



Vivek A. Manocha M.D.  
Physiatrist and Interventional Pain Specialist  
52 Remick Blvd.  
Springboro, OH. 45066

Please carefully answer these questions so that we can help you decrease pain and increase function.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age today: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F Height: \_\_\_\_\_ Weight (lbs): \_\_\_\_\_  
Referring Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Primary Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please describe your pain and the reason for this visit in your own words in one sentence.

(e.g. "I have pain in my low back"): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long ago did you pain start? \_\_\_\_\_

Under what circumstances did the pain begin?

\_\_\_ Accident/Injury at work      \_\_\_ Accident/Injury      \_\_\_ Secondary to repetitive activity  
\_\_\_ Following Illness      \_\_\_ At work, but not an accident      \_\_\_ Motor vehicle accident  
\_\_\_ Following Surgery      \_\_\_ Pain began unrelated to activity

If accident or activity, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your pain travel anywhere? \_\_\_ Yes \_\_\_ No If yes, where? \_\_\_\_\_

Where is your pain located? (Circle all that apply)

Head	Face	Neck	Right Shoulder	Left Shoulder	Right Arm
Left Arm	Right Forearm	Left Forearm	Right Hand	Left Hand	Chest
Abdomen	L/R Groin	Mid - Back	Low Back	Right Buttock	Left Buttock
Right Thigh	Left Thigh	Right Leg	Left Leg	Right Foot	Left Foot

Other: \_\_\_\_\_

Which words describe you pain? (Circle all that apply)

Sharp	Stabbing	Aching	Throbbing	Sore	Unbearable
Tender	Dull	Constant	Intermittent	Cramping	Miserable
Burning	Deep	Radiating	Shooting	Nagging	Exhausting

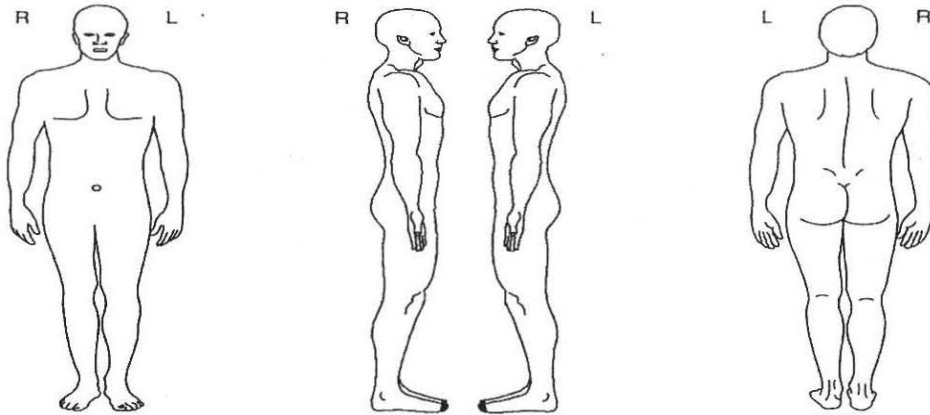
Do you have any of the following related to your pain? (Circle all that apply)

Numbness	Weakness	Dizziness	Problems with bowels related to pain	Nausea
Tingling	Pins & Needles	Headaches	Problems with bladder related to pain	

PATIENT NAME \_\_\_\_\_

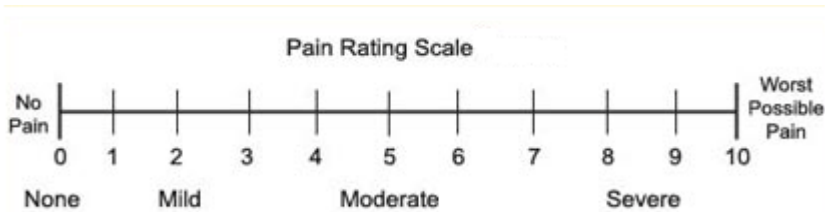
DATE \_\_\_\_\_

Please shade in the areas where you are having pain in the following pictures: (Shade areas darker for more severe pain and lighter for less severe pain).



