CALIFORNIA SPINE CARE
SANTI RAO, M.D.

Dear Patient:
We appreciate your making an appointment. In order to obtain as comprehensive an understanding of your important problem as possible, please supply as many details as you can remember. Together, let's try to find some answers to your problem. Thank you.

PATIENT HISTORY Appointment Date: / /

Name: Last:_____First_____
Age: _____years Smoker: Yes No (please circle one)
Where is the pain problem for which you are here today? Please circle ---
Neck / Upper back / arms / middle back / lower back/legs

BACK PROBLEM:
How many years / months / weeks ago did it start? _____
What date (approximately) did your problem begin? _____/_____/_____
Please circle how you injured yourself / how the pain started
Slip / direct impact / jerk / lift / twist / fall / bend / other / car accident
Comments_____
_____

your pain began	( ) gradually	( ) suddenly	( ) from an injury
your pain is in	( ) upper back	( ) middle	( ) lower back
it has lasted	( ) weeks	( ) months	( ) years
you have pain	( ) occasionally	( ) off and on	( ) constantly
pain radiates to	( ) R leg	( ) R / L leg	( ) does not
you have tingling / numbness		( ) R / L leg	
you have muscle weakness		( ) R / L leg	

do you have accidents with your: ( ) urine ( ) stools in your underwear or in bed?
( ) yes ( ) no

your pain is (check box)

worse	no different	better with	
( )	( )	( )	coughing or sneezing
( )	( )	( )	straining at stools
( )	( )	( )	sitting straight
( )	( )	( )	sitting reclined
( )	( )	( )	bending forward
( )	( )	( )	pushing
( )	( )	( )	pulling
( )	( )	( )	lying on stomach
( )	( )	( )	lying on back
( )	( )	( )	lying on sides with bent knees
( )	( )	( )	bending
( )	( )	( )	lifting
( )	( )	( )	standing

does your back get stuck when you bend forward? ( ) yes ( ) no
does your ( ) back ( ) leg pain stop you from walking at a particular distance?
( ) yes ( ) no
at a time you can comfortably -- sit _____minutes
stand _____minutes
walk _____minutes

If you develop leg pain with walking, does leaning forward and supporting your upper body on something relieve your leg pains –
( ) yes ( ) no ( ) do not develop leg pain with walking

NECK PROBLEM: (if this applies to you)
How many years / months / weeks ago did it start? _____
What date (approximately) did your problem begin? _____/_____/_____
Please circle how you injured yourself / how the pain started
Slip / direct impact / jerk / lift / twist / fall / bend / other car accident
Comments_____
_____

Your pain began	( ) gradually	( ) suddenly	( ) from an injury
Your pain is in	( ) front of neck	( ) back of neck	( ) back and front
It has lasted	( ) weeks	( ) months	( ) years
You have pain	( ) occasionally	( ) off and on	( ) constantly
The pain radiates	( ) R arm	( ) L arm	( ) does not radiate
You have tingling / numbness		( ) R / L arm	
You have muscle weakness		( ) R / L arm	
You have	( ) headaches	( ) blurred vision	( ) changed hearing

Your pain is (check box)

Worse	no different	better with	
( )	( )	( )	coughing or sneezing
( )	( )	( )	straining at stools
( )	( )	( )	sitting straight
( )	( )	( )	sitting reclined
( )	( )	( )	standing
( )	( )	( )	sexual activity
( )	( )	( )	turning to R side
( )	( )	( )	turning to L side
( )	( )	( )	looking up
( )	( )	( )	looking down

PLEASE DESCRIBE ANY OTHER SYMPTOMS YOU ARE HAVING:
_____
_____
_____
_____
_____

TREATMENT
How long have you been treated so far? _____months_____years
You are ( ) improved ( ) no different ( ) getting worse
With whom have you had your treatment so far –

Providing source	Treatment given
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

INVESTIGATIONS PERFORMED please list the tests done

Test	approximate date	Center / Doctors office
SPINE X-RAYS	_____	_____
CT SCAN	_____	_____
MYELOGRAM	_____	_____
MRI SCAN	_____	_____

EMG NERVE TEST _____ _____
ARTHRITIS BLOOD TESTS _____ _____
OTHER TESTS _____ _____

MEDICATIONS: you currently take _____ for your (whatever) medical problem
_____ for your
_____ for your _____
_____ for your _____
_____ for your _____
_____ for your _____
_____ for your _____

ANY PAST NECK/BACK PROBLEMS ( ) Yes ( ) No ( ) different
Previous motor vehicle accidents ( ) Yes ( ) No
Previous work injuries – describe when and who treated you. ( ) Yes ( ) No

_____
_____

PAST MEDICAL HISTORY:
What serious medical problems do you suffer from? Please list any surgeries you may have had for any problem.

