PAIN PREVENTION & REHABILITATION CENTER

PATIENT INFORMATION

UPPER EXTREMITY 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 legally responsible person (Parent/Guardian) Date/Time

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

What is your ***current*** occupation? _____

What company do you currently work for? _____ How Long? _____

Same company where injury occurred? ☐ Yes ☐ No_____

1. Are you currently working your regular job? ☐ Yes ☐ No Are you on modified duty? ☐ Yes ☐ No
2. If you are on modified duty, what are your work restrictions?
   _____
   _____
3. When did you last work? _____ How many days missed? _____
4. List Prior Work-related injuries:_____

JOB DETAIL:

How many hours do you normally work? _____per day _____per wk

Describe the work with your hands? _____

☐ How much do you lift? (weight): _____ How often? _____

☐ *If you do data entry*, how many hours a day? _____ ☐ Continuous ☐ Intermittent

Do you enjoy your job? ☐ Yes ☐ No Comments: _____
Is your job boring? ☐ Yes ☐ No _____
Is your job stressful? ☐ Yes ☐ No _____

Do you have a second job? ☐ Yes ☐ No _____ # of hours per day ____ # of hours per week

If yes, please describe what you do: _____

Chief/Primary Complaint

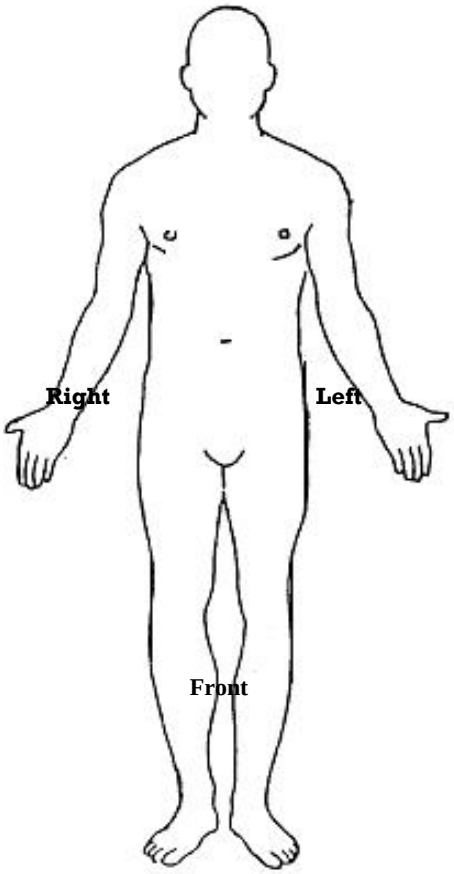
Please describe how the injury occurred and any immediate treatment received:

_____
_____
_____
_____
_____
_____
_____

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.