**SLEEP DISTURBANCE?** YES / NO If Yes, whether - Interrupted, Difficulty Falling Asleep, Waking Up Early, How much sleep (In Hours) a night do you get? \_\_\_\_\_

Please mark on the scale below where your pain level is **TODAY**.



WORST Pain Level (0-10) \_\_\_\_\_ LEAST Pain Level (0-10) \_\_\_\_\_

**What makes your pain worse (circle any aggravating factors)?**

- Walking      Standing      Sitting      Bending      Lying Down      Twisting      Heat      Cold  
 Anxiety      Sneezing      Coughing      Reaching      Lifting      Climbing Stairs      Bowel Movement  
 Other (Please Describe): \_\_\_\_\_

**What makes your pain better (circle any relieving factors)?**

- Heat      Cold/Ice      Rest      Pain Medications      Certain Positions (describe) \_\_\_\_\_  
 Lying Down      Physical Therapy      Massage      Other (describe) \_\_\_\_\_

PAST TREATMENTS:

Have You Had Any of the Following Treatments in the Past?      How Much Relief Do You Obtain?

TREATMENT	YES	NO	GOOD	MODERATE	MILD	POOR	NO
NSAIDS (Motrin, Aleve, etc.)							
OPIOIDS (Percocet, Vicodin, etc.)							
Physical or Massage Therapy							
Tens /Ultrasound /Traction							
Injections (Epidurals, Trigger Point)							
Surgery							
Biofeedback / Hypnosis							
Chiropractic							



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IMAGING STUDIES: Please write the **Date** of the most recent test

MRI/CT SCAN (Spine) \_\_\_\_\_ X-Ray: \_\_\_\_\_

BONE SCAN: \_\_\_\_\_ EMG: \_\_\_\_\_

**MEDICATIONS:** Please List All medications, vitamins, herbs, nutritional supplements you take.

Name of Medication	Dosage	Time/Day	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**If You Have More Medication Please Write Them on a Separate Sheet of Paper**

IF YOU ARE TAKING ANY OF THE FOLLOWING MEDICINES, PLEASE LET US KNOW

\_\_\_ Coumadin (Warfarin)    \_\_\_ Lovenox (Enoxaparin)    \_\_\_ Aggrenox    \_\_\_ Plavix (Clopidogrel)  
\_\_\_ Innohep (Tinzaparin)    \_\_\_ NSAID    \_\_\_ Ticlid (Ticlopidine)    \_\_\_ Fragmin (Dalteparin)  
\_\_\_ Aspirin    \_\_\_ Trental (Pentoxifylline)    \_\_\_ Pletal (Cilostazol)

**ALLERGIES TO MEDICATIONS or SUBSTANCES (LATEX, X-RAY DYE, ECT.):**

Medication/ Substance	Type of Reaction
_____	_____
_____	_____
_____	_____

**LIST YOUR OTHER MEDICAL PROBLEMS (Circle):**

AIDS / HIV    Heart Trouble    Anemia    Hepatitis / Jaundice    Anxiety    High Blood Pressure  
Arthritis/Joint Pain    High Cholesterol    Asthma    Kidney Disease    Pneumonia    Blood Transfusions  
Bowel Trouble    Reflux / GERD    Cancer    Tuberculosis    Stroke    Depression  
Diabetes    Thyroid Disease    Ulcers    Heart Murmur    Chronic Lung Disease  
Other: \_\_\_\_\_

**LIST PREVIOUS SURGERIES:** \_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY:**

Are You:    \_\_\_ Single    \_\_\_ Married    \_\_\_ Widowed    \_\_\_ Divorced    \_\_\_ Separated

How many Children do you have? \_\_\_\_\_ Are they in good health? \_\_\_yes \_\_\_no