_____
_____
_____
_____

COUNSELING: have you had or are you having any counseling, psychological or psychiatric treatment?
From date_____ till _____ For what reason?

_____
_____
_____

JOB DESCRIPTION:
Have you had to take time off from work for this problem? ( ) yes ( ) no
Duration of time off from _____ to _____
Your job title_____
You are currently ( ) working ( ) not working ( ) unemployed
Your last day worked _____
You are on ( ) regular duty ( ) modified duty
( ) full time ( ) part time

Please see the other side

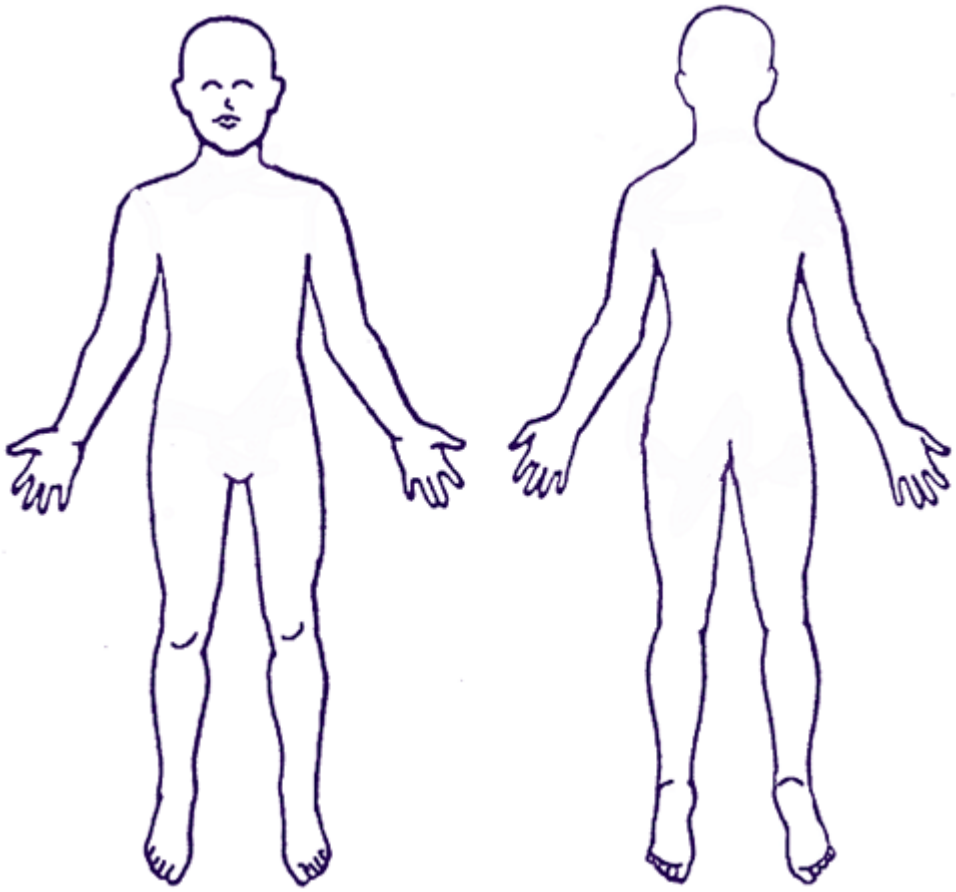
PLEASE DRAW A LINE OR MARK WHERE YOU THINK YOUR PAIN LEVEL HAS GENERALLY BEEN FOR THE LAST FEW DAYS:

NO PAIN										MINIMAL PAIN										SEVERE PAIN
0	1	2	3	4	5	6	7	8	9	10

not tolerable

Your pain is: ( ) once / few hours ( ) once / few days ( ) once / few week or two
( ) once / few weeks ( ) occasional ( ) almost constant ( ) constant

PAIN DIAGRAM:
Please draw in wherever you are feeling any of the following symptoms – use the following symbols:
PAIN (+) NUMBNESS (=) TINGLING (0) BURNING (X)



(Signature) _____