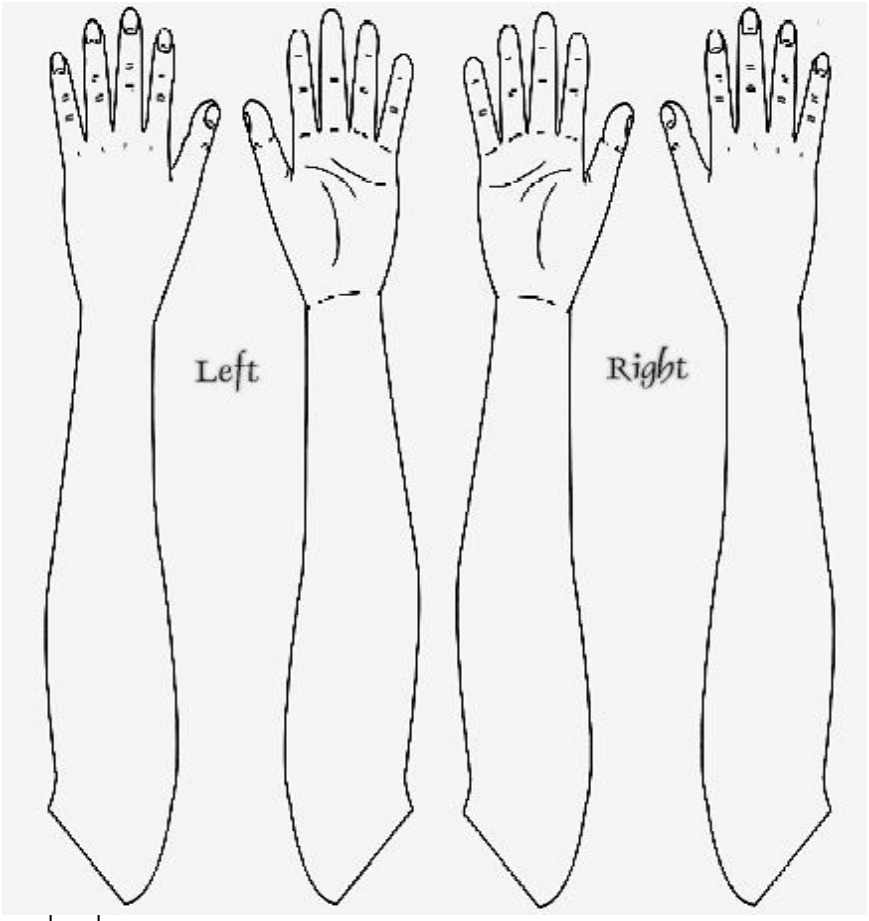
Numbness
•••••

Pins & needles
ooooo

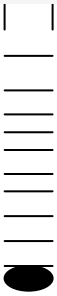
Burning
xxxxx

Stabbing
/////

Ache
^^^^^



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



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

1 (I have no pain at all.)

Chief/Primary Complaint (Cont.)

☐ "I don't know how it began" ☐ Recent injury/trauma
☐ No, I never had this before this work injury.

☐ It is recurrent – it comes and goes
☐ Yes, I have had similar symptoms in the past:_____
_____

☐ Are your symptoms: ☐ Constant? ☐ Intermittent? ☐ How often/day_____
☐ How long do your episodes last?_____
☐ Do you have weakness in the hand/arm?_____
☐ Difficulty opening jars, bottles, etc.?
☐ Pain with writing or typing?

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

	BETTER	WORSE	NO EFFECT	PLEASE RATE YOUR PAIN: USE 1-10 SCALE ("10 BEING WORST")
Heat				
Cold				
Sleeping/Night-time				
Daytime				
Sitting				
Driving				
Working with your hands				
Exercise/Activity				
Stress/Worry				

Nothing makes me feel better: ☐ True ☐ False

What decreases your symptoms?
_____
_____

What increases your symptoms?
_____
_____

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

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:				
☐ Physical Therapy/Rehabilitation				
☐ Work modifications				
☐ Braces/Splints				
☐ Cortisone 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 ☐ Neuropathy	
		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 below)			
Tonsillectomy		Carpal Tunnel Release	
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
Medications		

Review of Systems: *(Please list any additional complaints)*

I also have the following problems:

- ☐ Weakness, tingling, or numbness in the face
- ☐ Weakness of muscles in legs, ankles or feet
- ☐ Numbness (loss of feeling) in:
  - ___ arms/hands
  - ___ legs/feet
- ☐ Tremors (shakes) in the arm/leg
- ☐ 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)

Family Medical History

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			
☐ Neurologic problems		☐ Other: _____	
☐ High Blood Pressure		☐ **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

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

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

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

_____

_____

Hobbies/Interests:

☐ None ☐ Reading ☐ Computers ☐ Rodeo
☐ Sewing ☐ Knitting ☐ Painting ☐ Bowling
☐ Sports ☐ Housework ☐ Gardening ☐ Hunting
☐ Driving ☐ Woodwork ☐ Cooking ☐ Other, please list:_____

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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