <input type="checkbox"/> partial college training                                | <input type="checkbox"/> partial junior high school (7th grade through 9th)    |
| <input type="checkbox"/> high school graduate                                    | <input type="checkbox"/> elementary school (6th grade or less)                 |

32b. Employment: Please indicate the date of determination for following: \_\_\_\_\_

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Employed full-time | <input type="checkbox"/> Temporarily disabled | <input type="checkbox"/> Disability rating _____ | <input type="checkbox"/> Retired (Not due to health) |
| <input type="checkbox"/> Employed part-time | <input type="checkbox"/> Permanently disabled | <input type="checkbox"/> Medically rated _____   | <input type="checkbox"/> Permanent and stationary    |

If you have settled your claim, do you have future medical care: Yes No

Current occupation(s): \_\_\_\_\_ Current Employer \_\_\_\_\_

Former occupation(s): \_\_\_\_\_

- 32c.  My employment status HAS been affected by the present pain condition  
 My employment status HAS NOT been affected by the present pain condition  
 I have been off work for: \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ week(s)

32d. What are your present sources of financial support: (Check all that apply)

<input type="checkbox"/> Salary/Employment Income	<input type="checkbox"/> Disability	<input type="checkbox"/> Insurance
<input type="checkbox"/> Savings	<input type="checkbox"/> Workers Compensation	<input type="checkbox"/> Other

33 Your health insurance/s:

- HMO \_\_\_\_\_ name   
  Medicare   
  Workers' compensation   
  Self-Pay   
  Medi-Cal  
 PPO \_\_\_\_\_ name   
  Tricare   
  Automobile insurance   
  SSI/ SSDI   
  Partnership

34. PSYCHOLOGICAL TREATMENT

Have you ever had psychiatric, psychological, or social work evaluations or treatments?  Yes  No

If yes, when? \_\_\_\_\_

35. FAMILY LIFE:

36a. I am  single     married     widowed     separated     divorced

36b. I am currently living:  alone     with parents     with friends     other

with spouse/partner and children (how many? names? ages?)

37. How would you describe yourself?

- Asian   
  African American   
  Hispanic/Latino   
  Middle Eastern   
  White/Caucasian

I hereby authorize the release of the reports of my evaluations and treatments to my physicians and to other relevant persons listed below:

Physicians/Providers/Attorney/Case Manager/Other	Address	Phone
		FAX
Referring physician		Phone: Fax:
Primary care physician		Phone Fax
		Phone Fax
Adjuster		Phone Fax
Lawyer		Phone Fax

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please do not write below this line. Thank you.**

GENERAL	BP	Pulse	RR	Weight	Ht	ASA
	<input type="checkbox"/>	<b>normal body habitus</b>	<input type="checkbox"/>	<b>well nourished</b>	<input type="checkbox"/>	<b>well-groomed</b>
PSYCHIATRIC	<input type="checkbox"/>	<b>normal attention/concentration</b>	<input type="checkbox"/>	<b>poor attention/concentration</b>		
	<input type="checkbox"/>	<b>normal mood, affect</b>	<input type="checkbox"/>	<b>depressed</b>	<input type="checkbox"/>	<b>anxious</b>
EYES	<input type="checkbox"/>	PERRLA	<input type="checkbox"/>	conjunctiva anicteric	<input type="checkbox"/>	no ptosis
SKIN	<input type="checkbox"/>	no rashes, lesions, ulcers	<input type="checkbox"/>	skin palpation normal		
HEART	<input type="checkbox"/>	regular rate and rhythm	<input type="checkbox"/>	no murmurs, rubs	<input type="checkbox"/>	pedal pulses present
LUNGS	<input type="checkbox"/>	clear to auscultation				
ABDOMEN	<input type="checkbox"/>	no masses, tenderness	<input type="checkbox"/>	no hernias		

CRPS

MUSCULOSKELETAL		<input type="checkbox"/>	Mechanical allodynia		
Gait non antalgic	SI palpation	R	L	<input type="checkbox"/>	Hyperalgesia to single pinprick
Toe R L	Patrick's test	R	L	<input type="checkbox"/>	Summation to multiple pinprick
Heel R L	Gaenslen's test	R	L	<input type="checkbox"/>	Cold allodynia
L/spine Flex /90 Ext /25 Rot R /85 L /85	Piriformis	R	L	<input type="checkbox"/>	Abnormal swelling
SLR R at _____ L at _____				<input type="checkbox"/>	Abnormal hair or nail growth
L Facets _____ on R L				<input type="checkbox"/>	Abnormal sweating
C/spine Flex Ext Rot R L				<input type="checkbox"/>	Abnormal skin color changes
C Facets _____ on R L				<input type="checkbox"/>	Abnormal skin temperature (> 1.0)

	Right			Left		
	M	R	S	M	R	S
C5						
C6 b/c						
C7 t/c						
C8 b/r		X			X	
T1		X			X	

	Right			Left		
	M	R	S	M	R	S
L2		X			X	
L3		X			X	
L4 quad						
L5		X			X	
S1 achill						

IMPRESSION

1.	4.
2.	5.
3.	6.

Risk, benefits, alternatives of procedure explained to patient  Yes  No The patient understands and consents  Yes  No ASA I II III IV

PROCEDURE

1	gauge	<input type="checkbox"/> Touhy	Kenalog	<input type="checkbox"/> Fluoro
	inch	<input type="checkbox"/> Spinal	Depomedrol	<input type="checkbox"/> Epidurogram
2			Bupivacaine	<input type="checkbox"/> Arthrogram
			Lidocaine	
3				

RECOMMENDATIONS

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

\_\_\_\_\_/Val Tarasenko, M.D./