If No, Please List Major Health Problems: \_\_\_\_\_

Mother: Alive / Deceased Age: \_\_\_\_\_ Major Health Problems: \_\_\_\_\_

Father: Alive / Deceased Age: \_\_\_\_\_ Major Health Problems: \_\_\_\_\_

What would you like to be doing that you cannot do now? \_\_\_\_\_

What are your goals / expectations for coming to our office? \_\_\_\_\_



PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

## SOCIAL HISTORY

Education Level: \_\_\_\_\_ Degree: \_\_\_\_\_

Do you Smoke?  yes  no If yes, how many packs a day? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_  
If no, did you smoke previously? \_\_\_\_\_ How many years ago did you smoke? \_\_\_\_\_

Do you drink alcohol?  yes  no If yes, how much per day? \_\_\_\_\_ How long have you been drinking? \_\_\_\_\_  
If no, did you drink previously?  yes  no If yes, when did you quit? \_\_\_\_\_  
How much did you drink per day? \_\_\_\_\_ How many years did you drink? \_\_\_\_\_

Do you have a present drug addiction?  yes  no Do you have a previous one?  yes  no

Do you exercise?  yes  no If yes, what do you do? \_\_\_\_\_ How often? \_\_\_\_\_

Work Status:  Full Time  Part Time  Retired  Disability  Unemployed  Homemaker

If working, what kind of work? \_\_\_\_\_

If no, are you receiving any compensation?  yes  no

## REVIEW OF SYSTEMS

Do you have or have you ever had any problems related to the following systems? (Please Check)

### CARDIAC

Heart Disease  
 Heart Attack / MI  
 High Blood Pressure  
 Angina/Chest Pain  
 Heart Murmur  
 Pacemaker  
 Cong. Heart Failure  
 Other \_\_\_\_\_

### RESPIRATORY

Emphysema  
 Asthma  
 Cough  
 Bronchitis  
 Sleep Apnea  
 Shortness of Breath  
 COPD  
 Other \_\_\_\_\_

### NEUROLOGICAL

Headaches  
 Fainting/Dizziness  
 Seizures/Convulsions  
 Stroke/TIA  
 Head Injury  
 Balance Problems  
 Weakness/Numbness  
 Other \_\_\_\_\_

### GASTROINTESTINAL

Hernia  
 Liver Problems  
 Pancreatitis  
 Ulcers/Gastritis  
 Acid Reflux/GERD  
 Constipation  
 Diarrhea  
 Other \_\_\_\_\_

### MUSCULOSKELETAL

Arthritis  
 Muscle Pain  
 Joint Swelling or Pain  
 Joint Stiffness  
 Osteoporosis  
 Other \_\_\_\_\_

### PSYCHOLOGICAL

Anxiety  
 Depression  
 Panic Attacks  
 Mental Disorders  
 Considered Suicide  
 Other \_\_\_\_\_

### URINARY

Kidney Stones  
 Frequent Urination  
 Painful Urination  
 Blood in Urine  
 Urine Retention  
 Other \_\_\_\_\_

### IMMUNOLOGICAL

HIV / AIDS  
 TB  
 Hepatitis  
 Cancer  
 Swollen Glands  
 Other \_\_\_\_\_

### SKIN

Psoriasis  
 Open Sores  
 Skin Cancer  
 Skin Rash  
 Other \_\_\_\_\_

### HEAD / NECK

Eye Glasses  
 Glaucoma  
 Double Vision  
 Persistent Stiff Neck  
 Other \_\_\_\_\_

### ENDOCRINE

Diabetes  
 Thyroid Problems  
 Cortisone Replacement  
 Pituitary Problems  
 Other \_\_\_\_\_

### HEMATOLOGIC

Anemia  
 Blood Clots  
 Easy Bruising  
 Bleeding Problems  
 Other \_\_\_\_\_

## CONSTITUTIONAL

Fever  Chills  Weight Change – Lost/Gained – how much? \_\_\_\_\_ In how long? \_\_\_\_\_  
 Difficulty Sleeping  Other \_\_\_\_\_

Physician Use Only: (Notes/Comments): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_